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"Segregated Spaces" Colonial mental health and associated health practices in Rhodesia 1890-1980

Tinashe Chikafa,[a] Walter O. Mangezi,[b] Khameer Kidia[c]

[a] Kyrptos Solutions, Zimbabwe

[b] University of Zimbabwe, Zimbabwe

[c] Havard Medical School, USA

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ABSTRACT

Colonialism in Africa left a dark space more than what it had sought to extinguish from the continent, especially in Southern Rhodesia. Colonial practices of segregation were the most gruesome and most inhumane practices Africans were ever subjected to by such systems of governance. Of interest was how segregation perfected the art of subalternity and relegated Africans to the lowest rung of society and dependence on the European system and not their own. Looking from a post-colonial lens, the paper traces how medical institutions became a battle ground for proving master-servant relationships between African and European. Such a proving ground was clear in colonial psychiatry as it became a systematic tool which colonised the mind of an already vanquished and abused people through inhuman practices and treatment. The paper explores the institution of psychiatry practice and how it perfected colonial political administrative ambitions of servitude of Africans through denigration of African principles of healing, the person, beliefs, and healing systems. It utilises the subalternity principle to analyse the systems of European segregative practices and how they undermined the African through segregated practices and how these in turn affected indigenous medical and psychiatric beliefs Africans had in their own systems, in turn illustrating resistance of the newly adopted systems through the institution, healing, spirituality and the individual.

KEYWORDS: Colonialism, Segregation, Mental Health, Southern Rhodesia, Africans

CONTACT: Tinashe Chikafa tonychiks@outlook.com

Introduction

Segregation was the key hallmark of subalternity in most colonial states, especially those under British rule in Africa in the 1900's. Colonialism sought to subjugate the colonised in every facet including that of the mind (Ngugi, 1981). In Fannon's words, colonialism was not limited to the economic and political spheres alone, but also to the "psych" of the colonised. With Rhodesia, this transcended beyond the psych to the individual, institution and even spirituality (Fanon, 1994). British colonialism subjugated the African population in order to remain in control using political and economic means by limiting their economic competition and independence through the introduction of capitalist agriculture which necessitated the alienation of arable land from Africans, left families without father figures and created a mental burden for women too, as they assumed dual roles in the absence of the husband, leading to social distress (Weinrich, 1979).

Of interest, however, is how colonialism was able to subaltern the population of Southern Rhodesia through other means including medicine, especially through the provision of mental health services. (Jackson 2006) highlights that psychiatry as a practice was used as a conduit by the settler regime in order to ensure domination of the colonised and place them in a position of subalternity via imported social norms and values ensuring that non-conformity to such systems of 'socialisation' was seen as rebellion by the coloniser than liberation for the colonised (Jackson, 2006). To that end, utilising the subaltern theoretical concept as put forth by Fanon, this paper examines Western psychiatric practices and how they subjugated African culture and perceptions of mental health to second class citizenship and civilisation. It further elaborates that psychiatric practices and health service provision in the colony were joined at the hip with political motive, in order to destroy any belief and trust in indigenous medical practices, thus, ensuring a complete erasure of any innovation and identity in a now colonially established, the 'civilised society'.

The legacy of subalternity and segregation in psychiatry in colonial Rhodesia continues to be felt in contemporary times as African patients in formerly Southern Rhodesia, now Zimbabwe, and other parts of Southern Africa are still more likely to be diagnosed with schizophrenia and other severe mental illnesses than patients of European descent who did not suffer the impact of racial segregation (Antić, 2021). This paper is part of a growing movement to address the legacy of subalternity and segregation in psychiatry in Southern

Africa. Such a movement calls for the decolonisation of psychiatry, the provision of culturally appropriate treatment, and the end to human rights abuses against African patients, mistreatment which Africans got at the hands of European colonialism. Segregation, a deeply ingrained part of the history of many nations, had varying levels of impact on different aspects of individual and societal life. A perspective frequently overlooked is its effect on medical practice. A prominent illustration of this circumstance is the treatment of African psychiatric patients in Southern Rhodesia (present-day Zimbabwe) during the colonial era.

Medicine and Subalternity

The advent of subaltern studies has given post-colonial scholarship a voice to air out once 'taboo' issues which transpired under the colonial stewardship of African states. The subaltern theory (ST) locates segregation, which took place between Africans and Europeans seeking not only health services but mental health services specifically. The subaltern theory relates to epistemology focusing on the exclusion of African citizens from colonial service provision, and the link between the state, and medicine, in suppressing rights and culture of the colonised (Jambhulkar & Joshi, 2022). Subalternity can further refer to the social, political, and cultural marginalisation experienced by oppressed groups. In this context, African traditional healing practices were often relegated to a subaltern position due to the colonial administration's preference for Western medical approaches (Chavhunduka, 1977). However, despite these challenges, African communities continued to rely on their traditional healing methods, which were deeply rooted in spirituality, community support, and indigenous knowledge.

Such practices were not limited to Southern Rhodesia but also across societies which fell under British control, including Kenya, and India which had a robust indigenous health service practice before the advent of colonialism. Subalternity in this context, therefore, relates to the concept of post-colonial literature which seeks to emphasise how imperialism employed ruthless measures to marginalise and silence the 'native', people (Jambhulkar and Joshi, 2022). As such, before the onset of colonialism, a public healthcare system that was egalitarian existed in Zimbabwean society administered by professionals who underwent apprenticeship from a tender age with an experienced herbalist, dispenser, traditional healer, or spirit medium. However, with the annexation of the country by the British South Africa Company (BSAC) on 12 September

1890, this robust medical service was bound to suffer due to the segregated civilisation mission the new administration was promoting (Ncube, 2012).

Health Services in Rhodesia

Health is one of the most important needs in a human's life, as such, in Africa before colonial conquest, a public health system that was egalitarian existed which was administered by professionals who underwent apprenticeship from a tender age with an experienced herbalist, dispenser, traditional healer or spirit medium. However, with the annexation of the country by the British South Africa Company (BSAC) on 12 September 1890, this robust medical service floundered due to the civilisation mission the new administration was promoting(Ncube 2012). The colonial administration embarked on a conquest to promote Western culture together with medicine and health services whilst second rating and undermining the African Traditional Health delivery system through a so called "civilisation crusade". Resultantly, Africans were not fully catered for in the new health delivery system at first, inclusive of mental health service provision. On integration, the service was segregated and never equated to the services the European population enjoyed in Rhodesia. Instead of granting equal access to all, the state enacted various instruments of segregation laws which marginalised Africans from accessing basic goods and services like land and an efficient and standard health service.(Rhodesian Government 1930). As such, it is imperative to elaborate how health systems fulfilled the political subjugation of the colonised through health service provision.

The onset of segregative legislation in Southern Rhodesia gave impetus for the extension of such a practice to seep into medical health services as well and the subalternity of the African in colonial Zimbabwe. Colonialism subdued the powerbase of the colonised with specific regard to their beliefs and healing systems which had existed since time immemorial. The witchdoctor thesis which resulted in the destruction of African culture was one such practice colonialism utilised in order to psychologically subjugate the colonised since one's beliefs guided conformity or non-conformity to social order. The consultation of traditional healers in society was a common, if not cultural practice, to which the Africans could not function without, these multi-purpose practitioners represented a divine as well as medical function to society. They connected the society with health and spirituality, and therefore, provided function to a society which despite its own tiers, was egalitarian when it came to accessing its services. Due to colonialism and its legal systems, however, the imposition

of Western culture and practices led to the subalternity of African traditions and systems through exclusion, including those of healthcare provision too under the Witchcraft Suppression Act of 1899 (Mavheko, 2015). Which outlawed the use of the traditional medical systems in favour of the segregated Western health provision service. In turn leading to a loss of self-worth and identity of the African which to in some instances led to mental illness and untold suffering for men and women alike. With women bearing the brunt more as such social systems did not allow them access to Western medical facilities as their movement from rural areas had been curtailed by "pass laws" enacted to control the movement of people from now classified "rural areas" to urban ones, save for those employed there(Weinrich, 1979).

Unlike the Western mode of medicine, which segregated treatment methods according to colour, the African system treated royalty and peasant alike, no one was relegated to a position of inferiority regardless of class or ethnicity. Hence, if the African spiritual power base was destroyed which Africans identified as not only a healing system but a source of identity and social cohesion, the colonial one would then take precedence and lead to conformity and order on the basis of the coloniser. In that regard, psychiatry became a proving ground for subalternity which Fanon highlighted as intricately linked to the political and social conditions of colonialism thereby undermining the colonised persons' sense of identity, culture and traditions (Fanon, 1994).

Rhodesia's segregation policies had their roots in the colonial era when the British South Africa Company (BSAC) colonised the region in the 1890s. The BSAC established a system of governance in which Europeans were given preferential treatment and access to resources, while Africans were relegated to the status of second-class citizens. Such a policy led to many effects on the socio-cultural and economic way of life Africans had and also affected the way their health delivery system functioned as their cultural practices were denigrated through lawfare, which was the adoption of legal instruments designed to enforce Western civilisation at the cost of indigenous culture and practices whilst also relegating them to a position of subalternity. With regards to medical treatment, hospitals were segregated across racial lines with Africans getting less attention, and comfort when it came to treatment, hospital comfort and infrastructure as compared to European patients. Such a practice transcended down to include even the physical space which included the arable land the Europeans used, housing and amenities which were far better than conditions and services which were granted to Africans within the

same geographic and economic context. This system was perpetuated by the government of Rhodesia (GoR), which came to power in 1923, and instituted a series of discriminatory laws and policies that reinforced racial segregation. For example, the Land Apportionment Act of 1930 divided the country into separate areas for Europeans and Africans, with the majority of the land being reserved for European settlement. Mutiti, further highlighted that the Land Apportionment Act was the genesis of segregation and the second rating of the African as the law prohibited the simultaneous residence of African and European on the same space, be it the house, hospital, or mortuary (Mutiti, 1974). Segregation and subalternity therefore did not exist in life alone, but even extended to the afterlife.

Such a policy of segregation was further reinforced by the enactment of the Native Land Husbandry Act of 1951, which restricted African farmers' access to land and forced them to pay high rents to European landlords. These policies were underpinned by a belief in European supremacy and a determination to maintain European control over the country's resources, culture, and medicine alike. As historian Carol Summers noted that, Rhodesia's segregation policies were grounded in a deeply ingrained sense of racial superiority, which was used to justify the exclusion of Africans (blacks) from political and economic power, thus, relegating them to second class citizens in their own space (Summers, 1994). As Africans were subjected to medical practices and standards which were not at par with regards to what Europeans had when they fell sick or needed routine medical treatment. Regarding mental health issues and general treatment, (McCulloch 1995) illustrated that there existed significant differences which lay between African and European not only in the socio-cultural spectrum, but even in medicine, regardless of it being a sympathetic practice meant to save lives. Yet, in Southern Rhodesia, subalternity transcended even in the art of healing. McCulloth further highlighted that Europeans had a better hospital diet over the African who had “second-grade meal, coffee, sugar and vegetables” (p.15) as opposed to those which Europeans had whilst being treated in hospital. Europeans further paid, little to nothing, for admission to the institutions which catered for mental illness such as Ingutsheni in present day Bulawayo, whereas the colonised and oppressed African exploited of his labour, stripped of his political independence, and taxed had to pay for admission. In turn only to receive second class service with meals being second rated and illustrating the subalternity of the African patient over the European. Overall, Rhodesia's segregation policies were a product of the country's colonial past,

and a reflection of the European minority's determination to maintain its grip on power and resources at all costs, even if it meant extending it to the art of healing and saving lives.

The racial segregation policies instituted by the colonial government in the then Southern Rhodesia had profound, and far-reaching implications on the overall health system, engendering significant differences in the quality of medical service experienced by Africans and Europeans. Psychiatric care, commonly neglected, was significantly impacted by such policies as illustrated in McCulloth's work where he highlighted that the state focused on financing the eradication and continuous control of disease outbreaks including dysentery, malaria and typhoid which made settling in the colony more attractive to foreign investors and visitors, rather than "providing funds for the mad(McCulloch 1995). Leading African psychiatric patients to be further marginalised, failed by an under-resourced, under-staffed, and culturally insensitive health system which accentuated their pre-existing social vulnerabilities. With segregation strictly instituted, the Europeans had access to more advanced mental health facilities with better-trained personnel, translating to more effective treatment. Conversely, the African population primarily relied on poorly funded and resourced mental health institutions. Misdiagnosis was rife due to the cultural gap that impeded proper understanding and interpretation of psychiatric symptoms due to the language barrier which existed between the patient and consulting physician, leading to the prescription of wrong treatment at times, a point which Jackson also highlighted in her work on psychiatry in Rhodesia(Jackson 2006). Illustrating that doctors who did not have a cultural and historical understanding of local places and customs often misdiagnosed patients who would respond to their queries using local knowledge, as was the case of a local woman, Winnie who had identified the asylum with a different name to what the doctor knew (p.24). As a result, traditional African concepts of mental illness, often attributed to spiritual causes, were overlooked, leading to alienation and mistreatment of many patients.

Segregative practices beyond 'Southern Rhodesia' illustrate how medicine and psychiatry became a contested space to enforce subalternity of the African or Indian in the case of the 'Orient'. The orient in this instance refers to the context of British occupied Asian territories where the British system of government sought to convert local populations to their civilisation. This is indicated in the way the colonial government placed at first, little emphasis on African mental health and later invested in it to enforce Western ways of life. As such,

colonial psychiatry presents itself as a viewing glass of how society was at such a time, to emphasise this point, in the British West African colony of the Gold Coast (now Ghana). Mental health appeared in the colonial administration's annual reports under the prisons title (McCulloch, 1995). Such classification of the 'mentally insane' and treatment appearing under such a clause illustrates how mental health of Africans was considered a social misdemeanour and unacceptable to the European civilised mission. The intersection of colonialism, segregation, and mental health treatment had a profound impact on the lives of Black Rhodesians.

The history of colonial mental health treatment practice in Rhodesia is a complex and multifaceted topic that requires a nuanced understanding of the historical context in which it emerged from. McCulloch (1995) argued that the colonial government in Rhodesia implemented a range of psychiatric interventions in the late 19th and early 20th centuries in response to the perceived threat posed by the African population. As part of this process, the colonial authorities established psychiatric hospitals and clinics, with the intention to confine those deemed to be suffering from mental illness. In the same context, McCulloch notes that these institutions were used as a means of exerting control over the wider population, particularly during periods of political unrest (McCulloch, 1995). In addition, the colonial authorities also used psychiatric diagnosis as a means of justifying racial segregation and discrimination, with African people often being diagnosed as 'mentally deficient' or 'moral degenerates' to justify their exclusion from political and economic power. This is substantiated by the way suffrage rights were observed under the system, though not related to psychiatric treatment of Africans, suffrage rights hold a key towards understanding subalternity and segregation of health services in Rhodesia. The same way in which Africans were restricted to voting to attain political independence, restrictions to subjugate the African existed along health services too. Treatment was subjected according to race than illness and given a colour.

The person, treatment and practice

Segregation policies had a significant impact on the mental health of Africans in the then Southern Rhodesia. Such policies, enforced in Rhodesia and elsewhere, led to the formation of separate communities, which caused a sense of isolation and inferiority among Africans (Youe, 2002). The policies were crafted in a hegemonic way which led to dominance of the European minority, over an African majority by population, excluding Africans from equitable

access to education, healthcare, and other economic, and social services. This exclusion led to a sense of hopelessness, and despair, among Africans, which had a detrimental effect on their mental health. Moreso, the constant threat of violence and discrimination against Africans led to an elevated level of anxiety and stress. Some Africans developed symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD) as a result of the segregation policies and violence unleashed on the populace during the violent political and military demonstrations Africans later launched on the settler political administration. The strict segregation policy instituted by the colonial government also painted a clear picture of the hierarchical system that existed within the medical field. Much of the well-trained medical staff and infrastructure were concentrated in European institutions, contributing to a high-quality service unmatched in their African counterparts.

The medical practice, as it related to the treatment of psychiatric patients, was dominated by the Western biomedical model, overlooking the culturally specific, traditional practices prevalent among the Africans. Furthermore, mental health was given low priority, with the focus on controlling and preventing infectious diseases in the African population instead. This lack of attention to psychiatric care owed itself not just to racial biases but also to the severe shortage of medical professionals trained in psychiatric care as the Witchcraft Suppression Act had outlawed traditional healers who could diagnose and treat Africans from mental illness(Mavheko 2015). With African mental illnesses, there was a general belief that it was interconnected with the spiritual world, as such, Western medicine was believed to be inadequate to treat it. Unlike the Western model of medicine, "Traditional medicine" had a dual effect which served the spiritual and physical spheres, in the pre-colonial setting, medicine and religion could not thus be separated. Since particular ailments were diagnosed as being attributed to religious undertones, it was difficult for western medicine to completely diagnose and treat ailments suffered by Africans especially those related to mental sicknesses(Cleetus 2007). In order to fulfil the subjugation and subalternity of African society via medicine, legislative means were initiated by the colonial administration through a system of segregation and later legislative instruments outlawing the practice of traditional medical practices. Such actions fervently reconfigured the therapeutic landscape of local medicine as colonialism regarded it as witchcraft instead of a normal medical practice. Instead of granting access to all, the state enacted various instruments of segregative laws which marginalised Africans from accessing basic goods

and services like land and an efficient and standard health service(Rhodesian Government 1930). Moreso, in terms of manpower, the formal Rhodesian health services was understaffed prior to employing Africans to boost manpower as well as expanding primary and mental health services to the African too(Gear 1960).

Despite being displaced by the Native Land Husbandry Act, the African sought to find income by other means, and it meant looking for employment either in industry, agriculture, and other facets of the economy. However, this did not improve the status of Africans as the systems were segregated regardless of how one was good at their job; the way for upward mobility was null as segregation bottle-necked the system to accept just a few Africans into positions of status and authority over Europeans. The reality not only highlighted segregation as a practice of Western culture but also as a weapon used on the political battlefield for proving European capacity, and authority over the African and in Rhodesian society. In the same vein, the mental burden of the African grew as one was forced to work in a foreign environment away from their family; they contributed more to the national gross domestic product (GDP) output as the major labour provider, yet no equal remuneration was given to Africans (Weinrich 1979). Such a scenario led many to suffer from mental illnesses which included anxiety especially in women who experienced social isolation and psychological distress resulting from their husbands leaving behind families in the hands of women who had limited social mobility due to existing gender relational dynamics(Weinrich 1979, p.16-17). The same point is further highlighted by Sutcliffe who noted that during the Unilateral Declaration of Independence (UDI) in 1965 by the Rhodesian Front led government, the share of wages rose for both African and European wage earners. However, this pay raise favoured the European more than the colonised African (Sutcliffe, 1971). As such, many Africans were left distraught as their labour in mines, farms and industry endured the most of work, yet the remuneration was very little when compared to European peers, nor was their status as equal contributors to national GDP rewarded by relaxation of certain legal restraints which curtailed African upward mobility. A result which left many with psychiatric issues such as depression and anxiety leading to incarceration at asylums as mental inmates.

Under the colonial regime, segregationist policies restricted access to quality healthcare for Africans in Southern Rhodesia. The discriminatory practices prevalent in healthcare institutions meant that African mental health patients were often deprived of basic services, such as psychiatric treatment facilities

and specialised medical personnel. This limited access led to a lack of proper diagnosis, treatment, and support for mental health issues within African communities. Despite the dominance of Western medicine, Southern Rhodesian Africans continued to hold onto their cultural identity and beliefs, valuing the healing practices that had been passed down through generations. With community elders and traditional healers playing a crucial role in providing mental health support, which often addressed a range of psychological ailments through rituals, dances, storytelling, and herbal remedies. These practices were aimed not only at individual healing but also at restoring social harmony and balance within the community.

Imperialism advocated for civilisation which abhorred the aforementioned. As a result, such local practices of religion, social and medical practices were reframed as backward, in the hope that they would ensure pluralism of Western medical practices. To ensure total compliance, colonial authorities utilised legal instruments to expedite the civilisation mission. To that end, looking at the Indian context and several British colonial spaces such as Southern Rhodesia, traditional medicine and associated practices were labelled as 'indigenous medicine' which was not only derogatory but also subjugating the practice to an inferior medical system (Cleetus, 2007). The attack on the culture aspect had a huge blow back on the social system as medicine was a dual system which not only dealt with ailments but was conjoined with spirituality. Such is elaborated by Jackson (2006) who highlighted how colonialism sought to denigrate the social order of the day in a bid to evoke 'discontent' which could then be masked as mental illness and needing isolation in asylums. Jackson highlights how British systems transposed African spaces of social value into spaces of power for them to highlight subjugation of the African. This was illustrated by the site of the Ingutsheni mental hospital which was built on the same space where the Ingubo regiment, a royal 'queens guard' was based, and charged with protecting Lobengula's wives before colonialism. Termed 'Ngobeni' meaning 'covered up space of importance,' the space once a refuge of the elite became a space of cover for placing those who were deemed a threat and nuisance to Western civilisation. This was to be a place where the mentally ill were once integrated into normal society, and colonialism sought to pluck them out and banish them to a place of no return, where humanism was dissolved, and treatment was non-humane and segregation rife.

Through segregative practices, the colonial system in Rhodesia sought to also further undermine the social fabric which held the African's pride in a bid to

enforce subservience among the African population. This was done through dismantling traditional social structures and the stigmatisation of Indigenous spiritual and cultural practices as well as spaces. The European political systems ability to pinpoint spaces of African cultural importance prior to colonialism and using them for institutions of their own social enforcement was a final nail to the coffin for African dignity and a sign of African subjugation to European social norms. To that end, the Ingutsheni mental institute was used not only as an institution to treat and house those classified as mentally ill by European medical practitioners, but also as a tool to enforce subalternity of the African people as its location was the exact location of the former King Lobengula's wives' residence. Their ability to turn such a culturally significant space as aforementioned which used to house and protect the royal family of the Ndebele away from their subjects or enemies prior to colonisation. Into a space for confining the mentally ill was not only derogatory, but also a clear move designed to subaltern African culture and history by condemning the memory of the space from being a space of cultural significance to the Ndebele to that of an asylum for the mentally ill.

Such is the case which Jackson (2006) further highlighted with regards to the treatment of black inmates in the late 1950's, citing how conditions between European and African were severely apart to indicate social order disparities. Jackson (2006) highlighted how Africans became subjected to Electro-convulsant therapy (ECT) in that era without the administration of general anaesthesia whilst their colonisers got anaesthesia (p.175). African labour consisted of farm labour which the Europeans considered an occupation for Africans and thus, "Kaffir work" fit for Africans and not Europeans (Jackson, 2006, p. 5).

The place of psychiatry and psychology discourse became a contested space where it was interpreted according to European values of incarceration over inclusion as in the context of African medical standards. Such a monologue of reason as elaborated earlier was that it was considered as the only voice since it had political and moral authority and hence could dictate what was 'madness and not. Such, perhaps, could be illustrated by how the concept of 'madness' was arrived at and treated, unlike the concept of mental health which the Shona took as '*mhengeramumba*' denoting someone suffering from delusions, and finding treatment, whilst still being included in open society and accepted as

such. Laclau and Mouffe (2014) elaborated that social order in colonial society was created to ensure hegemony and subjugation of other social classes by a dominant one this extended to determining what was deemed as psychiatric and not. Such scenarios become contested and has created an environment of social struggles exposed as deviance, in essence providing the 'indocile nature' which needed to be tamed to fit into the social background of colonial authority of psychiatric healthcare.

Spirituality

African patients were often forced to abandon their traditional beliefs and practices in favour of European culture and psychiatry through denigratory legislative pieces meant to coerce them to a new civilisation. Legislative pieces such as the Witchcraft Suppression Act of 1899, a law which was amongst the first discriminatory ones passed by the colonial government in a bid to strangle African ingenuity and reliability of African medicine sought to demean the impact traditional medicine had on general medicine and psychiatry in favour of Western biomedicine. Crawford illustrated that:

> *Amongst the Shona, medicine is used not only to cure disorder of the body but to achieve almost any end that requires for its success control over forces which would otherwise be uncontrollable. Medicines are used to protect one against witchcraft; to pass examinations, to win the love of an unwilling woman; to see in the dark; to grow crops successfully; to dispel Ngozi or raise it; to cure a witch; and for many other purposes (Crawford, 1957 p. 103)*

Such acts instead of bringing better, in reality brought more harm on the African as these practices led to feelings of alienation and disconnection of Africans from their culture and community. As medicine in African culture, inclusive of psychiatry had a spiritual connotation, unlike the European one which had none save for therapeutic means alone. Despite the dominance of European medicine, Africans in Southern Rhodesia continued to hold onto their cultural identity and beliefs, valuing the healing practices that had been passed down from one generation through to the other. Community elders and traditional healers played a crucial role in providing mental health support, often addressing a range of psychological ailments through rituals, dances, storytelling, and herbal remedies. These practices aimed not only at individual healing but also at restoring social harmony and balance within the community.

Recovery

African patients were often denied access to the same treatment options as European patients. This could make it more difficult for them to recover from their mental health problems. The African healing process during this era was heavily influenced by belief systems, cultural traditions, and indigenous knowledge. In contrast to the European biomedical approach, healing was a communal process, encompassing spiritual, social, and physical dimensions. Traditional healing practices were prevalent and deeply ingrained within the African population; however, these were largely dismissed and discredited by the colonial healthcare system, exacerbating the disconnection between the patients and their providers. The disparity in therapeutic practices and the dismissal of indigenous healing processes resulted in a multilayered failure in the treatment of African psychiatric patients. The medical model of diagnosis hardly recognised the value of traditional healing methodologies, further amplifying the mistrust and creating not only a healthcare divide but a sociocultural one as well. Regardless of this, African communities in Southern Rhodesia exhibited resilience, and determination, in maintaining their healing customs despite facing systemic discrimination. Traditional healers, often given the derogatory label of witch doctors, laboured to dispel the negative stereotypes while incorporating aspects of Western treatments into their practices. In doing so, they attempted to bridge the gap between cultural traditions and the emerging medical advancements of the colonial era. This adaptive approach demonstrated a form of resistance and a desire to preserve African healing practices.

Segregation largely affected the process of healing as it sought to destroy the cultural belief systems of the African in a bid to subaltern the being and disease too. The imposition of Western medical practices on a people already socially undermined and whose principles clashed with traditionally and socially approved recovery mechanisms proved more harmful than good to the African(Stilson 2019). The inability of the colonial systems of medicine to consider cultural understanding of disease led them on a mission to become, "bio-prospectors" whose goal was never to heal but rather collect specimens on

Africans and claim to discover new diseases and cures which African medical systems already had "traditional remedies" which were both therapeutic and curative (p.31). The capture of medicine to become a "segregated space" meant to denigrate the African and his system of healing is further exposed through Crawford's work who highlighted the schism between African and Western systems of medicine as a battlefield. Referring to his work on "witchcraft and sorcery," it is evident that the colonial health system was not only a social conformity tool but also a political one which was a hand in glove with the political administration to relegate the African as a blank slate in need of civilisation.

Looking at the process of healing regarding mental health, Crawford explored the process of healing illnesses caused by avenging spirits termed as 'Ngozi' in Shona which could cause general or mental sickness(p. 88-89). He highlighted that a person could be possessed by a Ngozi and become delirious which in Western medicine appeared as delirium and thus requiring institutionalisation in a mental asylum. Yet in Shona culture this could be averted by simply paying reparations in the form of a cow or giving off a virgin girl to the victim's family as reparation, or in some instances the ingestion of a body part of the victim along with a concoction prepared by a traditional healer and thus lead to a full recovery. However, due to the way the colonial system structured its systems of governance and health delivery systems, medical and mental health delivery had no desire to heal, rather it sought to subaltern the African person as seen by its ability to outlaw healers in African society and then further alienate and strip the African of any shred of dignity through legislation such as the Witchcraft Suppression Act and the Land Apportionment Act, key pieces of legislation which segregated the space between the African and the European (Land Apportionment Act, 1930), (Mavheko, 2015).

Conclusion

Racial segregation in Southern Rhodesia had a profound effect on the African psychiatric patient and the process of healing, highlighting the importance of cultural sensitivity in healthcare. The divide between European and African medical practices created an environment of misunderstanding, mistrust, and misdiagnosis. Recognising and appreciating the role of cultural traditions in psychiatric care is critical for a comprehensive approach to mental health, as seen in the case of Southern Rhodesia and its legacy. The colonial administration promoted Western medicine and health services which denigrated the African traditional health delivery system in a so called 'civilisation crusade'. At first, Africans were not fully catered for in the health delivery system, including mental health services.

On integration, the service was segregated and never equated to the services the European population enjoyed in Rhodesia. This was done in order to illustrate the dominance of European over the African, regardless of the fact that medicine was the art of healing and sympathy and knew no colour or social standing save for healing. Instead of granting equal access to all, the state enacted various instruments of segregative laws which marginalised Africans from accessing basic goods and services like land and an efficient and standard health service (Land Apportionment Act, 1930). To that effect, medicine especially psychiatry became a battleground between African beliefs and the process of healing, versus conformity to European systems of civilisation, dominion and social setup.

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