

**GENDERED DISORDER IN COLONIAL ZIMBABWE:
CASE ANALYSES OF AFRICAN FEMALE INMATES
AT THE INGUTSHENI MENTAL HOSPITAL, 1932 to 1957**

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What did it mean to be mad in colonial Africa? To answer this question, one must determine: 1) the nature of that colonial context, 2) the "normal" within that context, and 3) if or how notions of normality mediated and were mediated by various social and economic forces within society.

This paper is a portion of the fourth chapter of my dissertation on gender and the disorder of madness. I have chosen, in this instance, to focus on the particular experience of African women, most if not all of whom were poor and rural. Their experiences were both different and the same as those of white women, black men and white men. This paper is primarily about differences. However, its goal is to contribute towards the identification of the boundaries, and boundaries within boundaries, of a colonial society as experienced by various social groups within that society. The goal of this exercise is to discern patterns in the incarceration of African women in the Ingutsheni Mental Hospital of colonial Zimbabwe (Southern Rhodesia). By identifying patterns and critiquing discussions within colonial psychiatry and the various administrative branches, I seek to explore the gendered aspects of madness as seen by the colonial psychiatrist, Native Commissioner, constable, as well as the indigenous brother, mother, husband or wife.

This exploration of colonial psychiatric discourse belongs to the larger discourse of medicine and power. Indeed, the focus here is really the medicalization of power, which, in this context, refers to the increasing dominance of a medical framework in the policing of social boundaries. This is a constituent element of the phenomenon of medical power described so accurately by Lipsedge and Littlewood, who wrote:

Relations between black people and white medicine have been the most characteristic of the association between science and social control. [1]

Along with the policing of social boundaries, medical power, particularly biomedical power, reified itself. Michael Gelfand, the most prolific medical writer of Southern Rhodesia, provides many examples of this phenomenon in his numerous works but perhaps most particularly in his book, *The Sick African*. The African was to be gazed upon, to be studied and mastered, like a sport or foreign language; one became proficient in the African mind and the African body. [2] Frantz Fanon put it this way: "The doctor rather quickly gave up the hope of obtaining information from the colonized patient and fell back on the clinical examination, thinking that the body would be more eloquent." [3]

Others did not confine their analysis to the physical, but turned also to the culture of "the sick African" and pathologized that as well. Thus B J F Laubscher, in his influential book, *Sex, Custom and Psychopathology*, referred to the interaction of the African cultural heritage of psychotic manifestations, arguing that "the native determines his perceptions according to mythological beliefs and [this] determines in the main the nature of his delusional content". It did not follow, however, that this relativity should preclude the application of white, male and middle-class concepts of normalcy or definitions of delusions upon the African. On the contrary, it was to justify and perhaps even extend the power of the European psychiatrist and his labels. Laubscher distinguished between the "particular irrational and the general

irrational" (witchcraft and other African beliefs) and argued that the *isangoma* and *isanusi* were really psychotics at large. [4] Power can always rationalize itself and in the field of psychiatry in general, and colonial psychiatry in particular, this was certainly the case.

Littlewood and Lipsedge ask whether or not mental illness is merely another cultural idea like witchcraft or spirit possession, and when a belief becomes a delusion. [5] These are questions which were categorically omitted from the psychiatric discourse of Southern Rhodesia and in discussions about "the African mind" [6], illustrating what Foucault referred to as the "monologue of reason about madness". [7] This paper is largely about this monologue and the nature of its mediation with and by the issues of race/culture, class and gender, and how families and individuals attempted to break into this monologue.

I look specifically at constructions of the "mad African woman" and examine the case records of 50 African women detained at Ingutsheni between 1932 and 1957. Information derived from these files is analysed within the context of the broader discourses relating to medicine and power and the process of the medicalizing power over the lives and bodies of African women.

Madwomen in colonial Zimbabwe, as in Victorian England and much of the world of the nineteenth and twentieth centuries, were often stray women found at the crossroads with a child but no man; or found wandering in the veld. Such women created unease within colonial society, so disruptive were they to the illusion of order. Some of them were pathologized and ferried to hospital or jail, ostensibly for observation.

I identify three interrelated factors which contributed to the likelihood of a black woman's incarceration at Ingutsheni. Two of these factors were identified by Laubscher in 1937. The first contributory factor was proximity to areas of European habitation, to the European gaze. For African women, such proximity was less common than for African men in that they were not generally employed by Europeans or migrating to urban areas at the same rate as African men. This meant that their route to the mental hospital usually was, more often, mediated through family members who sent them to a hospital where they were diagnosed as mentally unstable by a nurse, or if they wandered into the veld or on to the crossroads and were spotted by British South African Police (BSAP) and taken to jail. The result, fewer African women in the insane asylums, was interpreted by Shelley and Watson in 1936 as symptomatic of and confirmation of the association of madness with increased contact with European civilization, of deculturation with psychopathology, as African women have less "intimate contact with Europeans and their minds lack the stimulation which the male mind encounters by such contact". [8]

The second contributory factor which Laubscher identified was the relationship between the behaviour of the individual and her cultural and social milieu: in other words, the degree to which that behaviour fell outside of the boundaries of acceptability, or normalcy, in indigenous society. In the case of southern and central Africa, this often involved the woman running amok, being uncontrollable, attacking others, burning down huts and/or behaving indecently towards men. My agreement with Laubscher ends here, as he makes these points to convince the reader that there were actually scores of undetected deranged Africans roaming the kraals and villages, and that the uncivilized also had their discontents, their psychopaths, disguised as *isangoma* and *isanusi* (traditional healers). [9] In Laubscher's mind, African culture was riddled with what he referred to as "the general irrational". [10]

The third major factor, and indeed the factor to be stressed here, is that of "strayness", which I define as movement beyond acceptable geographic and/or social boundaries. I argue that, during the period under analysis, this was perhaps the single most important factor contributing to the incarceration of African women. This is illustrative of the process of the medicalization of what was construed as problematic yet not criminal; stray African women fell within this category. As Megan Vaughan has stated, in order to understand the abnormal African, it was necessary for the colonial power to define the normal African. [11] In this

discussion of the contributory factors in the defining and confining of African women as mad, the question of the non-mad or the sane African woman arises, as does the question of where African women should be.

On Medicalization and Stray Women

The pathologization of women in European society who did not conform to increasingly restrictive definitions of female normalcy has received considerable attention. [12] According to Steve Humphries, prior to the 1920s, the language of sin was the dominant language adopted in the case of loose or "fallen" women. After this time, however, "sin" was increasingly overtaken by a more scientific terminology. In England this meant that local authorities were empowered, through the Mental Deficiency Act of 1913, to lock up women and girls with illegitimate children, and destitute young women, in reformatories and mental hospitals. [13] In the case of Southern Rhodesia, as in nineteenth and twentieth century Britain and North America, the "problem" of women out of control had a long history, but in the 1920s and 1930s the problem was increasingly seen as medical.

In the context of Southern Rhodesia, African women fell outside of "the right place" when they fell outside of male control (father, husband, son), were not employed in the service of Europeans or under the tutelage of missionaries. This "strayness" facilitated or was a component of the colonial perception of them as pathological. It incited fear and anxiety among European colonial administrators, town councillors and African male authorities alike, and spurred on a debate which continues to this day. Sander Gilman has referred to the process whereby the individual normally objectifies the part of the self which is uncontrollable and brings on anxiety. This functions such that the "bad" self is identified with an external object which is then pathologized. [14] While Gilman asserts that the analysis of this process of representation is a normal process of the individual and can shed light upon the way the "we" structure the universe, I would assert that this individualization of power sheds only the narrowest beams.

The analysis of social power, particularly with relation to gender and race, must be central to any such investigation. When Dr A M Fleming, the Medical Director of Southern Rhodesia, in 1929 referred to the problem of "stray women in the Municipal compounds" who were "spreading disease all over the country", he was not only venting his individual frustration and fears. [15] An analysis of the metaphor that Fleming chose reveals much about the generalized anxieties of colonial and male power. In general, the word "stray" is used when referring to pets and other domestic animals who roam beyond the fence, or whose ownership is not clear, and are menacing. The word is also used in the sense of "to go astray", to deviate morally, or, as defined in the Oxford Dictionary of Current English, 7th edition, "to wander from the right place". However Fleming used the term, it is clear that this phenomenon, this mobility of black women, invoked fear in him, as well as in his compatriots. It must be added that this mobility caused anxiety in representatives of African male authority as well.

This analysis of 50 "native female lunatics" from the patient files of Ingutsheni is, in a large sense, an analysis of the interaction between African and European/colonial perceptions of strayness in women, and the pathologization of these renegades from the dominant patriarchal order through their certification and incarceration in the colonial mental hospital.

Case Studies in Context

The context is a colonial African society run by a minority of white men, with an economy organized around the steady flow of male migrant labour to the mines, commercial farms and towns, an economy premised upon the maintenance of the rural homestead and the work of African women. African women were theoretically not wanted in the towns, at least not until

the early 1930s when there were efforts to recruit some as domestic workers. However, as the long and ineffectual debate on stray African women will attest, the desire was never to eliminate them but to control them. [16] While some of the earliest Africans to settle permanently in the towns of Southern Rhodesia were women [17], the majority of the African populations in or near European habitations were always men from either Southern Rhodesia or the neighbouring territories of Portuguese East Africa, Nyasaland or Northern Rhodesia. It was from these men, these foreign and indigenous migrant labourers, that the majority of patients at the Ingutsheni Asylum were drawn.

The entire region of British South Africa was without any special facilities for the mentally disordered before 1908, when the Ingutsheni Asylum was opened in Bulawayo, Southern Rhodesia. Prior to this time, "lunatics" were either held in jails or sent to asylums in Cape Town and the Transvaal. In 1903, the colony's Medical Director, A M Fleming, considered this state of affairs unsatisfactory and noted that there were nine such lunatics being held in jails throughout the colony. He thought that "lunatics, cases of delirium tremens, and syphilis" should be segregated from genuine criminals.

They occupy the cells to such an extent as to cause crowding of the other prisoners, and they, as well as delirium tremens cases, disturb the place with their noise, breaking the rest of the other prisoners and the warder, and largely increasing the work of the latter. [18]

If this approach did not succeed in moving the Legislative Council to action, perhaps an economic expediency argument would. Hence in 1906 Dr Fleming informed the Legislative Council of the costs involved in keeping ten European and twenty-five Africans "in the various asylums in the Cape Colony and Transvaal [and] there are three native lunatics awaiting transmission to one or other of these asylums". [19] In 1907 the Legislative Council debated on the cost efficacy of caring for their own insane at home and decided that a Lunatic Asylum would be constructed in Bulawayo to accommodate the African insane, while "Europeans, for the present at any rate, should be detained there pending certification, when they will be sent on to one of the larger asylums in the South". [20] The Ingutsheni Asylum opened in June 1908. The asylum staff consisted, like that of the prison, of a Medical Superintendent (non-resident), an Assistant Medical Director, a head keeper, two European male keepers, one European female keeper, and four African keepers (whose sex was not specified in the report) and an assistant keeper (the asylum workers' salaries were commensurate with those of prison workers). [21]

In 1908 a Lunacy Ordinance was passed by the Legislative Council allowing that a Magistrate or a constable with information "that a person wandering at large is deemed to be a lunatic" could have the alleged lunatic apprehended and "convey the alleged lunatic to a prison or hospital" and present the legal proceeding which must be followed. [22] Between the passing of this ordinance and the 1930s, very little changed in the definition, care and treatment of the mentally disordered, and Ingutsheni remained a custodial institution, with "therapy" for the black patients consisting of unpaid labour on the asylum's farm.

From 1911 on, almost annually the Medical Superintendent made the point that the conditions in the "Native female ward" were overcrowded and inadequate. [23] At this time there were only six African women detained in the asylum. By 1919 there were 23 African women detained in the asylum and the situation was described as strained, inconvenient and "attended with dangers I need not go into". [24] This state of affairs seemed to contribute to the ill health of the ward, which suffered from frequent epidemics: for instance, in 1924 almost all occupants of the Native female ward came down with chicken-pox, and in 1935 that ward was the worst affected, in terms of deaths, by the influenza epidemic of that year.

Throughout the 1930s and the 1940s the "native female ward" was described as agitated, unruly and overcrowded, and there was a steady increase of African women in the asylum

from 86 treated in 1935 to 114 treated in 1940 and 198 in 1949. [25]

Until 1933, when the colony received its first specialist "alienist", Dr Kenneth Rodger, there was no regular policy of keeping patient records. Thus, prior to this point, the reconstruction of specific patient experiences is difficult, as few, if any, files exist. One of the earliest cases that I reviewed actually came from the Chief Native Commissioner's files on "Lunatics". The woman was referred to by the name of Elizabeth, which was not her actual name. She was found with a child "near a path which leads into Portuguese territory [Mozambique]", according to the Native Commissioner (NC) of Darwin, and her identity remained unknown. [26] According to the NC of Darwin, "she is mentally affected but not noticeably so, and not to the intent that she could be certifiable as insane". This meant that, according to the Southern Rhodesian Mental Disorders Act of 1936, fashioned after the 1930 Mental Treatment Act of England and Wales, a patient could be held against her will and without certification as a "non-volitional patient" and detained for one month, after which time the case would be reviewed and the detention could be extended for an additional six months and then at three-month intervals at the request of relatives, subject to government approval. [27] This new legislation allowed for individuals like Elizabeth to be held in the asylum even though the authorities doubted her insanity. I begin with this example, for which there was no file, because it sets the stage for numerous other cases of African women. She is a stray. They did not know where she belonged, nor to whom she belonged. What they did know was that she did not belong there. As mentioned before, stray women, mobile women, were by definition a problem, and that problem - the problem that the colonial official had with them - was projected on to them. They had a problem, a sickness.

In 1937 another stray female, this time a juvenile, "Matombi Muchanyargwa", was "found stranded in the Victoria Reserve" and sent to the hospital to be kept under observation. She ran away from the hospital, was captured and returned there, and then ran away again. She was later "found alone on a road by a lorry driver and taken to the police". The Government Medical Officer (GMO) signed the necessary documents for admission to Ingutsheni and she was sent there. As she was not certified or certifiable, she was discharged from Ingutsheni and sent back to jail in Fort Victoria. In response to an enquiry, one official wrote that "her trouble seems to be that she is out of control. She is, at the moment, lodged in the goal at Fort Victoria, but as she is apparently normal, mentally, there is no satisfactory reason for keeping her there." But they did keep her there until they were able to hand her over to "some man claiming to be her father". [28]

A recurrent theme in colonial documents is the equation of single women with pathology. In the case of another African woman, "Utopis", found in 1932 "wandering" in the Sinoia, who also had to be discharged from Ingutsheni after being found not insane, the Medical Director of the colony wrote: "She may not be a lunatic, but does not appear to be normal." [29]

Along with physical "strayness", the second major category was moral "strayness" which, in the case of African women and women in general, was exhibited in the form of sexual indiscretions. In the often cited report conducted by Shelley and Watson for Nyasaland, it is noticeable that one of the few references to an African female patient diagnosed as suffering from General Paralysis and syphilis of the nervous system along with seven other Africans, all men, had her "strayness" reinforced by a very judgmental description of her symptoms. They wrote: "Degenerate both mentally and physically. Lies curled up on the floor beneath a mat. Cannot walk. Never attempts to speak. Reflexes absent. Filthy habits. Forces her hand into her vagina. History of syphilis on admission." [30]

While none of the files of African women patients at Ingutsheni are as explicit and as damaging as this, there are numerous references to "degraded" behaviour, particularly for those described as suffering from organic diseases of the brain. Sexual exhibitionism was a significant causal factor for African women being presented to the authorities on the evidence of other Africans. In the case of Sigumbugumbu, a woman in her mid-twenties who had been deserted by her husband, her brother and legal guardian, Velemtonjeni,

petitioned for her admission to Ingutsheni. In 1937 her brother complained that she "sings, dances, swears and disrobes herself in front of men; attempts to seize hold of men's private parts and roams about by herself". Her mother confirmed this observation, and added that her daughter had become insane three months previously and had not been insane before. She added that she did not know of any insanity in the family. [31] Sigumbugumbu was sent to Ingutsheni but was apparently found to have improved and was not admitted. In the following year, her brother again petitioned for her admission, this time complaining that "she roams about by herself and I am unable to control her. A supporting medical certificate was filed, stating that she "talks freely about her cattle without sense", which, he felt, was caused by syphilis. [32]

Another such case was Makalala, a woman of Xhosa origin, whose husband submitted an affidavit attesting to her insanity, in 1939. He stated that his wife had fallen mad during the month of February for the past seven years and "behaved like a person of unsound mind, chasing her children away, breaking her utensils, disrobing herself and screaming". Toma, a compound policeman at the Turk Mine in Bulawayo, filed an affidavit describing how he saw the accused one day in February 1927. She was naked, washing herself near the machinery "in view of all the European and Native employees ... It was embarrassing." [33]

Makalala was one of numerous examples of women who were found on or near mines or who had been parading in such areas and were thus initially diagnosed by mine medical examiners as insane. While her husband also agreed that she behaved abnormally, it is evident that he did not rush to have her certified. Indeed, the patient's files indicate that her really damning act was to attempt to kiss a European constable. She is also an illustration of the differential constructions and methods of treating madness. Indeed, it is likely that Makalala was treated by traditional healers before coming into sight of Europeans. She would have remained one of the undetected psychopaths, as Laubscher argued: what the European considered to be symptoms of acute psychosis and a liability, the African considered a sign of selection as a healer. Would this have been the case for Makalala had she not strayed into European view?

In 1945 Dr Rodger wrote in his annual report on Ingutsheni of the perennial problem of the Native female ward, full of "agitated" and "unruly" women. Luckily for Dr Rodger and the rest of the hospital staff, new somatic therapies and psycho-surgical techniques were introduced, facilitating the quicker turnover of patients as well as the manageability of the more troublesome types. In 1946 Dr Rodger credited the new treatments, particularly the pre-frontal leucotomy, for greatly reducing "the nursing difficulties in the native female wards". This treatment was performed on 70 patients by the end of 1947. [34] One of these patients was Zwiripi, an "alien native" woman from Nyasaland who had been diagnosed as a Chronic Schizophrenic who suffered from mania and a "confusional insanity which is probably masking a considerable degree of imbecility". She also made "constant silly attempts to escape" from the sylum. The operation succeeded in making her "less agitated and quieter than before".

By the late 1940s, Electro-Convulsant Therapy (ECT) was extensively used at the asylum, bringing "gratifying results". [35] It figured quite highly in many of the patients' "delusions" as several patients referred to boiling and wiring of heads, which is of little wonder as some patients received as much as twenty shocks per course and several courses of ECT during their history at the asylum. "Winnie", a stray African woman who was treated to a total of 20 4-minute rounds of ECT at 130 volts each, in one of her interviews with a hospital psychiatrist referred to Ingutsheni as "a place for boiling people". This, of course, for the psychiatrist, was evidence of her lack of insight.

"Winnie" was diagnosed as a schizophrenic in 1947. In 1966, after 21 years in the hospital, Dr Baker, the Medical Superintendent at that time, interviewed "Winnie" to assess if her mental condition had improved. As evidence that it had not, the doctor recorded this conversation:

- Q Where are you?
 A At Enhlanyeni but my grandfather is not here.
 Q Why did you come?
 A I followed my grandfather and my brother-in-law because the grandfather had no gramophone and wanted some beer. [36]

“Winnie”’s case is yet another example of this monologue of “reason” about madness. The doctor assessed these responses as irrelevant and proof that the patient remained disorientated and without insight, for she could not even tell him where she was. But she did tell him where she was and how she got there. The problem was he was not capable of hearing. In response to his question concerning where she was, her response was “At Enhlanyeni”, which, in isiNdebele, means the place of mad people. When asked why she came, she said that she had followed, come after, her grandfather and her brother-in-law who had wanted a gramophone and beer. This probably refers to their desire to work and thus earn the money to acquire these things.

The above cases are illustrative of the pathways to the mental hospital for African women, which did not change dramatically in the twenty years under analysis. The “monologue of reason about madness” is apparent in the case studies reviewed here. Of fifty African female cases that I reviewed, twenty-six, over one half, fell into the category of “stray”, and, of this number, six were stray in the moral sense as they behaved in an objectionable way by removing their clothes or, in three cases, by attempting to grab men’s genitals. Nine of these women were described as aliens. In terms of direct route, e.g. who were the petitioners, the vast majority were referred to the asylum by either the police or prison, or the hospital. It is difficult to distinguish between the two routes because, for this purpose, the two institutions of colonial power showed marked interdependence. In a significant minority of cases, nine, the patient was referred by a family member, a male guardian, often a brother or a son, and the central factor in these cases was uncontrollability and violence, e.g. throwing stones at people or chasing children.

What factors led to these referrals? How was madness, mad behaviour, constructed? As we see above, a woman found wandering without husband, father or son, was always suspect. If she could not provide a good reason for being thus, if she could not or would not assist the officials in returning her to her rightful place, she was incarcerated in the asylum if attempts at certification proved successful. Symptoms of madness in the African woman were most commonly presented as wandering through the veld, taking off clothes in public, resistiveness, aggressiveness, resentfulness, obstinacy and noisiness.

Christina (1944) was admitted to Ingutsheni after exhibiting this symptom, as relayed by the doctor who filled out her medical certificate: “States that she likes to roam around the country. Has no specific reason for doing this. Has no regrets about leaving her family.” Christina was diagnosed as having Confusional Psychosis, “probably of senile origin”, and was confined to Ingutsheni for the next fifteen years until she died. [37]

A patient referred to as “Annie” (1941) who, however, said her name was actually Diwene but Europeans called her Mary, was found wandering about by two policemen and was sent to the hospital in Bulawayo, where she would wander around continuously and scream at night, refuse to undress and was difficult about food. Her medical certificate stated, by way of reasons for her certification, that she was “depressed and apprehensive ... has grievance against the police for arresting her”. Once she arrived at Ingutsheni, the examining doctor diagnosed her as suffering from Depressive Psychosis with “mild persecutory delusions at the hands of the police”. The doctor prescribed a course of Cardiazol and then Electro-Convulsant Therapy when he saw no improvement. In 1942 she was diagnosed as Schizophrenic with Dementia: she was “negativistic, struggles to remain stubborn and statuesque”. In 1954, when asked by the doctor, through an interpreter, how she came to be at Ingutsheni, she answered that she was “enticed by other girls”. According to the doctor,

this made no sense. [38]

This very preliminary discussion of gender and the asylum highlights the factors which contributed to the incarceration of African women in the Ingutsheni Asylum. These factors were, in the main, either moral or physical strayness in the case of African female inmates. This complete separation of African women has its drawbacks, and in a later analysis I will include the experiences of European women, African men, and European men by way of establishing the differences in the respective pathways to the asylum and, consequently, in the nature by which gender, race and class interact with constructions of madness in colonial society. It is hoped that, in this later analysis, some headway will be made in establishing the boundaries of normalcy for the various social groups, with various relationships to power, in the colonial society.

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Notes

- 1 Roland Littlewood and Maurice Lipsedge, *Aliens and Alienists: ethnic minorities and psychiatry* (New York, 1982), p 35.
- 2 See, for example, Michael Gelfand, *The Sick African* (Cape Town, 1937, 3rd edition).
- 3 Frantz Fanon, *A Dying Colonialism* (New York, 1965), p 126.
- 4 B J F Laubscher, *Sex, Custom and Psychopathology: a study of South African pagan natives* (London, 1937).
- 5 Littlewood and Lipsedge, *Aliens and Alienists*, p 33.
- 6 Megan Vaughan points out that in 1954, in front of the Federal Parliament in Salisbury, Prime Minister Huggins recommended that everyone there read Carothers's work, for in it "they will find a description of almost every race in the world emerging from the pre-literate stage". In M Vaughan, Unpublished Manuscript, 1991, p 22.
- 7 Michel Foucault, *Madness and Civilization: a history of insanity in the age of reason* (New York, 1965), p xi.
- 8 Horace Shelley and W H Watson, "An Investigation Concerning Mental Disorder in the Nyasaland Natives", in *The Journal of Mental Science*, Vol 82 (341), 1936, pp 708 and 709.
- 9 Laubscher, *Sex, Custom and Psychopathology*, Chap 5.
- 10 *Ibid.*, p 226.
- 11 Vaughan, Unpublished Manuscript.
- 12 See, for example, Judith Walkowitz, *Prostitution and Victorian Society* (Cambridge, 1980); Frank Mort, *Dangerous Sexualities* (London, 1987); Elaine Showalter, *The Female Malady* (London, 1987); and Steve Humphries, *A Secret World of Sex* (London, 1988).

- 13 Humphries, *A Secret World of Sex*, pp 63-65.
- 14 Sander Gilman, *Difference and Pathology: stereotypes of sexuality, race and madness* (Ithaca, 1985), p 24.
- 15 National Archives of Zimbabwe (NAZ), Public Health file no S1173/221.
- 16 See Lynette A Jackson, "Stray Women on the Colonial Mind: African women and the disease metaphor in colonial Zimbabwe", presented at post-graduate seminar, Sociology Department, University of Zimbabwe, 20 August 1991. Unpublished.
- 17 Charles van Onselen, *Chibaro* (London, 1977), p 123.
- 18 *Ibid.*, p 16.
- 19 Report on the Public Health (RPH), Year ending 31 December 1906, pp 10-12.
- 20 RPH, Year ending 31 March 1907, p 12.
- 21 NAZ, T 2/29/55/1, 1921.
- 22 Ordinance No 3, 1908, sections 1-6.
- 23 Southern Rhodesia, Report on the Public Health, Year ending 31 December 1911.
- 24 Ellis in Annual Report of the Medical Superintendent, Ingutsheni Asylum, 1919, in Report on the Public Health, Year ending 31 December 1919.
- 25 Report on the Public Health 1935, 1940 and 1949.
- 26 Correspondence between NC of Darwin and CNC Salisbury, 1 July and 28 August 1938, in NAZ, S1542/L15.
- 27 Report on the Public Health, 1936.
- 28 NC Fort Victoria to CNC Salisbury, in NAZ, S1542/L15.
- 29 Medical Director to Secretary, Department of Native Affairs, 9 March 1936, in S1542/L15.
- 30 Shelley and Watson, "An Investigation", *op. cit.*, p 728.
- 31 NAZ, File no 22/Lunatics/4/38, 1938.
- 32 NAZ, 22/Lunatics/3/38.
- 33 NAZ, Lunatics S1900/13, 1938.
- 34 Report on the Public Health, 1946, p 10; and 1947, p 16.
- 35 Report on the Public Health, 1948, p 10.
- 36 Bulawayo Records Office (BRO), Box no 9/2/8R, B7693.
- 37 BRO, Box no B2027.
- 38 BRO, Box no B 2/1/1R, B1464.