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PUBLIC HEALTH AND RURAL POVERTY IN SOUTH AFRICA: "SOCIAL MEDICINE" IN THE 1940S AND 1950S[1]

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Introduction

This paper is part of a larger study on the history and contemporary practice of health and healing in southern Africa. It argues that the medical history of the era of segregation and apartheid contains important lessons for health planners today. The region's post-apartheid governments are all committed to the establishment of national health care systems that will address the needs of the impoverished millions who live precariously at or below the margin of subsistence.[2]

The delivery of health care is complicated by the existence of a variety of competing medical systems and traditions. A debate is underway among the region's health planners concerning how and how far western and non-western medicine can and should be integrated in a transformed public health service. These are not new questions, and the historical and anthropological record should be researched for relevant experience. Considerable work has been done in contemporary anthropological studies of health and healing in Africa, in the political economy literature on disease and capitalism, but many aspects of the social history of medicine have been little examined.

Even assuming that the needed funding becomes available, years or even decades will be required to deliver even basic care across the region.[3] In South Africa, a small number of pioneering health planners have been considering how to deliver effective care to impoverished communities at least from the 1930s. Zambia's Health Minister, Katele Kalumba, recently said that he wanted to replace the country's crumbling health system with one that is "...equitable, cost-effective, quality-assured, and as close to the family as possible."[4] Beginning nearly sixty years ago, an innovative group of South African medical professionals put in place the framework of such a system, which their successors after 1948 then systematically undermined and finally destroyed.

Perspectives on Medicine and Society

Partly as a result of the AIDS epidemic, there is increasing recognition among medical practitioners and social scientists of both the biomedical and the social dimension in understanding disease causation and treatment. It has been convincingly argued that an examination of how these elements affect each other should be the central focus of any study of medicine in society. Physicians no less than others are social actors and their understanding of disease and the treatment regimes that they institute both grow out of and legitimate class, race and gender interests. Equally, however, the biological element, the specific aetiology of particular diseases, constrains the choices that physicians and public health professionals make.

In several influential books and articles,[5] Charles Rosenberg has charted an approach that, while giving careful emphasis to the biological aspects, is also sensitive to the social elements. He insists that disease must be studied and understood in its full complexity as:

> ... at once a biological event, a generation-specific repertoire of verbal constructs reflecting medicine's intellectual and institutional history, an occasion of and potential legitimation for public policy, an aspect of social role and individual -- intrapsychic -- identity, a sanction for cultural values, and a structuring element in doctor and patient interactions.[6]

To contribute effectively to the debates underway concerning the future shape of the subcontinent's medical services a multi-faceted, interdisciplinary approach is needed. It must be sensitive to changing cultural norms and social forces, knowledgeable of medical science and medical history and understanding of the health issues around poverty and industrialisation.

The literature on health and disease in southern Africa is dominated by the political-economy perspective. Recent historical work on particular diseases and particular industries has laid bare the class, demographic and other forces that produced much of the poverty and illness afflicting the region today. Randall M. Packard's research on tuberculosis, malaria and pneumonia and the work of Shula Marks and Neil Andersson on typhus are key examples of the value of this approach. From a somewhat different standpoint, Howard Phillips on influenza and Elaine Katz on silicosis have also analysed the structures and institutions that shaped health and disease in South Africa.[7] Important as these studies are, they illuminate only one part of the complicated history of medicine in southern Africa. Their focus is on the structures and institutions of capitalist society in a racial order that maintained white prosperity, ensured black poverty and produced the associated health and disease outcomes in each community.

The Emergence of "Social Medicine:" South Africa in the 1940s

The contribution of historical inquiry to understanding contemporary medical dilemmas emerges strikingly through an examination of an experiment in "social medicine" that was played out in South Africa in the 1940s and 50s.[8] At that time, South Africa became a world leader in experiments designed completely to reorient the way modern medicine delivered health care to impoverished rural and urban communities. Social medicine cannot be understood simply as an emphasis on preventive rather than curative medicine -- that is a public-health concentration on proper sanitation, improved water supplies, adequate nutrition particularly for infants and school children, mass immunisation programmes and health education. It was these things but also much more.

The movement emphasised that community health was bound up with the welfare of the family and that people's physical health could not be separated from their social well being. It proposed to address both the biomedical and the social dimensions of wellness using multiracial teams of caregivers and researchers operating in community health centres. The purpose of the health centre, as it evolved, was fundamentally to empower families, to show them that good health was something that they could achieve and maintain with the assistance of the centre and to get them to take responsibility for their own physical condition. Its particular focus was on the needs of women and children. As anAnnual Report of the Department of Public Health explained: "The achievement of obvious clinical improvement by the utilisation of resources which [the people] themselves can command and without bottles of medicine [sic] will undoubtedly have far reaching and most beneficial effects...."[9]

Social medicine in South Africa challenged some of the central orthodoxies of modern medical practice. Its clinical methods de-emphasised the individual doctor-patient relationship. It opposed medical specialisation, called for social investment in disease prevention, wanted to shift funding from expensive, high-technology hospitals and proposed to integrate medical and welfare services. It urged that social

and economic research had a fundamental role in identifying the underlying causes of illness and premature death. It proposed to bring anthropologists and other social researchers into the medical team. This striking originality and radicalism were largely responsible for some remarkable early achievements but also had much to do with the ultimately fatal opposition that grew up against the movement in South Africa.

Within the government, interest in social medicine emerged from developments within Departments of Public Health (DPH) and Native Affairs (NAD) going back to the late 1920s and early 1930s. These discussions culminated in 1939 in the proposed establishment of three experimental public health centres (when the War intervened later that year the number of centres was reduced initially to one).[10] The new approach reflected an understanding of the urgent need to address the disastrous decline in the health status of communities throughout the black rural areas. In the late 1930s, the department commissioned health surveys of school children.[11] The first study, a comprehensive examination of the health status of white school children, had revealed an alarming situation. The Bantu Nutrition Survey of 1938-9 was much less comprehensive but produced evidence of an even more disastrous state of rampant illness, disability and premature death, especially in the rural areas.[12]

At the political level, attention centred on the chaotic state of the country's public-health system with financial and administrative responsibility divided confusingly among municipal, provincial and national governments. In particular the provincial hospital system had completely failed to meet the health needs particularly of rural black communities. Parliamentary concern about the spread of preventable disease created an opportunity for a better-financed and more experimental approach that the DPH began to exploit. Over the next decade a small group of innovative public-health professionals took control of policy making in what had been an under-funded, small and cautious sub-department of the Department of the Interior. Together they began to move policy in radically new directions. Secretary of Public Health E.H. Cluver (1938-40), his successors, Peter Allan (to 1946) and George Gale (1946-52) and other officials, including H.S. Gear, a Senior Assistant Health Officer (Union), were the key actors.

Their efforts were facilitated by a growing bi-partisan political consensus on the urgent need to address the health needs of both black and poor-white communities.[13] A small group of Parliamentary advocates emerged led by Dr. Harry Gluckman, who was appointed in 1942 to Chair the National Health Services Commission (NHSC) and became Minister of Health in 1945. In Malan's National Party, the health spokesman, Dr. Karl Bremer, was interested in preventive health and advocated a national health service before the war.[14] The annual debates on the DPH's budget estimates produced calls on both sides of the House for a more rational, comprehensive and better-financed health service. The political support for fundamental change should not, however, be exaggerated. Despite sharp increases in the department's annual budget vote, funding remained tight. Under both Hertzog and Smuts, there was a refusal throughout the period to accept repeated calls in parliament and in successive investigatory commissions, including the NHSC, to remove public hospitals from the jurisdiction of the provinces. In the National Party, interest in health-service reform was driven mainly by concern about illness in poor-white communities. As white poverty eased during the war and after, that concern began to wane. Nevertheless, the window that briefly opened for a more innovative approach produced some remarkable results.

The Pholela Health Centre

The first of the new clinics opened at Pholela in 1940 in the foothills of the Drakensberg of south-

western Natal. The DPH chose this site because of the poverty and disease that flourished there (the "locations" around Bulwer were thought to be some of the worst in the Union) and because it was adjacent to an area designated by the NAD for "betterment" (agricultural rehabilitation).

One aim was to facilitate cooperation between the two departments (never successfully accomplished because the NAD did not proceed with its plans), one focusing belatedly on agricultural rehabilitation in a depressed migrant community, and the other on some of the consequences of that poverty, the collapse of the health of the rural people.[15] The idea of the health centre owed something to American and British precursors and something also to health centres established by the Dutch in Java before the war, using local paramedical health workers.[16] George Gale and H.S. Gear in particular led the campaign within the department for the new approach based on district health units.[17] Its later development was influenced by the social-medicine movement in the United Kingdom. However, the overall programme that emerged out of the Pholela experiment was an original and uniquely South African achievement.

Training of black "health assistants" became a key feature of the DPH's proposed health service. Their effectiveness had been demonstrated in the anti-malaria campaigns in Natal; later they were used against malaria in the Transvaal lowveld also and, after additional training in the DPH's "Bantu Nutrition Survey." The malaria assistants provided a model for the health assistants in another respect. Their role was primarily educative and focused on prevention. The malaria assistants, however, had received very rudimentary training, typically delivered over only ten days. Despite these precedents, the Pholela clinic, with its focus on low-cost preventive medicine using a multiracial team of health workers, developed along lines unlike anything established in South Africa up to that point.

The founding medical officer at Pholela, Sidney Kark, had earlier joined the DPH as a young staff clinician. His first assignment had been to work with Dr. Harding le Riche on the department's "Bantu Nutrition Survey" in 1938-9. Shortly thereafter the opportunity arose to establish the facility at Pholela. In the six months before moving to Natal, Kark worked at some of the DPH's main facilities, such as the King George V Tuberculosis Hospital in Durban. Sidney Kark was accompanied by a medical aid (a product of the Fort Hare training scheme). His spouse, Emily, also a trained doctor, joined the project shortly after its inception. Most of the promotive health education and data collection on burden of disease and community health status were to be carried out by a new type of paramedic, the "health assistants," who initially would be trained at Pholela. Four of the five had had experience as malaria assistants.

During the start-up phase, the Karks carried out a survey of existing medical services in the area. There was one Western-trained physician whose large practice of black and white patients took in the entire region. He had built his practice there over the previous twenty years and was well known to both black and white residents. He functioned as parttime District Surgeon and in that capacity provided medical care to the indigent and to public servants. Like all district surgeons, he performed autopsies, examined prisoners and was responsible for public health and the prevention of infectious disease. In addition he was medical advisor to a large mission boarding school in the vicinity. The mission also had a hospital with a nursing sister but had recently lost its physician. In any case, the mission hospital was too far from Pholela (about 45 kms.) for people to travel there. Black residents of Pholela also found modern medical help by commuting to hospitals and clinics in Pietermaritzburg and Durban.

Within the Pholela community, Sidney Kark learned, most of the health care was delivered by a large number of (mainly female) diviners (*sangoma*) and many (mainly male) herbalists (*nyanga*). Some of

visit per family per month. Apart from the value of such visits in promoting health awareness and education, they offered an excellent means of controlling outbreaks of epidemic disease since all of the homes in the designated area would be visited not merely those with suspected cases. There was considerable resistance to this approach, however. It was intrusive and paternalistic; some heads of families refused to admit the health assistants, regarding them as spies and interlopers bent on undermining authority structures within the family.[24] Nevertheless, the value of the family-welfare service soon proved itself. Those who stayed with it apparently understood that participation gave them greater understanding of and control over their health and lives. By 1945, the intensive service involved 10,000 people, and the clinic provided outpatient services to another twenty-five thousand in the wider region. The health centre delivered these services with a staff that included: Sidney Kark and Emily Kark, respectively the Medical Officer-in-charge and the assistant Medical Officer, four medical aids, graduates of the course at Fort Hare, two medical aid probationers, five male health assistants and six male assistants-in-training, four female health assistants-in-training, a clerical stores assistant and seven general labourers. During 1944-5, the native health assistants carried out nearly 7500 home visits which meant that the families in the intensive welfare programme were each visited on average about ten times during the year. The early experience of the family-welfare programme led Dr. Kark and his colleagues to broaden and reconceptualise their definition of the function of the health centre: We were no longer satisfied to view the problem of sanitation as one involving the digging of pit latrines and building a superstructure; no longer could we view the question of water supplies protection as being a non-personal public health service; a person attending our clinics was no longer a case of this or that; nutrition work could not be divorced from food production; and food production was no longer to be regarded as something apart from health work.[25]

In addition to the preventive services and school visits, the centre held a general curative polyclinic three days per week at the centre itself and a fourth clinic at Impendle, a nearby community. Emergency services were available to the people around-the-clock, seven days per week. The clinics had 22,770 patient visits in 1944-5. There was a small laboratory for basic medical testing by a fulltime assistant but no X-ray equipment. The staff continued to focus on the health needs of pregnant women and children. It saw 244 expectant mothers on average eight times each during 1944-5. Routine examination found that fully thirty-one per cent of them had syphilis. Within a decade, infant mortality among those who used its services had fallen from 275/1000 in 1942 to 117 in 1950 and general mortality from 38.33/1000 to 13.3.

A committed opponent of the trend toward specialised medicine that was already well advanced in the 1940s, Sidney Kark was opposed also to separate clinics for the treatment of particular diseases as "dividing the indivisible." Like the traditional healers with whom he increasingly tried to work, he was concerned with the social and psychological as well as physical well being of his patients. A determined generalist, he believed that treatment of particular illnesses should always be in the context of the overall health status of the patient, the patient's family and the wider community. The venereal disease clinic that was necessary when the health centre first opened was the last of the specialised clinics to be phased out. The ethos of the family-welfare service taught that physical wellness was bound up with social health. The Karks put the health centre in the midst of a comprehensive programme of community activity. They invited the school children to the centre on Saturdays for classes in gardening, nutrition and first aid in the morning and games in the afternoon. These visits allowed centre staff to monitor their health as well. A Pholela People's Club organised concerts, dances and debates. A helping-hand fund assisted with school expenses and a Women's Club taught sewing, knitting, mending and cooking. The annual report outlined plans to combat the incessant community beer drinks and to try to do something about the rampant

alcoholism that was a major symptom of the social pathologies and economic hardship afflicting this migrant community. They opened a library, sought donations and gradually enlarged it.

These projects and activities tried to counter the instability that afflicted all of the families with whom they were workings. Oscillating migration was the means by which the infectious diseases associated with industrialisation, notably tuberculosis and syphilis, spread into every family in this remote, rural community.[26] Already in 1940, most of Pholela's men were absent for much of the year working in the industrial centres of Pietermaritzburg, Durban or Johannesburg. Bewildered by the resulting high rates of chronic illness and premature death, people clung even more tenaciously to long-held beliefs that seemed to offer some prospect of control and relief. Understanding that much of Pholela's burden of disease had socio-economic origins, the Karks and their colleagues gave equal weight to the social and the biomedical dimensions. They began to work closely with social anthropologists to ensure that their programmes took full account of their patients's deeply rooted cultural beliefs and practices.[27] In the mid-1940s, Dr. Kark himself spent a period in the United Kingdom working with social anthropologists so that he could better understand the persistence of non-western ideas about health and disease and the continuing influence of traditional healers. While the 1944-5 report had much that was encouraging to record, there were also some ominous signs. Control of tuberculosis remained "very difficult." Twelve of the homes in the intensive Family Welfare Programme were sites of active TB in 1944-5. An incidence rate of less than two per cent was not alarming in itself, but TB contributed disproportionately to general community mortality. There were plans for a small "tuberculosis colony" where infectious cases could be isolated at the health centre, mortality reduced and the dangers of the spread of the disease lessened. Apart from the tuberculosis menace, the incidence of syphilis remained high. The clinic had identified 497 people with the disease during 1944-5, an infection rate of nearly 100 per 1000. Between 1940 when the centre opened and the end of 1944, the staff kept careful records of 146 children born during that period. Of these, only ten were free of "gross abnormality," that is of the effects of congenital syphilis, TB, other serious infectious diseases and/or gross malnutrition. Despite the impressive evidence of medical successes during the year, the report contained many signs that the health of this migrant community remained precarious and so too the centre's ability to maintain the gains it had made.[28] It seems that the health workers at Pholela encountered a problem well recognised in the public health community today.[29] When a medical team first enters an unserviced or underserviced area, particularly one in which poverty and ignorance flourish, it is likely to be able quickly to produce dramatic reductions in morbidity and mortality and to improve people's quality of life. Simple preventive measures and health education will produce immediate results. Once these improvements have been made and the dramatic reductions in infant mortality and other disease indicators experienced, however, the team will come up against the basic structural constraints that produced worsening poverty, family instability and declining agricultural productivity. All these symptoms characterised the situation at Pholela. Social medicine successfully alleviated the symptoms but not the underlying causes that were rooted in the wider political economy. In such an environment, further improvements in the health status of poor communities will be hard to make, and there is likely to be some slipping back. So it was at in this case.

The Expansion and Decline of Social Medicine in South Africa

The high point in the development of the social-medicine movement was reached in 1944 with the report of the Gluckman commission that proposed to use it as the basis of a national health service, involving the centralisation of the public medical system under the Union Department of Health with funding through a progressive national health tax.[30] Several hundred health centres on the Pholela model would deliver preventive, curative and promotive health services throughout the country in both black and white

areas. Centralisation was designed to end the chaos and confusion of divided responsibility that had increasingly crippled the whole system. At the same time, the health centres were to have a high degree of autonomy in practice so that they could respond effectively to local community needs.

Within weeks of the publication of the report, however, the Smuts government began to pull back. Smuts himself said in a speech that the government would not remove hospital services from the jurisdiction of the provinces.[31] The provincial systems had not been a success; they had developed separately along quite different lines in the virtual absence of national standards; governments at all levels declined to fund the system adequately; confusion and waste resulted from lack of coordination of activities at local, provincial and national levels. Ever since the Vos committee report on hospital services in the mid-1920s,[32] successive inquiries had recommended the removal of the provinces from the system. Smuts, like Hertzog before him, was simply unwilling to take on that political fight. Following National Party gains in the 1943 election, the government seemed paralysed and unable to act on any of the myriad problems confronting it. Another blow to the Gluckman report was the growing opposition from the medical profession once it became clear that the commission's proposals would turn many doctors into public servants and involve them in a radically different kind of system. The NHSC envisioned a medical service that was not only administered and funded differently from what they knew but that also gave participating doctors significantly less freedom than they were used to. The recommendations were implicitly hostile to the specialisation that in South Africa medicine, as elsewhere in the western world, was the irresistible trend. Nevertheless, Harry Lawrence, the Minister, and his successor from 1945, Henry Gluckman himself, urged on by George Gale as Secretary of Health (SH) and Kark now at the Institute of Family and Community Health, Clairwood continued to put money and energy into the health-centre concept. Even their much diluted version of the Gluckman recommendations did not long survive, however. The conventional explanation -- echoed in this paper -- for the decline and eventual collapse of the health centre system is that it was killed by the National Party (NP) government after 1948 for political and ideological reasons. Under Malan, Strijdom and Verwoerd the state was hostile to spending central government funds on an elaborate medical system for the Homelands. Like the Smuts government before it, the National party was quite prepared to use the health centres for propaganda purposes overseas; the Department of Information produced a film and brochures to serve that objective.[33] However, funding it at any reasonable level was another matter entirely. There might have been a greater willingness to continue with the programme if World War II and rising prosperity in the white community had not done much to eliminate poor whiteism and the associated burden of disease in rural white communities. After 1948 the state increasingly relied on influx control, group areas and rigorous police enforcement to prevent growing poverty and illness in the black areas from impacting on white communities.

Second, the emphasis on multiracial teams essential to the health centre concept and to what was going on at the Institute of Family and Community Health at Clairwood was deemed, rightly, to be antithetical to apartheid doctrine. There is a sad correspondence in department files in which Kark and George Gale tried to explain to the Minister how segregated their system really was.[34] As civil servants, they felt obliged at least not openly to oppose established government policy.[35] Gale wrote to the Minister in 1952 that "...We have done our best, under difficult circumstances and against a persistent campaign of what I call 'smearing,' to carry out fully and loyally the policy of the government with regard to non-Europeans." However, they did so with great misgiving and growing reluctance. Of course their efforts failed; the Department of Health by the early 1950s was deeply suspicious of Dr. Kark. National Party stalwarts and their appointees in the Department thought, rightly, that he was politically unreliable. When he was invited by the BBC to give a presentation of his ideas on the World Service, there was much anxiety and hand-wringing in the Ministry about what he might say and about whether he could be

silenced.[36] The later emigration of both Gale and Kark is forecast in their increasing isolation within the government. Apart from apartheid politics, however, there are other reasons why social medicine was rejected at the policy level and the health centres either closed or turned over to the provinces or local authorities. In the mid-1940s, the Department probably tried to expand the network of clinics too quickly before sufficient staff could be recruited and trained to run them. Salaries were low in the public sector and it was difficult to attract and retain high quality physicians. Problems with the functioning of the health centres made them vulnerable to criticisms within the Public Service Commission and elsewhere.[37]There was another, probably more serious problem. What comes through in the views of the critics is the hostility of many physicians imbued with the values of curative medicine to Kark's basic approach. It represented a repudiation of too many of their core beliefs: he was opposed to specialisation; he did not even want specialised clinics to treat TB or VD. He wanted to treat whole families rather than individual patients on their own, which was deemed by some as a threat to the doctor-patient relationship. He believed that curative and preventive services belonged together. Implicitly he stood for less spending on hospitals and expensive, modern equipment in order to get a decent basic service available to the broad mass of the people throughout the country. If people could be treated early and shown the value of good nutrition and disease prevention, fewer of them would become patients in need of expensive hospital treatment.

Kark was not hostile to research; indeed all of the health centres associated with the Institute at Clairwood were expected to engage it; but from the standpoint of his critics, he believed in and advocated the wrong kind of research. What he emphasised was applied social research using teams of medical doctors, nurses, the health assistants and social scientists, particularly professionally-trained anthropologists and sociologists. He used the black health assistants to gather data and to monitor the health status of the families in the intensive welfare service and brought all of these practitioners together to analyse their data and to discuss cases. At his urging the Council for Scientific and Industrial Research established and funded an unit for research in social medicine. It functioned as a sub-division within the Institute of Family and Community Health. It appears from the department files that many in the medical profession found this approach to be misguided at best: it was centred on the wrong kind of research: applied and social rather than basic and medical; it was oriented toward family welfare rather than the fundamental biomedical causes of disease; it was amateurish in its use of poorly trained health assistants to gather data. Some of the critics were more than a little contemptuous of Dr. Kark, a trained physician, who seemed to prefer busying himself with vegetable gardens, pit latrines, sewing circles and day nurseries rather than focusing on the actual practice of medicine. To them, his insistence on addressing the social and economic origins of much of the illness that afflicted impoverished communities was at best a distraction from treating the sick and addressing the biomedical causes of disease. The Karks were more interested in lowering the incidence of disease in impoverished communities than in adhering respectfully to traditions and ideologies entrenched in the medical profession. While this approach was instrumental in transforming the health of communities around the health centres, it cost the movement dear at the professional, bureaucratic and political levels.

Unwittingly some of the outside experts who came to South Africa to give advice in their well-intentioned criticisms provided ammunition to the critics both inside and outside the government. John A. Ryle, the Oxford social-medicine specialist, who was brought in by the government early in 1948 to review the operation of the health-centre system, was one such. He was a strong supporter of the concept (Dr. Kark had trained with him while in the UK in the 1940s) but wanted to change the basic approach: he wanted larger centres; he wanted the training and research functions to be closely associated with universities; he was not against social and applied research but wanted it carried out by university-trained researchers;

he criticised the use of the health assistants to gather data for that reason. The health assistants with their rudimentary education and training had no business in the research team, he argued. He did not think they should be investigating the social aspects of medical cases either. Ryle also expressed concern about the lack of experience of some of the medical officers who were teaching at Clairwood.[38]What the medical and academic criticisms of the health centres did was to arm the politicians in both the United and National parties with "scientific" and apparently objective reasons first to strangle and then to kill a concept to which many of them were hostile for other reasons. Thus ended by the mid-1950s the most innovative and effective programme ever developed in South Africa to address the real health needs of poor people. The state ordered the health centres to abandon prevention and focus on curing the sick. Later, these facilities were mostly closed or transferred to other jurisdictions. The Institute at Clairwood was also terminated, some of the staff assigned to the new UND medical school and the site transferred to the province as an outpatient facility. George Gale had jumped ship to become founding dean of the medical school. Sidney Kark soon followed him as the first head of Family Medicine. They both left the country within a few years.

Conclusion

A number of those involved in this important experiment in social medicine wrote up their findings in a collection published in 1962. There is growing recognition in the public-health community particularly since the early 1990s of the significance of the experiments of the 1940s and 50s. More recent work, including a forthcoming book by the Kark's themselves, will help to recover the importance of the social-medicine movement. Still, the specific lessons learned at Pholela are not well remembered in the South African medical community. Yet those lessons, only some of which could be discussed above, still resonate powerfully fifty years later as the country moves into the post-apartheid era and contends with a medical system seriously compromised by decades of NP misrule and incapable in its present form of serving the health needs of the people. For the 1990s and beyond, the creation of an effective health-care system that reaches the country's poor depends on the restoration of that approach, more than it does on an extension of curative medicine, important though the latter certainly is. More is involved than building new facilities in under serviced areas or even than conscripting doctors and other medical personnel to staff them. The Department of Health and those who work in the public sector need to recover the ethos of the pioneering social-medicine advocates in the 1940s, particularly the integration of preventive and curative medical services and the equal emphasis that social medicine gave to the biomedical and the socio-economic dimensions of health and disease.

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[2] See, Department of Health, "White Paper on the Transformation of the Health System in South Africa," Government Gazette, no. 17910, 16 April 1997.

[3] See the Manchester Guardian Weekly's report on the World Health Organisation's recent study, "Bridging the Gaps," 7 May 1995.

[4] Business Day, 21 May 1997.

[5] Charles E. Rosenberg. No Other Gods: On Science and American Social Thought. Baltimore, Johns Hopkins University Press, c1976; Healingand History: Essays for George Rosen. New York, Science History Publications, 1979; "Disease and Social Order in America: Perceptions and Expectations." Milbank Quarterly 64 (suppl. 1, 1986):34-55; "Disease in History: Frames and Framers." Milbank Quarterly 67 (suppl. 1, 1989), 1-15.

[6] Charles E. Rosenberg, "Introduction" in Framing Disease: Studies in Cultural History, Charles E. Rosenberg and Janet Golden, eds., xiii-xxvi. New Brunswick, N.J., Rutgers University Press, 1992.

[7] Elaine N. Katz. "The White Death: Silicosis (Miners' Phthisis) on Witwatersrand Gold Mines, 1886-1910." Unpublished Witwatersrand University Ph.D. Thesis, 1990; and her *The White Death: Silicosis on the Witwatersrand Gold Mines 1886- 1910.* Johannesburg, Witwatersrand University Press, 1994; Shula Marks and Neils Andersson. "Typhus and Social Control: South Africa, 1917-50" in Disease, Medicine, and Empire: Perspective on Western Medicine and the Experience of European Expansion, eds. Roy MacLeod, and Milton Lewis, 257-83. London and New York, Routledge, 1988; Randall M. Packard. "Agricultural Development, Migrant Labour and the Resurgence of Malaria in Swaziland." Social Science and Medicine, 22(1986), 861-7; "Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand 1902-32." Journal of Southern African Studies 13(1987), 187-209; "Industrial Production, Health and Disease in Sub-Saharan Africa." Social Science and Medicine, 28(1989), 47596; White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa. Berkeley, University of California Press, 1989; "Industrialisation, Rural Poverty and Tuberculosis in South Africa, 1850-1950" in The Social Basis of Health and Healing in Africa, eds. Feierman, S. and J. Janzen, eds., 104-30. Berkeley, University of California Press, 1992; "The Invention of the 'Tropical Worker': Medical Research and the Quest for Central African Labor in the South African Gold Mines." Journal of African History 34(1993), 271-92; Howard Phillips. "'Black October': The Impact of the Spanish Influenza Epidemic of 1918 on South Africa." University of Cape Town, unpublished Ph.D. Thesis, 1984; Published in Argief-yaarboek vir Suid-Afrikaanse Geskiedenis, 1989; "The Local State and Public Health Reform in South Africa: Bloemfontein and the Consequences of the Spanish 'Flu Epidemic of 1918." Journal of Southern African Studies,

13(1987), 210-253.

[8] Recent accounts are Shula Marks, "South Africa's Early Experiment in Social Medicine: Its Pioneers and Policies," American Journal of Public Health 87(1997), 452-59; Stephen Tollman, "Community Oriented Primary Care: Origins, Evolution, Applications," Social Science and Medicine 32(1991), 633-42; Derek Yach and Steve M. Tollman, "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era," American Journal of Public Health 83(1993), 1043-50.

[9] Annual Report of the Department of Public Health, Year Ended 30/6/41. Pretoria, Government Printer, 1941. U.G. 46--'41, 58, emphasis original.

[10] On the health centre concept and the work of the Pholela Clinic see the following: Sidney L. Kark. "Health Centre Service: A South African Experiment in Family Health and Medical Care" in Social Medicine, Eustace Henry Cluver, et all, 661-700. [Johannesburg], Central News Agency, 1951; Zelda Jacobson. "Case Note-Book of the 'Riversend' Community," in A Practice of Social Medicine: A South African Team's Experiences in Different African Communities, Sidney L. Kark, and Guy W. Steuart, eds., 256-66. Edinburgh, E. and S. Livingstone, 1962; Sidney L. Kark. "The social pathology of syphilis in Africans." South African Medical Journal 23(1949), 77-84; Kark and J. Cassel. "The Polela Health Centre: A Progress Report." South African Medical Journal 26(1952), 101-4, 131-36; Kark and Guy W. Steuart, eds. A Practice of Social Medicine; Shula Marks and Neil Andersson. "Industrialisation, Rural Health and the 1944 National Health Services Commission in South Africa" in The Social Basis of Health and Healing in Africa, eds. Feierman, S. and J. Janzen, eds., 131-61.

[11] Derek Yach and Steve M. Tollman, 1044.

[12] Annual Report of the Department of Public Health, Year Ended 30/6/39. Pretoria, Government Printer, 1939. U.G. 57--'39, 71-2.

[13] Union Government, House of Assembly Debates (Hansard), vol 35 (1939), A.O.B. Payn, 6371-2; V.L. Shearer, 6384-7; C. Bain-Marais, 6382; R. Stuttaford, 6391-4.

[14] Hansard, vol. 35, col. 4613, Dr. Karl Bremer, M.P. (Graaff-Reinet), 12/5/39.

[15] Pholela Health Unit, Annual Report for the Year Ending 30 June 1950 inGES 1917 46/32.

[16] GES 2704 1/62 Medical and Health Services for the Union. "Social Medicinein South Africa" prepared by Dept of Information and revised by SPH, Dr. George Gale, in 1951 -- he says he made little change to the text but updated the figures.

[17] Marks, "South Africa's Early Experiment," 453.

[18] Sidney L. Kark. "Health Centre Service: A South African Experiment inFamily Health and Medical Care" in Social Medicine, 661-700.

[19] GES 2704 2/62 Pholela Health Unit General Matters, 1940-53 Kark's monthlyreport, 5/2/41; and Summary of Main activities at Pholela, February-March, 1941, n.d.

[20] Kark, "Health Centre Service," 668.

[21] Kark and Steuart, eds., passim.

[22] See in particular Stephen Tollman, "Community Oriented Primary Care," 633-5.

[23] GES 1917 46/32 Polela Health Unit, Annual Report for the Year Ending30/6/45.

[24] Ibid., 670-2; GES 1883 1/32,O Annual Report, Health Department, DraftReport to year ending 30/6/44.

[25] GES 1917 46/32 Pholela Health Unit, Annual Report for the Year Ending30/6/45.

[26] J. Crush, A. Jeeves and D. Yudelman. South Africa's Labor Empire: AHistory of Black Migrancy to the Gold Mines. Boulder and Cape Town, Westview Press and David Philip, 1991); J. Crush and W. James, eds. Crossing Boundaries: Mine Migrancy in a Democratic South Africa. Cape Town and Ottawa: IDASA and IDRC, 1995; M. Heap. "Health and Disease in South-Eastern Lesotho." Centre for African Studies Communications No 16, University of Cape Town, 1989; and R. Packard, "Holding Back the Tide: A History of Tuberculosis Control in South Africa" in H. Coovadia and S. Benatar, eds. A Century of Tuberculosis: South African Perspectives. Cape Town, Oxford University Press, 1991, 42-57; R. Packard and D. Coetzee, "White Plague, Black Labour Revisited: TB and the Mining Industry," in Crush and James, 101-15; J. Leger, "Key Issues in Safety and Health in South African Mines," South African Sociological Review 2(1990); and J. Leger, "Occupational Diseases in South African Mines--A Neglected Epidemic?" South African Medical Journal 81(1992), 197-201.

[27] See for example the studies reported in Kark and Steuart, eds. A Practiceof Social Medicine.

[28] Ibid.

[29] Dr. Geoff Solarsh, Medical Research Council, University of Natal MedicalSchool, Durban, personal communication.

[30] Report of the National Health Services Commission, 1944.

[31] GES 2851 PC1 Minutes of the first meeting of the National Health Council,Bloemfontein, 11/8/47.

[32] Cape Times, 28/2/28, clipping in GES 1166 1/19.

[33] GES 2704 2/62 Pholela Health Unit General Matters, 1940-53 SPH to Director Bureau of Information, 12/6/46; and 2629 60/38O Chief, Publications Section, State Information Office to SH, 26/4/51.

[34] GES 2900 PH42, 3 Gale to the Minister, n.d. [1952] a memorandum on the observance of apartheid at the Institute of Family and Community Health.

[35] Ibid.

[36] GES 2901 PH42A Minister of Health to Administrator of Natal, 3/2/56.

[37] Shula Marks, "South Africa's Early Experiment in Social Medicine," 452-59.

[38] GES 2746 65/70A Gale to the Minister, 7/11/51, summarising ProfessorRyle's 1948 critique.

them were itinerant; some resided in the area. Patients also sought the help of renowned *sangoma* and *nyanga* based in Durban and other urban centres. The diviners addressed the social and magical causes of illness and misfortune and sometimes referred the afflicted to the herbalists for treatment using a wide variety of plant and herbal remedies. The *nyanga* did not depend only on referrals from the *sangoma* but took their own cases too and for those combined both diagnosis and treatment.

From the beginning the Pholela centre adopted a holistic approach that resembled that of the non-western healer more than it did the usual Western model of curative services delivered by individuals to individuals in a private practice. Instead a multiracial team of physicians, fully trained nurses and a variety of medical aids and health assistants provided comprehensive family and community care. After basic research identified the most pressing needs, the clinic developed an innovative programme for the promotion and preservation of health that integrated preventive and curative medicine. The medical staff gave special attention to the health needs of the most vulnerable, pregnant and nursing women and infants.[18]

On arrival at Pholela, the Karks found a community ravaged by serious illness and death that affected every family without exception. Tuberculosis and syphilis, including particularly congenital syphilis, were the main killers. Although the DPH had decided from the beginning that the new clinic would focus on prevention, the Karks found that they had first to address the pervasive ill health that afflicted every family. Apart from treating the people who came to the health centre because they were sick and knew it, the staff focused on those who, though perhaps equally ill, were unaware that their condition was the result of disease. Often in an advanced state of nutritional failure, they simply had no experience of wellness against which to measure their present condition. Naturally, people in that state of mind would be equally unaware of the possibilities of treatment and cure. The task was not only to persuade people unaccustomed to western medicine of its benefits but also to show them that their poor state of health need not be a permanent condition.

Sidney Kark's reports in the first several months of 1941 showed rapid progress both in getting the clinic's programmes into operation and in educating the people as to their potential value. By the end of March, he wrote that 791 Pholela residents had attended the clinic over the previous two months, nearly a third of them seeking treatment for venereal disease. Gonorrhoea was more prevalent than he had expected, and although the disease was easily treated, there were many cases of recurrence. Meanwhile, syphilis was nearly as prevalent and a much more difficult disease to deal with. To meet the health needs of children, he had launched a programme of school visits, and more than a hundred students had been medically examined in the same two-month period. He found a high incidence of malnutrition and scabies among them. His study of the diet of the school children was yielding valuable information on the relation of nutrition and health. The clinic's vegetable garden occupied a full acre, and the produce was reserved for use in the school feeding scheme that the clinic had recently established. In the first several months of operation, the health assistants had visited about 450 homes mainly to promote good sanitary practices and to encourage the proper disposal of refuse. There had been two outbreaks of typhus in the area, and the clinic had mounted an extensive propaganda campaign to educate the communities on the means of prevention.[19]

After some initial suspicion and resistance, the community began to discover the health centre. By respecting and working through established structures of authority, the Pholela team campaigned to break down people's suspicions. Thus regular meetings with chiefs, headmen and their advisors began immediately. If community leaders accepted the health centre, the Pholela team reasoned, the community

would be more likely to use its services.[20]

Sidney Kark did not wait for patients to show up at the door. His school visits involved not only the medical examination of children but also lectures to the teachers. By giving the teachers basic information on sanitation and personal hygiene, he enlisted them as apprentice health educators. He talked separately to groups of boys and girls at the school. Through the schoolchildren, he reached out to their families. Resistance was strong, however, and progress slow and uneven. Nevertheless, about one year after the Karks' arrival, they felt that they could begin to shift their attention from treating disease to addressing what was supposed to be from the start their main focus: health education and disease prevention.

The Family-Welfare Service

During that first year the health centre carried out a variety of studies and investigations and experimented with different forms of health-care delivery. The Karks decided that close monitoring of individual households was the key to transformation of the health of the Pholela community as a whole.[21] They proposed to use the health assistants to visit selected families on a regular basis for the purpose of delivering health education, monitoring the state of their health and progress in acting on the advice received and delivering basic health care and first aid. He encouraged family units to visit the health centre for further counselling and regular medical examination. With his tiny staff and small budget, he could not begin to mount such a programme for the whole district. He started with a small group of 130 cooperating families involving fewer than 1000 people in all. The initial step involved a detailed census of those households to survey their level of education, income and wealth, to measure the families' assets, to assess their methods of dealing with sanitation and water supply and other factors. As the programme developed, the health assistants gathered complete data on birth rates and the incidence of morbidity and mortality.

The welfare service stressed that applied social research was essential to achieving the goal of improved family and community health. In addition to vital statistics, the health centre maintained careful medical and social histories of participating families and aggregated the data to measure changes over time in the health status of whole communities. At that stage and for decades afterwards, the state did not collect vital statistics for the black population. In any case, the need for such data led to an emphasis on generating capacity within the centre to collect and analyse it. The importance of building capability in health centres for this kind of basic social research in support of policy making and programme evaluation at local and district level is increasingly recognised. Over the past decade health professionals in southern Africa have been rediscovering this aspect of the Pholela experiment in their search for precedents and lessons that will promote the transformation of the region's health services today.[22]

Sidney Kark later described the programme as an intensive family-welfare service.[23] He proposed that the centre provide this service to a limited number of families in a closely defined area so that vital statistics and demographic information could be collected and maintained in a consistent way among a stable group of households (there was provision to increase the number of participating families). From the beginning, he aimed to ensure that all of the families in the project were visited by the health assistants on a regular basis whether or not illness was present. The objective was to educate the people to health maintenance and promotion, to get them to take responsibility for their own health and to monitor their progress closely. At the outset, he found that each family should be visited weekly or at least bi-monthly but planned to reduce the frequency once the programmes was well established to one