"We Sow the Seed": Perspectives of Health Educators at the Institute of Family and Community Health in Durban in the 1940s and 1950s

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in the Department of Community Health,
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by Louise Vis

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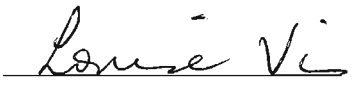
Declaration

This thesis is my own work and all primary and secondary sources have been acknowledged.

Signed 

Louise Vis

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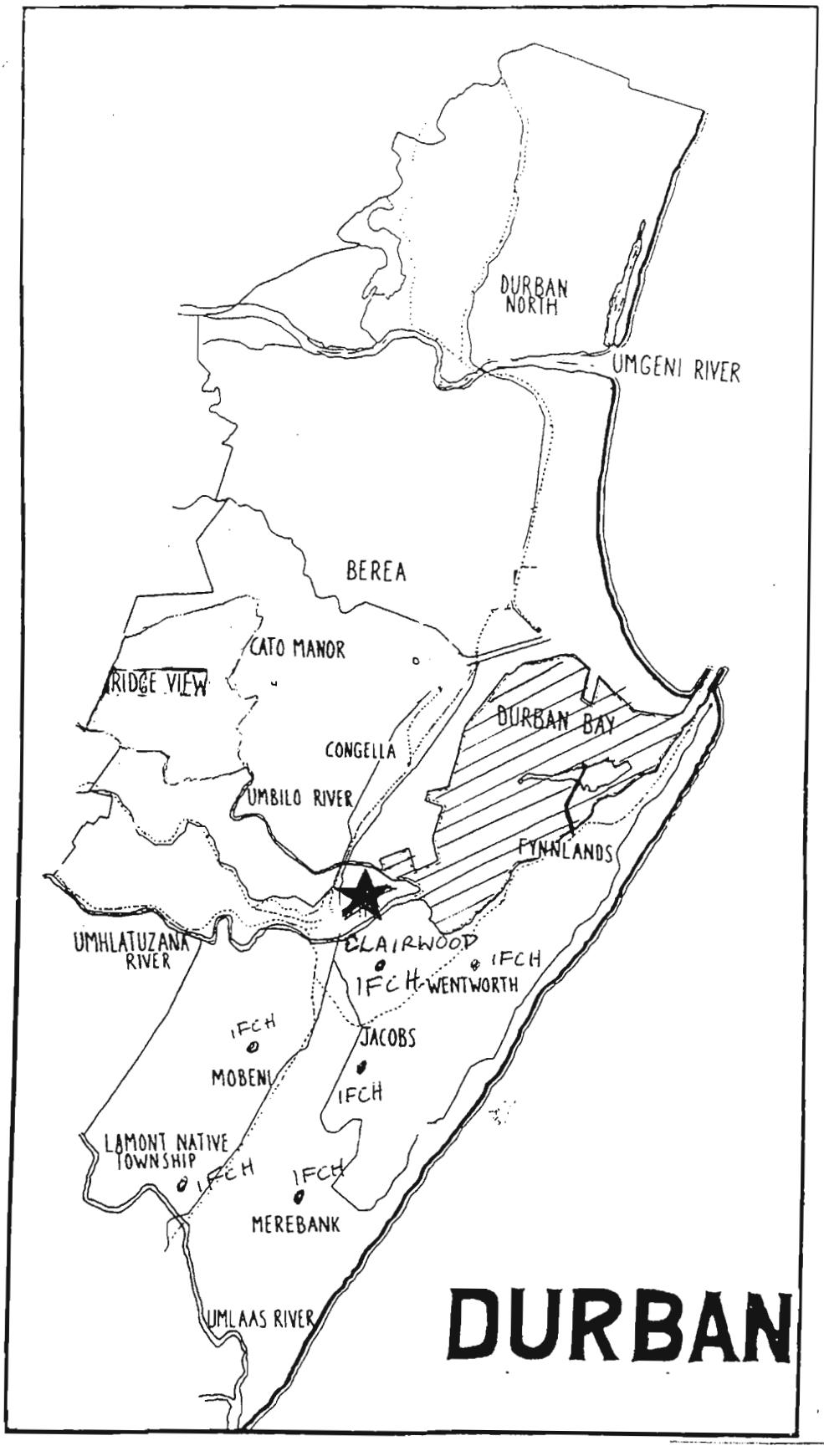
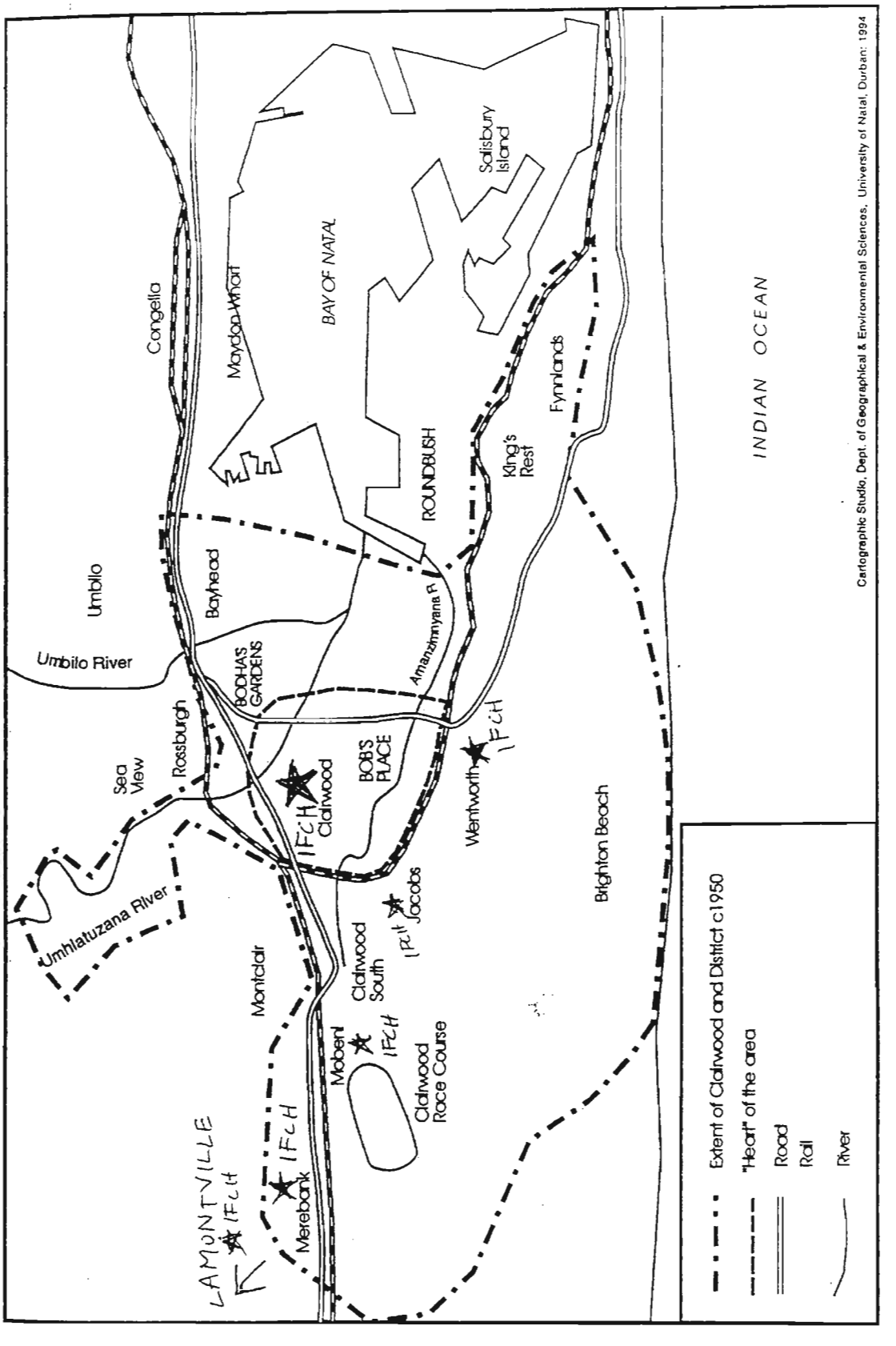
Map of Durban, circa 1950
(Adapted from Scott, 1994)



Source: University of Natal, 1952

★ = Main IFCH centre in Clairwood
● = IFCH-affiliated centre

Location of IFCH Centres in Clairwood and District
(Map of Clairwood adapted from Scott, 1994)



Clairwood and District as perceived by its residents

Timeline of IFCH and South Africa

1895 **Native Ordinance (Natal Exception)**
Protects existing traditional healers and provides for their licensing by Magistrates in the absence of other medical facilities.

1913 **Native Land Act**
Limits the amount of land available for African ownership to "scheduled areas" (e.g. reserves) amounting to 8 percent of the total land in South Africa, increased to 13 percent by the Native Lands and Trust Act of 1936.

1919 **Public Health Act**
Establishes the Department of Public Health (DPH); coordinates control of epidemic infectious diseases at a national level. DPH remains a sub-department in the Department of the Interior until 1945.

1923 **Native (Urban Areas) Act**
Gives the state powers enabling it later to impose residential segregation as national policy and a form of influx control. Amended in 1930, 1937 and 1945.

1926 **Hertzog Native Bills**
Lays the legislative ground for 1930s segregation

1927 **Medical, Dental, and Pharmacy Act**
Facilitates stricter controls and policies with regard to health care practice and training

1928 **Loram Committee**
CT Loram, inspector of education in Natal and founder member of the Joint Councils, proposes a system of health centers for rural African areas to be staffed by black doctors, nurses, and medical assistants. Recommends that African students receive full medical training at University of Witwatersrand.

1929 **South African Institute of Race Relations (SAIRR) formed.**
Serves as the major conduit of liberal thought throughout the 1930s and 1940s.

1933 **Thornton Committee.**
Edward Thornton, Secretary for Public Health 1932-38, objects to the training of black doctors and advises the establishment of a 5-year Medical Aid course based on the French West African model. Minister of Education and Public Health, Jan Hofmeyr, backs Thornton's plan.

1936 - 1946 **Training course for Medical Aids at Fort Hare.**

1939 Debate in parliament re: removing provincial control of health. Prime Ministers Smuts and Herzog oppose the transfer of control from provincial to national level.

1940 **Pholela Health Unit established**. Sidney and Emily Kark at Pholela 1940-45.

1940 First group of black doctors begin training at Wits (graduate in 1945).

1942-1944 **National Health Services Commission** (NHSC)
Henry Gluckman as Chairman. The NHSC visits Pholela Health Unit the

1944 **NHSC Report published**
NHSC recommends the establishment of over 400 health centres throughout South Africa, as the cornerstone of a new National Health Service. Parliament passes the plan, but allocates only 3% of overall health budget to health centres.

Nursing Act (non-racial); segregated Nursing Act Amendment 1957

1945 Department of Public Health receives full departmental status and its own Minister, with control over District Surgeons.

Dec 1945 **IFCH established in Durban** (Springfield). **Karks leave Pholela** after designating Dr. Dorothy Ryan as Sidney's temporary replacement as director of the Pholela Health Center. Karks assume their posts at IFCH in January 1946, Sidney as Director and Emily as Chief Medical Officer.

1945-48 **Henry Gluckman Minister of Health**

1946 **Six-month training course for HEs begins mid-1946 at IFCH.**
By 1948, training course is a full year.

British National Health Service Act

Central Health Services and Hospitals Coordinating Council established, under Gluckman's chairmanship. Responsible for coordinating central and provincial health services. Gluckman also sets up National Health Council, with the Advisory Committee on Health Centre Practice as a sub-committee established to advise the Department. of Health (DOH) on health centre practice and to link the DOH to medical universities.

1947 **IFCH headquarters move to Clairwood**
Over the next two years, IFCH centres are set up in nearby **Lamontville** (African), **Merebank** (Indian), **Woodlands** (white), **Mobeni** (African, Indian and white factory workers), **Newlands** (Coloured and Indian), as well as the **Springfield** centre. **Pholela** remains the rural training centre. Later added **Tongaat** on the North Coast (African and Indian sugar cane cutters), and provided services in **Umlazi**.

John Ryle tours South African health centres, releases critical report.

1948 **Nationalist Party wins election by a narrow margin.**
Official beginning of apartheid.

1949 **Three-year HE training course at IFCH begins.**

1950 **Group Areas Act**
Authorizes the extensive relocation of designated racial groups (Indians, Africans, Coloureds).

1951 **Establishment of Durban Medical School**
Alan Taylor first Dean (part-time for one year); George Gale Dean 1952-55. I.G. Gordon Dean 1955-1971.

1952 **IFCH training of health educators ends**
The class of HEs that had begun training in 1951 was allowed to finish their 3-year course, graduating in 1954.

Transfer of administration of IFCH centres Pholela, Springfield and Newlands from Central Dept. of Health to Natal Provincial Administration (NPA). Centres around the IFCH headquarters in Clairwood (Blackhurst, Bluff, Gale Street and Lamont) remain in IFCH control

National Health Council unanimously recommends to multiply health centres throughout the country, but the DOH refuses: **no further health centres established.**

Head IFCH nurse **Helen Cohn leaves South Africa**; teaches at Harvard School of Public Health before joining WHO.

1953 **Bantu Education Act**

Pholela Health Centre Director **John Cassel leaves** for Univ. of North Carolina (Chapel Hill).

1955-60 **Rockefeller Foundation grant to the IFCH and the Durban Medical School launches the Department of Social, Preventive, and Family Medicine,** headed by Sidney Kark.

1955 **George Gale leaves South Africa** for Uganda, Makerere University (until 1958, then takes WHO assignments as visiting professor of Preventive Medicine in Malaysia and Thailand.)

1956 **Remaining IFCH centres in Clairwood area transferred to provincial control** (Blackhurst, Bluff, Gale Street and Lamont).

1958 **Karks leave South Africa** for University North Carolina, Chapel Hill, where Sidney joined John Cassel at the Dept. of Epidemiology for a year;. In 1959 the Karks emigrate to Israel.

1960 **Department of Family and Preventive Medicine closes.**

All forty-four health centres established under NHSC either close down or are handed over to provincial administration as limited-service outpatient clinics.

Jan 1961 **IFCH closes.**

1965 **Guy Stueart** (former head of Health Education at IFCH) **leaves South Africa** for Israel, followed by UNC.

Declaration

This thesis is the unaided work of Louise Vis. It has not been submitted previously to the University of KwaZulu-Natal or any other University.

Acknowledgements

I am grateful to my advisors, Dr. Stephen Knight of the Department of Community Health, and Dr. Catherine Burns of the Department of History, for their insight and encouragement. Dr. Stephen Knight's valuable interventions steered my understanding of community health in South Africa. Dr. Catherine Burns was not only instrumental in my selection of topic, but guided my research from beginning to end.

This project was initiated in the lead-up to the July 2000 International Workshop on "Social Medicine and Reform of the Health System in South Africa, 1940-2000" at the University of Natal, Durban. As one of the organizers of this event, Catherine Burns offered me an opportunity to gather the stories of individuals who worked with Sidney and Emily Kark during the 1940s and 1950s. During this preliminary period of research, I was privileged to work alongside Prof. Alan Jeeves, conducting interviews with health educators who featured later in a special "Witness Session" of the Workshop. Following this event, Alan Jeeves continued to provide constructive criticisms, for which I am most appreciative. Dr. Howard Phillips and Dr. Angela Mickalide also read and commented on drafts of this thesis.

I express my profound gratitude to the health educators who shared their memories with grace, good humour, and wisdom. I have been immeasurably enriched by

my experiences with these dedicated professionals. In particular, I wish to thank Neela Govender, Maureen Michau and, especially, Violet Padayachi Cherry.

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initiatives in South Africa during the 1950s, as did Marcia Wright, regarding a more recent period. Jeremy Kark also offered encouragement and timely responses to queries.

My parents, Peter and Marlene Vis, my sister Moira, and mother-in-law, Betsy Carton, have been unstinting in their support. But the most unwavering companion on this journey has been my husband, Benedict Carton. He not only provided a model of disciplined scholarship but also facilitated my study in countless ways. It is to him, and to our sons, Isaac Sipho and Jacob Dingani, that this work is dedicated.

"We Sow the Seed": Perspectives of Health Educators at the Institute of Family and Community Health in Durban in the 1940s and 1950s

Abstract

Health education is critical to the success of a community health program. Yet the majority of research on health education is conducted from the point of view of programme designers or evaluators. Where health educators themselves are the focus, data is often generated through surveys, questionnaires, field notes, or quantitative measures. Narrative accounts by health educators describing their activities and their perceptions of programme efficacy are thus a neglected line of inquiry.

My thesis examines one group of health educators who trained and worked with Sidney and Emily Kark at the Institute of Family and Community Health in Durban during the 1940s and 1950s. The importance of health educators in the Institute's project has often been acknowledged by key figures like the Karks, but few scholars have highlighted the contributions of these paraprofessionals. As catalysts of change and disseminators of knowledge, their role was encapsulated by health educator Neela Govender: "So many things people can do to [become] aware of health problems, and how much they themselves could be responsible for their own health…that's not something they can forget. They will pass it on to another generation, or influence each other. We sow the seed, and it must grow, and spread".

In focusing on the health educators' role, I seek to integrate perspectives of "history from below" to enhance previous analyses that concentrated on doctors and government administrators as the main architects of the Institute of Family and

Community Health. To this end, I have collected testimony of health educators as a valuable source of historical evidence, which not only uncovers a foot soldier's view of what the Karks called a "practice of social medicine" but also illuminates various social, political, and economic contexts underpinning health education in South Africa.

This study used oral history techniques to explore how retired health educators perceived their experiences at the Institute. It thematically analysed their narratives to gain a sense of their training, goals, methods and working conditions in segregationist- and apartheid-era South Africa. My interview subjects were predominantly women whose work reflected the centrality of maternal, child, and family health to the Institute. As intermediaries between the clinic and the community, they were integral to the Institute of Family and Community Health's investigation of the links between health and culture.

The themes of race, gender and culture were as pertinent in the mid-twentieth century as they are today in the delivery of health services; health educators' narratives might provide insights into how such conceptual factors influence the operation of community health programs in contemporary South Africa. The ways in which the Institute's health educators became active agents in the face of oppressive circumstances also contain potential lessons for their counterparts currently struggling to address an HIV/AIDS epidemic with inadequate resources and governmental support.

CHAPTER ONE:

BACKGROUND AND THEORETICAL FRAMEWORK

1.0 AIM OF THE RESEARCH

To gain an understanding of health educators' (HEs) experiences at the Institute of Family and Community Health (IFCH) by conducting and analysing in-depth interviews for thematic content.[1]

1.1 OBJECTIVES OF THE RESEARCH:

To establish how health educators (HEs) at the IFCH describe their goals, methodology and working conditions.

To explore how race, class, culture and gender shaped their experiences as health educators at the IFCH

To place the IFCH within its broader historical, political and theoretical context.

1.2 BACKGROUND TO THIS RESEARCH

A more detailed description of the IFCH and health educators appears in subsequent chapters, but a brief synopsis is necessary here. The IFCH had its roots in the 1942-44 National Health Services Commission's (NHSC) vision of a unified health

[1] A note re: terminology: "health educator" was the term used by the interview subjects to describe themselves, and it is the term used by Sidney and Emily Kark in their writings (Kark 1951; 1962), later used interchangeably with "community health worker" (Kark, 1981; Kark and Kark, 1999). Archival sources from the 1940s and 1950s feature the government designation "health assistant". In accordance with the interview subjects' preference, I employ the term "health educator".

service for "*all* sections of the people of South Africa."[2] Health centres were to be the backbone of this service, integrating curative, preventive, and promotive care, with "health education [as] an important promotive service" receiving "high priority in the overall plan."[3] A total of 400 health centres were to be established throughout South Africa. However, due to budgetary constraints and a lack of widespread political support from all-white legislators, only 44 health centres came to fruition.[4]

The model for the health centres was the Pholela Health Unit, set up in 1940 in a rural Zulu-speaking community in southern Natal (now KwaZulu-Natal). The health centre was under the direction of a married couple, Drs. Sidney and Emily Kark, and was funded by the Union Department of Health (DOH).[5] Over the next five years at Pholela, the blueprint for the "Karkian model" emerged, featuring anthropological study of cultural factors affecting health and illness, community participation, recruitment of local health assistants, and epidemography.[6] To provide enough personnel—specially-trained

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[2] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944),1. The most influential government figures associated with the National Health Services Commission (NHSC) were its chair, **Henry Gluckman**, Minister of Health 1945-1948 and **George Gale**, Assistant Health Officer 1939-1946 and Secretary of Health 1946-52. Other government figures pertinent to the NHSC include: **Eustace Cluver**, Secretary of Health 1938 –1940; his successor **Peter Allan** (1940-46) and **Harry Gear**, a Senior Assistant Health Officer (the title was changed in 1939 to "Deputy Chief Medical Officer") from the early 1930s to 1950, with a break for military service between 1939-1945.

[3] ibid.

[4] See Appendix 1 for number and locations.

[5] Throughout this thesis, I refer to "the Karks" as a unit except where indicating their specific positions or research. Similarly, the term "Karkian" comprises a model associated with both Sidney and Emily Kark. I do not wish to elide these two individuals, who had distinct roles within their common projects. Rather, in using the plural, I follow the practice of other scholars (see Chapter 2.3 of literature review) as well as the example of Sidney and Emily themselves, who consistently portrayed their work as a mutual enterprise (Kark and Kark, 1962; 1981; 1999). However, many of their earlier publications describing their work in Pholela and Durban are under Sidney Kark's name (Kark, 1944; 1951; 1952).

[6] "Epidemography" is the collection of data that is both epidemiological and demographic. See Chapter Five for further discussion.

doctors, nurses, and community health educators—for the other planned health centres across South Africa, a larger training centre was required, and in late 1945 the IFCH was established in Durban (Springfield). Sidney Kark became director of health centre training, practice and research while Emily Kark was appointed chief medical officer. The following year the IFCH headquarters moved to Clairwood, a primarily Indian settlement in the southeast outskirts of Durban, ideally situated because of its easy access to the various racial groups in the surrounding areas. The IFCH services were available to all four designated racial groups through a network of seven health centres in the Durban area, as well as Pholela and Tongaat.[7]

Beginning in 1947, white, African, Indian and Coloured health educators trained at the IFCH, entering a prototype 6-month training course which by 1949 had expanded to three years. Training of health educators continued until 1952, when increasing pressure from the Nationalist Party government curtailed this aspect of the health centre service, though already-trained HEs were retained until about 1958.[8] In total, the IFCH trained more than 300 health educators, employing 30 at the IFCH centres in Durban and Pholela, with other HEs assigned to government health centres elsewhere.

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[7] The demography of the IFCH areas may be summarised as follows: **Springfield**: Indian sub-economic housing. Neighbouring Coloured suburb of Sydenham; **Clairwood and District**: Indian freehold area incorporated into Durban in 1932, included surrounding areas of **Merebank** ("an urban slum area with 500 mainly Indian Hindu population who had settled there some three generations earlier" (Kark and Kark, 1999); **Clairwood-Jacobs** , Coloured slum area. To the southwest of Clairwood was **Lamontville**: 1300 families, mostly Zulu. Established in 1932 by the Durban City Council, parts of it were still under construction in the early 1950s; **Mobeni** Industrial Zone: mostly African factory workers, some white workers; **Woodlands** – white housing estate developed for ex-servicemen and their families: Univ. of KZN, Pmb Archives (hereafter UKP) H6/2/3, "Family Health and Medical Care: the Need for Training a Family Doctor", S.L. Kark, 26 May 1954. The Tongaat health centre was on the North Coast about 40 km from Durban; it served African and Indian sugar estate workers.

[8] The group of HEs who had begun training in 1951 were allowed to finish their three-year course, but as of 1952 no new applicants were accepted.

In 1952, to gain a reprieve from the threatened closure of the IFCH, then-Secretary of Health George Gale (an architect of the IFCH and its unswerving defender) arranged the transfer of several of the health centres to the Natal Provincial Administration. Two years later Gale again staved off the inevitable dénouement by securing a five year grant (1955-60) from the Rockefeller Foundation, to provide community health training for medical students through the Durban Medical School's Department of Social, Preventive, and Family Medicine.[9] By 1956 the transfer of IFCH control from the central to the provincial authorities was complete, but did not arrest the gradual strangulation of resources. The twilight of this era of social medicine culminated in 1960, with the downgrading of the remaining IFCH centres to outpatient clinics; other NHSC-inspired health centres in other parts of South Africa faced the same fate. The Department of Social, Preventive and Family Medicine shut down in 1960, and the IFCH formally closed in January 1961.

While the exodus of key figures such as George Gale in 1955, the Karks themselves in 1958, and other "guiding lights" signalled the closing of a chapter in South Africa's health care history, new pages opened in other countries, namely the United States, Israel, Uganda, Malaysia and Thailand.[10] The Karkian model eventually became known as Community Oriented Primary Care (COPC).[11] Many of COPC's key features

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[9] George Gale left government in 1952 to become the Durban Medical School's second dean, remaining in this position until 1955 when he left South Africa for Uganda, where he founded the Department of Preventive Medicine at Makerere University. In 1960 Gale tried to persuade the Rockefeller Foundation to renew its funding of the IFCH medical student-training programme in community health but the Foundation was unwilling to resuscitate a project which was clearly being politically suffocated.

[10] For a complete listing of where and when IFCH staff emigrated, see Chapter 4.3

[11] COPC's main components, as summarised by Dr. Jack Geiger, an American practitioner of COPC and a Karkian disciple since his 1957 Rockefeller-funded medical clerkship in Pholela, Lamontville and Merebank, are "the community as focus; the development of family health teams; the training of

inform the philosophy of primary health care (PHC) adopted by WHO in 1978 at Alma Ata.[12]

1.3 SIGNIFICANCE OF THE STUDY

The experience of IFCH HEs may offer useful lessons for contemporary health educators, CHWs, and programme planners and evaluators by incorporating HEs' own perspectives about successful or unsuccessful methods of health education.

This study broadens the historiography of community health in South Africa, engaging studies of the IFCH, health education, and public health personnel representing various "racial groups". Many previous investigations into the scope of IFCH activities in South Africa draw the bulk of their evidence from the writings of the Karks and their professional colleagues. This thesis taps into these primary sources but it also uses oral histories of HEs as frontline workers to explore how the Karks' programme of social medicine emerged on the ground. Where previous scholarship about the implementation of the Karkian model focused largely on the African communities of Pholela and Lamontville, this study explores the IFCH's impact across racial boundaries. All four of

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indigenous workers as family health aides, environmental sanitarians, and health educators; and the emphasis on demography and epidemiology."

[12] The Alma Ata Declaration, adopted by 134 countries, outlined seven principles of PHC, summarized by Bender and Pitkin (1987):

1. PHC is a product of a country's economic conditions and sociocultural and political characteristics
2. PHC responds to the main health problems in a community
3. Priority programs of PHC: health education (prevention and control of prevailing problems; promotion of proper nutrition, water supply and sanitation; maternal and child health, including family planning; immunisations; prevention and control of locally endemic diseases; treatment of common disease and injuries; and the provision of essential drugs.
4. Intersectoral co-operation is important.
5. Community participation and initiation are necessary.
6. PHC is sustained by integrated and supportive referral systems.
7. PHC relies on health workers of all levels (doctors, nurses, midwives, community health workers, as well as traditional practitioners).

South Africa's designated racial groups participated in the IFCH, both as providers and receivers of services. Rather than singling out one group for study, the emphasis here is on exploring the contributions of white, African, and Indian HEs, individually and as a whole.[13]

1.4 OPERATIONAL DEFINITIONS USED IN THE STUDY

1.4.1 Health Education

"Health education" may be defined as "the art and science of helping people change their lifestyles to move toward a state of optimal health" (O'Donnell, 1986) as well as any related organisational, political and economic interventions (Green et al,1980). As a "continuum of learning", health education "enables people as individuals and as members of social structures, to voluntarily make decisions, modify behaviours and change social conditions" in ways which enhance their health (Joint Committee on Health Education Terminology, 1990).

Since the 1980s, health education has also been referred to as "health promotion" in literature about the health sciences. The two terms are not necessarily synonymous, though they are often used interchangeably (Caplan, 1993; Israel et al, 1994). "Health education" is used throughout this thesis because it is the terminology chosen by the interview subjects, the Karks, and scholars writing about the IFCH; I also believe that there is sufficient overlap in tenets and practice to justify using a single term. Historically, the phrase "health education" emerged in the 1940s and largely subsumed

[13] The exclusion of Coloured health educators is not intentional but rather is a consequence of the convenience sampling method used in this research (see Chapter Three). The research was conducted in KwaZulu-Natal, a province with a relatively small Coloured population historically and today. For an exploration of Coloured HEs who served a Coloured community, see Phillips (2005, forthcoming).

what was previously known as "health propaganda", which referred more specifically to a variety of media conveying information and instruction about health-related topics. The term "health promotion" emerged in the mid-1980s, within the context of the "new public health"; the 1986 Ottawa Charter on health promotion articulates its "action arenas" and methodologies (Epp, 1986). While there has been much debate about whether and how "health education" differs from "health promotion", various comparisons of the two disciplines in the late 1980s and early 1990s concluded that they comprised the same aims and strategies. As one analyst noted, "there appears to be a shift in title rather than a true shift of paradigms" (Rawson, 1992).

1.4.3 Health Educator

A definition comprehensive enough to encompass the range and variety of health educators, past and present, professional and paraprofessional, would necessarily be a sweeping generalisation. Any individual who facilitates the educational activities and ecological supports aimed at improving people's personal health behaviours may be described as a health educator. A central concern of this thesis is to ascertain the role and duties of "health educators" within the Karkian model, so definitions of these personnel appear throughout.[14] Health educators at the IFCH and Pholela were paraprofessionals who worked closely with families and groups to address and change harmful health-related beliefs and practices in favour of more salutary ones. The venue for HEs' interventions included home visits and community forums such as schools. In addition, health educators performed a key research and evaluation function by collecting epidemiological and demographic data in door-to-door surveys.

[14] See for example Chapter 2.6 and Chapter 4.4.

1.5 THEORETICAL FRAMEWORK OF THE STUDY

1.5.1 Social and Oral History

The methodologies of social history as well as oral history inform the theoretical approach of my thesis. Social history in South Africa, pioneered by historians Phil Bonner, Peter Delius, Charles Van Onselen and their colleagues at the Wits History Workshop, focused on reclaiming the testimony of people marginalised by colonial rule. Scholars such as Belinda Bozzoli, Jo Beall, Cheryl Walker, Cathy Burns, and Shula Marks, expanded the theoretical angles of social history by incorporating perspectives of gender.

If, as Shula Marks points out in *Divided Sisterhood* (1994), power relations in the health sector—shaped by class, race, and gender divisions—made nurses in South Africa "invisible", how much more invisible are health educators, who lack the protections of a professionalised identity? How much more "irrelevant" to the grand narrative of elite history, which until recently had dominated the history of medicine in South Africa and elsewhere?

Historian Gert Brieger demonstrates that over the last twenty years social historians increasingly challenged longstanding historiographies of medicine that emphasised great men of science and their technological advances (Brieger, 1993). The protean historian Roy Porter was one of the foremost advocates of this approach, and his panoramic study, *The Greatest Benefit to Mankind,* broadens the history of medicine to encompass evolving health beliefs and practices in different cultures, the respective roles

of the physician and patient, and changing patterns of health care and policy (Porter, 1997).

Closely linked to social history's mandate to uncover neglected sources is oral history's aim to record previously silenced voices. The multiple versions of the past that oral historians elicit illustrate the epistemological premise that history is not made up of verifiable truths, but rather layers of interpretation. Oral history is concerned not only with events, but with the *meaning* of events. In this sense, individuals' stories become more than discrete phenomena; they are social constructions embedded within particular historical moments and power structures. My thesis illuminates how the IFCH health educators' narratives are shaped by their structural milieux, just as the practices and discourses of medicine and public health are subject to mutable political and social contexts as well as time and place.

South African and Africanist oral historians' who have most influenced my work include Philippe Denis, Isabel Hofmeyer, Carolyn Hamilton, Charles van Onselen, Paul la Hausse, Jan Vansina and David Henige. These scholars provided methodological models as well as crucial insights into the nature of oral history, such as its capacity (particularly in a country like South Africa) to "affirm and consolidate identities, individual as well as collective, that have been repressed in the past. In oral history process counts as much as the contents" (Denis, 2003). In addition, an overview of the broad concepts and problems of oral history come from the scholarship of Ronald Grele, Paul Thompson, Luisa Passerini and Alessandro Portelli. Grele's injunction to view oral history as a collective effort of interviewee and interviewer, moulded by what he calls their ideological "worldview", informed my analysis (Grele, 1985). The perceptions that

Luisa Passerini brought to the question of contradictions or omissions in oral testimony were invaluable when I encountered disjunctures in the HEs' interviews (Passerini, 1987). I also employed Alessandro Portelli's concept of multiple modes of history-telling—personal, community, and institutional—to probe health educators' narrative descriptions of the IFCH (Portelli, 1997:27).[15]

1.5.2 Political economy of health

A body of scholarship dealing with the political economy of health helped me place the IFCH within wider historical processes. This paradigm applies insights from a materialist perspective (often but not exclusively Marxist theory) to scrutinize how capitalist dynamics combine with state power to dictate the unequal provision of health care services. Reisman (1993) and Doyal and Pennel (1979) apply the paradigm to health care services and policy in general; Fayola and Ityavyar (1992) and Feierman and Janzen (1992) focus on how structural forces ordain health care distribution in Africa. In the South African context, historians Maynard Swanson (1977), Randall Packard (1984, 1986, 1989, 1992), Shula Marks and Neil Andersson (1988, 1989), Elaine Katz (1994),

[15] Portelli's three modes of history-telling:

1. Institutional
   - Social referent: politics and ideology; government, parties, unions, elections, etc.
   - Spacial referent: the nation, the state
   - Point of view: third person, impersonal
2. Communal
   - Social referent: the community, the neighbourhood, the job; strikes, natural catastrophes, rituals, collective participation at the institutional level
   - Spatial referent: the town, the neighbourhood, the workplace
   - Point of view: first person plural
3. Personal
   - Social referent: private and family life; the life cycle: births, marriages, jobs, children, deaths, personal involvement in two other levels
   - Spatial referent: the home
   - Point of view: first person singular.

Karen Jochelson (2002), Susan Parnell (1993) and Alan Jeeves (2001) showed how segregationist ideology and industrial development steered public health policy, particularly when diseases ran rife as a direct consequence of capitalist activities such as mining and the migrant labour system. The work of Randall Packard in particular, illuminates the complex relationship that evolved between changing sets of political interests, and patterns of sickness (e.g. malaria and tuberculosis) in the African population.

1.5.3 Critiques of health education and public health

Theoretical considerations of health education share certain concerns with the sociology of medicine, such as how human and power relationships are formulated and perpetuated by the institutions and discourses of medicine and health (Jones, 1991). Critical analyses of health education investigate the values, assumptions and constructions inherent in health policy and rhetoric (Lorig and Laurin, 1985). From the 18th and 19th century eras of sanitary reform and hygienism to 20th century innovations such as health propaganda films, public health has always had a "medico-moral" agenda. Since the mid-20th century, health education has increasingly served as the vehicle for this agenda (Lewis, 1986). Health education's attempts to induce people to change "unhealthy" beliefs and practices into health-promoting ones hinge on the manufacturing of consent. As Jeeves and Vaughan show in their discussions of health propaganda films about venereal disease that were shown in Africa in the 1940s, health education and the biomedical model it advanced intended to not only to cure but to transform audiences (Vaughan, 1991; Jeeves, 2001*b*).

Critical approaches to health education entail questioning "whose voices are being heard and privileged, the alliances and conflicts involved, what body of expertise is cited in support...and how [knowledge] is organised, controlled, authenticated...and used by health promotion practitioners" (Lupton, 1995:49). Often, such questions are framed by the theories of Michel Foucault.

Foucauldean notions of governmentality[16], bio-power[17] and subjectivity[18] have been adopted and applied by a number of scholars writing about health and medicine (Turner 1994, 1997; Gastaldo, 1997; Lupton, 1995, 1997; Butchart, 1998). These concepts provide a provocative prism through which to consider aspects of the IFCH approach to health promotion, but ultimately, they jostle uneasily against the realities of the disease landscape that defined South Africa in the Karks' time and continue to define it today.

Foucauldean disciples such as Alexander Butchart contend that the Pholela health centre's efforts to collect health statistics on a community previously deemed to be beneath statistical notice, represent an insidious extension of the "clinical gaze" by the state and other controlling bodies. Similarly, he regards health education in African communities (by Africans) as an attempt to co-opt them into self-castigating "subjectivies". However, his analysis ignores the actual status of health and disease in the

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[16] "Governmentality" incorporates both self-government, and the more apparent forms of external government such as policing, surveillance and regulatory activities carried out by the state or other institutions (Foucault, 1991). However, power relations are seen as diffuse and embedded in all areas of social life.

[17] "Bio-power" refers to mechanisms of control and coercion employed to manage populations and discipline individuals through norms of health behaviours (Foucault, 1983).

[18] "Subjectivity" involves the internalisation of ethical systems and moral imperatives, which then produce identities and self-transforming behaviours (Foucault, 1986).

African population (Jeeves, 2000), and appears to deny African agency in changing health-related attitudes and behaviour patterns.

Nevertheless, since my thesis seeks to situate the health education component of the IFCH within a broader theoretical context, critiques such as Butchart's provoke necessary debates about competing interpretations of the impact of medicine and public health on "subject" populations.[19] Some arguments challenge the notion that the state has a right to "interfere" into the activities and attitudes of its citizens, even if its interventions derive from the utilitarian objective of achieving a better health status for all (Minkler, 1989). Such objections spring from opposite sides of the ideological spectrum. On the right, opponents of public health measures favour a laissez-faire model of government (Davies, 1991), and on the left, radical critics argue that public health fails to address the structural causes of ill-health and enable people to challenge and remove these conditions through collective action (Bunton and MacDonald, 1992). Both sides question whether the state ought to be the final arbiter of the public's best interest (Brown and Margo, 1978).

Another outcome of postmodernist-inspired debates about public health, medicine and health education, is an engagement with the concept of reflexivity.[20] Reflexivity in public health workers, medical practitioners and health educators involves a self-interrogation about their use of knowledge and awareness of the interests they serve as part of their practice. Yet reflexivity's temptation to shade into solipsism may seem a

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[19] For a wider discussion of the typology of "native subjects" and colonial "citizens", and the unequal relationships between them, see Mahmood Mamdani (1996).

[20] "Reflexivity" entails an awareness that no discourse or knowledge is value-free, so it is important to concede one's own position as a producer and reproducer of certain discourses and practices, and to acknowledge the personal values that permeate them (Lupton 1997).

callous luxury amidst the exigencies of life and death, particularly in developing countries. Still, it must be remembered that this self-consciousness first came as a corrective to the complacencies of the past, when health professionals and assorted experts moralistically prescribed codes of conduct to ensure not only health but also social control, particularly for African populations that were seen as unable or unwilling to control themselves (Vaughan, 1991; Wylie, 2002). References to the "backwardness" of Africans abound in the medical discourse of much of the 20th century, and were present even in the early writings of Gale (1934) and Kark (1952), in which "backwardness" is evoked as a justification for health interventions. Public health (and housing) policy in South Africa was long distorted by fears of African contagiousness—the "sanitation syndrome" (Swanson, 1977)—and well into the 1940s, the state reacted to epidemics in the African population by measures apparently intended to humiliate and control rather than cure.[21] Given this history, anyone writing about health in South Africa may do well to be aware of the complexities of power relations, and the myriad ways in which they operate, both consciously and unconsciously.

1.5.4 "Community" and Health

One area in which hidden (power) agendas may lurk is the seemingly commendable sphere of community empowerment as a correlative of health programmes.[22] The Karkian model encouraged what it called "community organisation"

[21] Marks and Andersson (1988) cite the government response to various typhus epidemics in African populations, including forced fumigation of Africans travelling on trains. Even after effective vaccines became available in the early 1940s, the government deferred their distribution to Africans, citing cost and concerns about their efficacy.

[22] "Community empowerment" is a process by which individuals work collectively to increase control and access to resources and to ensure that their needs are addressed and/or met, thereby enhancing such quality-

as a vector of better health.[23] While the term "community" will be used throughout this thesis without the dubious protection of quotation marks, the problematic and nebulous meanings of the term must be acknowledged. "Community" implies a homogenous entity, obscuring differences within the group itself. In South Africa, the term has particularly ambiguous connotations, as it was used since the 1930s in the discourse of separatism and domination. Only since the 1970s was "community" adopted by liberation actors such as the Black Consciousness movement, sometimes in an equally indifferentiated sense: "The assumption was often made that a community of purpose always existed and that people representing a 'community' would act for the common good"(Ramphele and Thornton, 1988; see also Bozzoli, 1987).

In the post-Alma Ata health sphere, "community development" and "empowerment" have more commonly been used to describe the decentralization of services rather than substantive changes to health and state systems (Walt, 1990; Watts 1997; Phillips and Verhasselt, 1994). In South Africa, as in other developing countries, Alma Ata rhetoric was co-opted even by the apartheid state as a smokescreen to legitimate inequalities (Marks and Andersson, 1989)[24]. Despite its potential for questionable usage, "community" is an unavoidable, indeed central, term, and will be

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of-life indicators as health and safety. An empowered community is one that can work through existing social networks to influence political, social and economic processes (Schulz et al 1997; Rappaport 1995; Booker et al 1997)

[23] See Chapter Five for a discussion of the Karkian model's promotion of community organisation.

[24] During apartheid, representatives of the state mechanically assigned the label 'community' to groups of people forced to reside in designated areas, thus reinforcing arbitrary racial categories and the concept of 'group areas'. "Community empowerment" was sometimes used to suggest that what transpired within 'communities' was more important than developments in the wider society, and to deflect attention away from broader social transformation. (Butchart and Seedat, 1990).

used in this study in the same spirit in which it occurs throughout the Karks' writings and the IFCH HEs' interviews.

1.6 RESEARCH APPROACH

- Qualitative, naturalistic, and exploratory.

Qualitative research is more appropriate when the research aim is to find out what people do, know, think and feel, and where context, setting, and subjects' frame of reference are such important and complex factors (Denzin and Lincoln, 2000). As an alternative to quantitative methods of assessment commonly found in discussions of community health programmes, qualitative evidence—health educators' own narratives about themselves and their work, presented through in-depth interviews—may reveal themes that cannot be fully conveyed through evaluations and surveys.

The study's research approach is also informed by a naturalistic paradigm which assumes that a single reality does not exist (Guba and Lincoln, 1989). The perceptions of people (i.e. health educators) in a particular context combine to constitute "reality", with significant variance among these perceptions. No one person has the one true or correct perception. Collectively, perceptions complement each other and create a representation that contributes to an understanding of the context.

The research design and methodology will be discussed in greater detail in Chapter Three.

1.7 ORGANISATION OF REPORT

Chapter Two is a literature review and is organised into six sections, which define key concepts.

Chapter Three presents the study's research methodology. The choice and selection of the sample are described in the context of the research design. The chapter concludes with a discussion on the study's limitations and ethical considerations.

Chapter Four expands on the historical background relevant to a study of the IFCH, including the 1942-44 National Health Services Commission's recommended plan of health centres, and contextualises health educators within the IFCH's structure.

Chapter Five focuses on various aspects of the IFCH approach, particularly its merging of anthropology and epidemiology, and its efforts to stimulate community development.

Chapter Six presents and analyses the collected data from interviews with IFCH HEs.

Chapter Seven discusses the findings from Chapter Six and outlines the study's conclusions.

CHAPTER TWO: LITERATURE REVIEW

Various bodies of scholarship helped situate my research within currents of social science and identify gaps or controversies where further explorations are necessary. I will outline the historiographical debates as well as the extant literature dealing with health education and Community Health Workers (CHWs), dividing this chapter into six major themes with corresponding key references.

2.1 Twentieth-century South Africa and apartheid

Over the last forty years, historians of twentieth-century South Africa have worked within certain scholarly approaches that tend to positions themselves in reaction to a rival, preceding academic trend. Rather than attempt a cursory overview of that apply to my study.[25]

[25] I am indebted to analyses of South African historiography by Wright (1977), Rich (1984); Saunders (1988); Grundlingh (1988; 1991); Cell (1982); Thompson (1985); Posel (1983; 1991); O'Meara (1991); Nuttall and Coetzee, eds. (1998); Cobley (2001); and Carton (2003).

An early "settler" version of history postulated by George M. Theal in the late 19th and early 20th century, amended shortly thereafter by G.E. Cory, is a pertinent starting point because it posited views of pre-colonial African "tribes" and the "heroic" incursions of white civilisation which dominated academic curricula until at least mid-century and formed the basis of popular white conceptions of race. By the 1920s, this "settler" or "frontier" tradition began to be disputed by the nascent "liberal" school through the work of historians such as W.M. MacMillan, Eric Walker, C.W. de Kiewiet, J.S. Marais and by the late 1940s, Arthur Keppel-Jones and Leonard Thompson. Other prominent liberal scholars representing disciplines from anthropology to economic history and political science, included figures like Monica Wilson, David Welsh, Edgar Brookes, Alan Paton, Leo Kuper and Francis Wilson, to name a few.[26] The work of these liberal writers formed part of the intellectual and political habitat of the principal actors of my thesis, from George Gale, Henry Gluckman, Sidney and Emily Kark, to some of the health educators themselves.[27]

Parallel in development to the liberal tradition but contrary in intent, was Afrikaner historiography. Since the late 19th century, scholars such as S.J. du Toit, E.G.

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[26] Obviously, these figures span a wide range of time and views; they also express different liberal positions from paternalist humanism to democratic socialism. Due to space constraints, many of the fascinating permutations of South African liberalism cannot be explored here. This proviso also applies to the liberal historiography that developed since the 1970s led by Jeffrey Butler, Richard Elphick, Phyllis Lewson, and others. I assume a risk by using the term "liberalism" with the same imprecision that characterises its popular usage in South Africa, as a catch-all phrase denoting a spirit of inter-racial goodwill, constitutional protections, and a relaxation of state interference in the lives of "non-whites".

[27] The Karks, for example, were exposed to many of liberalism's most eminent formulators while studying at the University of Witwatersrand in the 1930s. The Karks cite the lasting influence of early mentors such as Winifred Hoernlé, who initiated the Social Anthropology Department at Wits, and her husband R.F.A Hoernlé; J.D. Rheinhold Jones and his wife Edith (co-founders of the Institute of Race Relations in 1929); W.M. MacMillan and in the Medical School, Raymond Dart, Joseph Gillman, W.H. Craib and Eustace Cluver. The Karks' deep interest in anthropology was, in part, sparked by noted liberals Leo and Hilda Kuper. In Natal, the Karks most likely came into contact with Edgar Brookes and Alan Paton. Finally, some of the HEs interviewed were Liberal Party members under Alan Paton's leadership.

Jansen and C.J. Langenhoven promoted a nationalist project that reified Afrikaner cultural identity, with attendant political and economic protections based on ethnicity and race.[28] After the Nationalist Party came to power in 1948, the Afrikaner interpretation of history permeated school curricula until well into the 1980s (Grundlingh, 1988; Freund, 1989; Thompson, 1985). While central racial assumptions of white English-speaking South Africans and Afrikaners were fundamentally similar from the late 19th century into the segregationist era (and arguably afterwards), post-1948 Afrikaner historiography increasingly detailed a set of positions that liberal historians actively rejected.[29] For example, the latter saw apartheid as an ascendant form of Afrikaner nationalism that entrenched cultural and racial exclusiveness. This view, which saw the 1948 Nationalist Party victory as the death-knell of liberal aspirations, accounts for the demise of institutions such as the IFCH, according to the Karks (2001), their associates (Susser, 1993; Salber, 1989), and some of the health educators.

The liberal commitment to more equitable race relations, attained through incremental political, legal and moral means, rather than by revolutionary structural change, underpinned the IFCH's mission. Although liberal figures expressed a broad spectrum of opinions regarding the role of capitalism and economic development, they achieved some consensus when discussing the necessary creation of a stable, urban black labour force which would facilitate the eventual assimilation of Africans, Indians and

[28] This encompassed a version of Afrikaner history that stressed triumphalist historical progress and a divinely ordained "Covenant" that ensured frontier military victories, as well as Afrikaners' persecution at the hands of British forces.

[29] For examples of liberal historians' anti-Afrikaner stance, see Thompson (1964) and Troup (1972).

Coloureds into South African society.[30] By the late 1960s liberal commentators such as Hobart Houghton, W.H. Hutt and Ralph Horwitz championed the view that a free market economy would inexorably correct racial disparities. Other liberals such as Monica Wilson were more hesitant about capitalism's "enlightened self-interest" but nevertheless accepted free market economics as a viable arena for the amelioration of racial inequality (Wilson, 1972).

By the 1970s Marxist historians such as Martin Legassick, Shula Marks, Stanley Trapido, Anthony Atmore and Harold Wolpe, leaders of the nascent "radical" or materialist school, had begun to assess critically the dominant liberal paradigms.[31] From this period onwards to the first all-race elections in 1994, South African historiography revolved around tensions between these two schools. Materialist historians differentiated themselves from liberals by repudiating the view of modern South African history as a struggle between economic and social integration versus racial oppression and political segregation. Indeed, Marxist scholars argued that racial oppression and political power were the handmaidens of capitalist exploitation. Harold Wolpe, for one, proposed that the South African state acted as a proxy for capitalist interests, resulting in a "paradoxical neglect...of state structures and the political terrain in work concerned with the state." (Wolpe, 1988:39). This interpretation has intriguing implications for how the NHSC and the IFCH operated as state initiatives.

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[30] In the 1940s and 1950s, the most visible proponents of economic assimilation were Native Representatives Margaret and William Ballinger and Leo Marquard. These parliamentary liberals called for a qualified franchise of "civilised" blacks, and were opposed to ANC demands (from 1943) for universal suffrage (Everatt, 1988).

[31] It must be emphasised that historiography, like any other discipline, is dynamic. Scholars aligned with a particular school at one time may be associated with its repudiation a few years later. Several of the Marxist scholars mentioned above have followed just such variegated trajectories.

Within a few years, the materialist view faced critiques by "revisionist" scholars who veered from the economic reductionism of previous Marxist approaches. Representative revisionists such as Colin Bundy, Charles van Onselen, Deborah Posel, John Cell (the latter two from a sociological perspective) moved away from more orthodox materialist analyses to consider the complex interactions of race and class, with a sharpened awareness of how these categories emerged as constructed identities.[32] For example, Cell (1982), Dubow (1989) and Posel (1991), argued that early apartheid was characterised not by a monolithic racist "grand plan" but contingent rather on provisional developments and shifting political exigencies.[33] Understood in this more flexible explanatory framework, the NHSC's plan to provide health services for "non-whites" (and the continued existence of the IFCH until 1960) may be viewed less as a liberal anomaly than a typical instance of early apartheid contradictions. Marks and Andersson (1989) pointed out that hallmark health legislation in South Africa—punctuating the years 1919, 1944 and 1977—emerged in the wake of heightened worker militancy. Accordingly, the government's decision to implement even a fraction of the NHSC's reforms may be seen a canny attempt to co-opt the support of liberals and placate black radicals.

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[32] Race, in particular, may be viewed as a shifting and provisional construct. Racial or ethnic identification and self-identity may change according to political or social pressures. As Irina Filatova pointed out regarding the colonial context, 'Africans', 'Europeans', and 'Indians' were created "as a mechanism of redistribution and exploitation within the framework of colonial society. Their corresponding colour-tainted identities gradually emerged as a result of common interest formed by colonial social engineering." (Filatova, 1996:11). For more on race and the IFCH, see Chapters Six and Seven.

[33] Cell (1982) and Dubow (1989) asserted that it was precisely white supremacy's flexibility and ambiguities, including its ability to enlist the consensus of "non-whites" through collaboration and accommodation, which ensured its continuance. See also Ivan Evans' analysis of the Dept. of Native Affairs (DNA), which incorporated African chiefs into its administrative apparatus to ensure a "culture of compliance" (Evans, 1997).

A parallel development in social history of South Africa, ascendant since the late 1970s, was the advent of oral history as a means to recover "hidden" pasts of marginalised groups. Pioneering work by Phil Bonner (1983), Peter Delius (1983), Jeff Peires (1981), William Beinart (1982), Helen Bradford (1987), Jeff Guy and M. Thabane (1987) used oral testimony in conjunction with archival sources in a quest to deepen understanding of various communities and the fabric of their social, economic and cultural life.

Since the 1980s, South African historiography has been increasingly eclectic, with historians employing a range of theoretical perspectives. Variants of liberal, materialist, revisionist or social analysis may be applied, and the work of previous historians may be considered from diverse standpoints rather than from an opposing school of thought, allowing for more subtle evaluation. For example, a defender of liberalism such as Richard Elphick observed—somewhat ruefully—that elected liberals such as Edgar Brookes and the Ballingers operated "more like social workers than social analysts...rarely subject[ing] the society or themselves to a systematic critique" (Elphick, 1987:73), while Paul Rich, from a more tendentious angle, similarly concluded that "[liberals] concentrated on questions of welfare rather than those of power" (Rich, 1984:22). Such assessments are crucial to understanding the role of liberals who inspired and implemented the IFCH's vision.

2.2 History of health services in South Africa

This study's concern with social history has benefited from scholarship on the history of medicine in South Africa that explores social, racial, and economic dimensions

of health care provision.[34] Pioneering works by Burrows (1958) as well as Laidler and Gelfand (1971) demonstrated that medical services for non-whites (excluding traditional healing) were minimal to non-existent in the colonial period and beyond.[35] Throughout the 19th century and for much of the 20th century, the predominant providers of basic health care for Africans were medical missionaries, whose contributions have been well documented by Gelfand (1984), Etherington (1987), Comaroff and Comaroff (1991), among others.[36] Although the NHSC and the IFCH emerged in an era when the South African state exerted greater control over such services, the medical missionary influence, embodied by figures such as James McCord, Alan Taylor and institutions like McCord Hospital, remained a powerful force in the provision of health services for Africans, particularly in rural areas.[37] While not primarily historical, investigations by

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[34] For a general overview of the links between Western medicine and European expansion in Africa, see MacLeod and Lewis, eds. (1988); also Ernst and Harris, eds. (1999) for explorations of the influence of racial and "scientific" theories on colonial medicine.

[35] See also a study by Gelfand (1976), on health services for Africans in Southern Rhodesia (Zimbabwe) from the late 19th to mid-20th century.

[36] Studies by Megan Vaughan (1991) and Terence Ranger (1981; 1992) on medical missionaries in Central and East Africa place missionaries within the larger context of colonialism and African health.

[37] The ties between medical missionaries and the IFCH are myriad and intriguing, given the Karks' (resolutely secular) Jewishness. Sidney Kark's first intensive exposure to missionary medicine occurred in 1938, when as a recent medical school graduate, he conducted the Bantu Children's Nutrition Survey for Harry Gear, Deputy Chief Health Officer. While carrying out this research in rural areas, Kark usually stayed at mission hospitals. As he later recounted, "I really got an introduction to a number of missionaries who at that time were probably the most liberal white element around us." Interview of Emily and Sidney Kark by Prof. C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992. p. 2. Further links between the IFCH and missionaries include Dr. James McCord's early sponsorship of Edward Jali (later the Chief Medical Aid at Pholela and Durban, and an extremely important figure in the Karks' life and work). McCord employed Edward Jali as a dispensary assistant at McCord Hospital, and later helped fund Jali's training as a medical aid at Fort Hare. Jali's wife, Amelia, did her nursing training at McCord Hospital. The Jalis were introduced to Sidney and Emily Kark by Dr. Alan Taylor, McCord's successor as director of McCord Hospital. Emily and Sidney Kark had also worked at McCord Hospital following their graduation from Wits Medical School. Moreover, George Gale was the son of a missionary and in 1928 established a medical mission in Msinga under the auspices of the Church of Scotland; in 1932 he moved the hospital to Tugela Ferry, where he stayed until 1936. Edward Jali worked as a medical aide at this mission hospital and its outlying districts in 1940, after which he joined the Karks in Pholela. UKP H6/1/1 Dr. George

Van Rensburg et al (1986), Nobuhle Torkington (2001) and especially, Cedric de Beer (1984) on the impact of apartheid on health services in South Africa, provided an incisive overview of racially-dictated inequalities in the health sector.[38]

Catherine Burns extensively documented the intersections between gender and race in the medical arena, particularly women's health care in South Africa (1994), male nursing (1998) and African therapeutic practices (1996). Burns' analysis of how medical authority and gender norms shaped legislation, services and nursing training provided valuable points of comparison for my study. Shula Marks' history of South Africa's nursing profession (1994) illuminated the challenges confronting African nurses struggling to gain a foothold in a field rife with racial, gender and class divisions. As paraprofessionals whose functions did not include hands-on care, African, Indian and Coloured HEs occupied a different occupational stratum from African nurses, but they too faced institutional barriers exacerbated by race, gender, and professional restrictions.[39] Karin Shapiro's account of the ill-fated Medical Aid training scheme at Fort Hare (1936-46, with interruptions during the war) offered penetrating insights about debates surrounding the training of black male health care providers (Shapiro, 1997).

Scholarship on the relationship between disease and social inequality in South African history from a political economy of health perspective includes seminal

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William Gale and the Medical School at the University of Natal: A Short Tribute (By His Wife); see also Gelfand, 1984:136-9. Re: Jali at Msinga: see McCord, 1946:273-6).

[38] de Beer's study does contain a strong historical element, particularly his chapters on the social history of tuberculosis and on the National Health Services Commission.

[39] Although HEs were a crucial component of the health team, as conceptualised by the NHSC and the IFCH, their status was nebulous in the larger health care sphere. Sidney Kark attributed the refusal to formally incorporate HEs/CHWs into health teams in the 1980s and beyond to the gate-keeping efforts of Charlotte Searle, for many decades head of the South African Nursing Council (Kark, oral communication with Stephen Tollman, February 1992, cited Tollman, 2002).

investigations by Maynard Swanson (1977); Randall Packard (1989; 1992), Karen Jochelson (2001); Elaine Katz (1994), Howard Phillips (1990) and Diana Wylie (2001). These authors respectively used bubonic plague, tuberculosis, syphilis, silicosis, Spanish flu and malnutrition as test cases to demonstrate how high rates of African mortality in the 20th century reflected overarching patterns of mine labour, migration and racial domination. Responses by government, industry and the medical profession to these "crises in African health" operated within a narrowly conceived biomedical framework, preserving both the exploitative status quo and the resultant disease burden of Africans. The work of Marks and Andersson (1988, 1989, 1992) comprehensively analysed the unequal allocation of health resources in South Africa in terms of class, race and structural factors such as industrial capitalism.

Public health policy and discourse is an important theme within the history of medicine. Here Maynard Swanson's 1977 article remains the classic commentary on the "sanitation syndrome", in which the metaphorical association of Africans with disease was invoked by medical and municipal authorities as a rationale for social control, principally residential segregation.[40] In a similar vein, Sue Parnell demonstrated how the discourse of public health and hygiene was wielded by policy makers intent on "slum clearance" of urban Africans (Parnell, 1993).[41]

2.3 The NHSC, the IFCH, the Karks and COPC

[40] Swanson coined the term "sanitation syndrome" to refer to "a metaphor of disease and infection [which] became an almost universal currency for the conception and discussion of race questions and social policy" (Swanson 1976:172).

[41] Parnell focussed on race as a critical instrument of urban partition and land-use change, and documents how municipal councils invoked the 1919 Public Health Act and the 1934 Slums Act in their ostensible quest to prevent overcrowding and insanitary conditions.

In their detailed examination of how South Africa's prevailing social and economic order doomed the NHSC and the IFCH, Marks and Andersson compared the NHSC's attempts to introduce reform with the apartheid government's ostensible revival, in the 1970s and 1980s, of the rhetoric of social medicine; they note that "in the absence of far more fundamental changes of the kind envisaged by the planners of 1944, the recent reformism is unlikely to have much impact on the 'health of the people'" (Marks and Andersson, 1992:160).[42] Marks later revisited her examination of the NHSC (1997) and of George Gale, one of the NHSC's chief visionaries (Marks, 2000). Gale warned that portraying primary care as a cheap solution to the health needs of the poor will inevitably marginalise it as a second-class service, a message that is as opportune today as when first issued in the 1940s. Marks' assertion that the eclipse of social medicine in South Africa predated political opposition from the Nationalist Party is an important corrective to an over-emphasis on 1948 as a cataclysmic finale to the health centre scheme (Marks, 1997).

Marks' concern with drawing out the implications of contemporary South African health sector "reform" is shared by other scholars, particularly Steven Tollman, who in a number of articles explored past and current applications of the Karkian/COPC model (Tollman, 1991, Tollman and Yach, 1993; Tollman, 1994; Tollman and Pick, 2002). Highlighting various strands of COPC such as epidemiology and community diagnosis, Tollman pointed to the "holistic understanding of the causal inferences and roots of disease" shared by the Karks and their associates—George Gale, David Landau, Henry

[42] The "social medicine" features evoked by the South African government in the1970s and 1980s were limited to superficial service delivery mechanisms such as the role of local clinics and the training of paraprofessionals (Marks and Andersson, 1992).

Gluckman, Raymond Dart, and Eustace Cluver—and observed that these reformers' emphasis on the socio-economic dimensions of disease is often missing from current epidemiology (Tollman and Yach, 1993:1044).

In their 1993 article, Tollman and Yach advanced an optimistic vision for a new South African health service that would apply the COPC model, including longitudinal health status surveillance as well as expanded public health training with strong community development and participation components. By 2002, Tollman and Pick offered a more sober appraisal: "the 'pure' form of COPC, with full expression of its essential elements, is unlikely to emerge and be maintained in the South African health sector" (Tollman and Pick, 2002:1727).[43] Full implementation of primary health care at national, provincial and district levels has remained an elusive goal (Tollman and Pick, 2002).[44] Similarly, Alan Jeeves, using the syphilis epidemic in the 1930s and '40s as his example, concluded that the prototype of epidemiological research pioneered in Pholela has not yet been widely implemented in South Africa despite the stated intentions of the current government (Jeeves, 2001*b*). These assessments are pertinent to a consideration of possible parallels between the IFCH health education programme and current initiatives.

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[43] The five essential features, as delineated by Sidney Kark and John Abrahamson (1982) are:
1. Complementary use of epidemiologic and clinical skills.
2. A defined population for which the service is responsible.
3. Defined programs to address community health problems.
4. Community involvement in promoting its health.
5. Health service accessibility; geographic, fiscal, social and cultural.

[44] Tollman and Pick cite examples of individual projects such as the Mamre Community Health Project in the Western Cape and the Agincourt project in the Northern province, that have applied elements of COPC, particularly the use of defined-area census and health monitoring as a programmatic tool to inform interventions and evaluate impacts.

Other important studies on the NHSC and the IFCH include Harrison's examination of the origins and outcome of the NHSC, situating it within the context of reformist calls for a unitary state-run health system in the 1920s and 1930s (Harrison, 1993).[45] Vanessa Noble's history of the Durban Medical School provided an accomplished summary of the Karks' work in South Africa and the IFCH's role in providing community health training for medical students (Noble, 1999). Alan Jeeves expanded on aspects of the IFCH's demise, including a compelling section on a damaging 1947 evaluation of the IFCH by John Ryle (Jeeves, 2000). In the same article, Jeeves' review of Alexander Butchart's *Anatomy of Power* (1999) refuted Butchart's Foucauldean critique of social medicine and the Karks' work in Pholela, particularly Butchart's insistence that the health and census statistics surveyed in Pholela represent a "totalitarian regime" rather than an attempt to address devastatingly high morbidity and mortality rates among Africans. The Karks' contributions to epidemiology and anthropology are the focus of an article by James Trostle (1986), which also highlighted the work of the Karks' colleague John Cassel. Trostle's explication of how the Karks and Cassel amalgamated anthropology and epidemiology was helpful in guiding my interpretation of this component of the IFCH approach (see Chapter Five).

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[45] As early as 1920, parliamentary representatives such as George Mills called for a comprehensive state medical service, combining preventive and promotive care. By 1931, a proposal for such a service came from no less prominent an advocate than Francis Napier, president of the Medical Association of South Africa (MASA). However, Napier's vision was not widely shared by his peers: in the impassioned debates for and against a unitary health service that dotted the pages of the South African Medical Journal throughout the 1930s, calls for a segregated service steadily gained ground. Although MASA had been a (halfhearted) participant in the NHSC meetings, by 1951it had dropped any pretence of support for a plan which jeopardised professional interests. Parliamentary commitment to a unified service, desultory at best, inexorably withered and by 1954 the Tomlinson Report entrenched a separate "Bantu Health Service" (Harrison, 1993).

Finally, among the most indispensable sources of information about the IFCH are the published accounts of key actors and associates: Sidney and Emily Kark in various books and articles (1981; 2001), Jack Geiger (1987; 1993), Mervyn Susser (1987; 1993), Harry Phillips (1993), and Eva Salber (1989). As a correlative to the HEs' interviews, such written sources provided both "global" synopses and vivid portraits of how the IFCH emerged and functioned. They contain revealing details such as Eva Salber's aside about "the white janitor, a Pretoria stooge who spied on us" (Salber, 1989:95). Retrospective in nature, these chronicles offered a more intimate counterpart to earlier reports about the IFCH intended for an official or medical audience (Kark, 1944; 1952; 1962); Gale (1949); Phillips (1962); Salber (1962). At least one HE, Langford Letlhaku, published an article about the IFCH (Letlhaku, 1961), yet like the above-mentioned medical articles, the intent is expository rather than autobiographical.[46] To my knowledge, none of the HEs have yet published autobiographical accounts of their IFCH experiences, so the retrospectives by the Institute's doctors offer a valuable glimpse of the institution "from above".[47]

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[46] Langford Letlhaku, mentioned by the Karks as "one of the outstanding community health educators" at the IFCH, left South Africa in the late 1950s to join George Gale and John Bennett (former director of Pholela health centre) at the Department of Preventive Medicine at Makerere College in Uganda. Letlhaku became a Senior Lecturer, training medical students in health education. He later became head of one of the ministries of Boputhuswana: Interview of Sidney and Emily Kark by Prof. C.C. Jinabhai and Dr. Nkosazana Zuma, 1992, p. 14. The author's attempts to trace the subsequent career and wherabouts of Mr. Letlhaku through archival sources, government departments and networks of Fort Hare alumni (particularly Lesotho graduates) bore no fruit.

[47] One HE, Violet Padayachi Cherry, has co-authored articles on South African health (Susser and Cherry 1982) but has not thus far published accounts of her work at the IFCH. Another, Pramda Ramasar, is currently writing an autobiography about her experiences as an Indian social worker, including her association with the IFCH.
Another essential source of first-hand information about the IFCH are transcribed interviews with Sidney and Emily Kark: Interview by Prof. C.C. Jinabhai and Dr. Nkosasana Zuma Durban 1992 (not in archives); UKP H6/2/3 Interview with Sidney Kark and Professor Gordon on the facts and Aspects of our Medical School which are not Recorded, by S. Cameron-Dow, Dec. 1980.

2.4 Durban in the 1940s and 1950s

As the site of the IFCH, the city of Durban plays a critical role in this thesis. Historical scholarship on Durban in the period under study includes pivotal articles by Swanson (1976; 1983) about Durban as "apartheid laboratory" in which segregatory measures strove to contain white fears about urbanised Africans and the "Asiatic menace" embodied by Indians.[48] A pathbreaking volume about Durban edited by Paul Maylam and Iain Edwards spanned a broad spectrum of black urban life, including chapters germane to this study such as Louise Torr's portrait of Lamontville as well as an examination by Ari Sitas and Tim Nuttall of mid-20th century employment patterns and worker militancy among African labourers (Torr, 1996; Sitas and Nuttall, 1996).

Any consideration of Durban must include an attempt to sift through the complex minglings and divisions among Africans, Indians, Coloureds and whites.[49] Given the preponderance of Indian HEs in the study sample, and the location of IFCH centres in Indian areas of Clairwood and Merebank, the literature on Indians in South Africa is particularly salient. As well, previous discussions of the Karks' work in Pholela and Durban have tended to focus on the African communities served; there is a dearth of

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[48] Swanson argued that African urbanisation was considered illegitimate because it represented a "distortion of natural order". The system of pass laws and barracks for African workers, which emerged in the 1870s, culminated in the 'Durban System' of administration, which aimed to control the movement of African labour in urban areas, and to regulate their living conditions in the towns (Swanson, 1976). Swanson also studied how the importation of indentured Indian labour influenced land allocation in the late 19th century, shaping Durban's segregated spatial-racial geography (Swanson, 1983).

[49] Broader considerations of race and class in South Africa include classic studies by Magubane (1979) and Marks and Trapido, eds. (1987).

scholarship on other communities (namely Indians) that participated in IFCH programmes as service providers and recipients.[50] Key texts on Indians in South Africa include Surendra Bhana and Joy Brain's sweeping history of the early period of Indian settlement (1860-1900), from the arrival of indentured and passenger Indians to their eventual absorption into the political economy of the colonial state (Bhana and Brain, 1990) and a documentary history edited by Bhana and Pachai (1984). Further investigations of socio-economic aspects of working class Indians include studies by Bill Freund (1995) and Vishnu Padayachi and S. Vawda (1999). Freund provided acute insights into aspects of Indian life such as how gender affected the economic logic of the Indian family, and how Indians in Durban responded to the forced removals sanctioned by the 1950 Group Areas Act. Using extensive oral interviews, Freund explored the intertwining of two factors: "the sense that people make of their own lives...[and] the structures which limit the circumstances in which men and women pursue their own destiny" (Freund, 1995:xiii). Freund's quest to trace the connections between these factors offers a potent model for the analysis of oral history.

In his perceptive examination of Indian politics during the 1930s and 1940s, Goolam Vahed explored features of Indians' social and material conditions during the period under study, including the waxing and waning of union activity, competition with African labour, and outbreaks of violence such as the 1949 Durban Riots (1997). Other useful sources were S.R. Maharaj's article on primary and secondary education among

[50] There is similar scholarly inattention to Coloureds who participated in IFCH programmes, but it is more understandable given the small size of the Coloured community in Durban in relation to African and Indian communities. However, some of the health centres set up in the 1940s under NHSC auspices did serve Coloured communities, including one at Grassy Park (Cape Town), studied by Howard Phillips (in Jeeves and Dubow, eds., 2005 forthcoming.)

Indians (1979); R.E. Johnson on Indian political resistance and accommodation to apartheid (1981); and Dianne Scott's geographical analysis of Clairwood, home to the IFCH (1994). The latter work probed how Indians came to occupy the southern Durban corridor (Clairwood and District), a process that was eventually formalised under the municipality's segregatory urban planning. The consignment of Indians to the shack settlements of Durban's "black belt" fed into systematic underdevelopment and neglect of services for health, housing, and education. As the locale of several IFCH health centres, Scott's scrutiny of Clairwood as a "communally constructed space" provided important background for this thesis.

Like the participants' accounts cited in the previous section, Hilda Kuper's study of Indians in Natal (1960) presented an intimate view of this multifaceted community, from an anthropologist whose close ties with the IFCH sharpens her work's relevance to the present study. Some of the material for Kuper's book was collected by the IFCH's Indian HEs (including those interviewed) through fieldwork in Merebank, Springfield and Newlands.[51] Kuper outlined both shifts and continuities within the matrices of Indian culture and tradition, including rituals and beliefs relating to health. As with the Indian health educators' testimonies about their background and the circumstances in which they worked, Kuper unveiled a community at an earlier stage of acculturisation. Another contemporaneous work by an IFCH associate is Leo Kuper's analysis of Durban's "racial ecology" (Kuper, Watts and Davies, 1958). The economic and geographical data collected by Kuper delineated the structural conditions in which the IFCH operated.

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[51] Another researcher with the CSIR unit was Fatima Meer, who worked closely with Hilda Kuper in the anthropological studies of Indian child-rearing. Oral communication with Fatima Meer, 18.02.04. Meer's own work on Indian South Africans (1969) also offered pertinent information for this thesis.

2.5 Similarity between Health Educators and Community Health Workers

While it is not the intention of this thesis to compare various CHW models with the IFCH model, it will provide a broad definition of a CHW to demonstrate a functional equivalence to HEs, and to provide a framework for potential parallels between the experiences of IFCH HEs and contemporary CHWs.

The most compelling argument that IFCH health educators were analogous to CHWs is the fact that in books and interviews, Sidney and Emily Kark used the terms "health educators" (or "community health educators") and "community health workers" interchangeably, to describe the paraprofessionals formerly known as health assistants.[52] Former colleagues of the Karks and other scholars who write about the IFCH or subsequent applications of the Karks' approach also used both terms to refer to this type of personnel (Kark, 1981, Kark and Kark, 1999; Tollman, 1991; Tollman, 1994, Cohn, 1975; Salber and Service, 1979; Steuart, 1987; Geiger, 1984).

Literature about CHWs encompasses a vast variety of programmes and models, yet despite this diversity a broad definition of a CHW emerges: a paraprofessional who ideally is indigenous to his/her community, has similar sociodemographic characteristics to the families he/she serves, and functions as a link between community members and the service delivery system (Ofusu-Amaah, 1983; Berman et al., 1987, Eng et al., 1997; Bender and Pitkin, 1987; Friedman, 2002).[53] This definition applies equally well to the

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[52] See Kark and Kark, 1999:82; also UKP H6/1/1 Interview with Sidney Kark Dec.1980 by Prof. Gordon: Some Facts and Aspects of Our Medical School Which Are Not Recorded, p. 11.

[53] Other synonyms for CHWs: *village health worker, lay health advisors, health aides, natural helpers, navigators, peer educators, and outreach workers* (Eng and Young, 1992). In South Africa, the favoured nomenclature is *Community Based Health Worker* (CBHW), a term which also comprises *environmental*

IFCH HEs. Like their historical counterparts, CHWs participate in home visits, communicable disease control and vaccination campaigns, community development activities, record keeping, and collection of data on vital statistics. (Ofusu-Amaah, 1983; Knight, 1996; Love et al., 1997). CHW duties may include maternal and child health, nutrition, hygiene, sanitation and safe water, use of latrine, solid waste disposal, keeping animals out of dwellings, use of oral rehydration salts and contraception, first aid and immunization. Of these duties, it is only the last four that the IFCH health educators did not perform, though they often referred clients to the clinic for immunisations. Pholela HEs provided first aid and vaccinations for the first few years of the health centre's operation, but by the late 1940s these functions were limited to medical and nursing staff.

Contemporary reviews of CHW and HE programmes are generally presentist in tone, concentrating on contemporary definitions of the approach, programme evaluations, and case descriptions (Karlsson, 1983; Steyn and Meyer,1992; Frankel, 1992). Although some researchers trace the evolution of CHW models and policy over several decades, there has been little attempt to explore previous incarnations of the CHW or primary

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health practitioners, community resource persons, and *Onompilo,* the Zulu word for CHWs. These personnel may represent quite different positions, but they all act "as agents for health promotion, care, and health development. They also provide local outreach for health services that might not otherwise be available" (Friedman, 2002). As "generalist" CHWs, they are distinct from personnel who address specific, isolated areas such as TB (DOTS), HIV/AIDS, nutrition, Home-Based Care (HBS), etc. At the formal end of the continuum is the paid, paraprofessional CHW, who extends the service delivery system by performing tasks that would otherwise be carried out by health services staff, including first aid. Such CHWs must meet certain minimal qualifications (e.g. literacy) and at the completion of training must demonstrate an acceptable level of standardized competencies. These CHWs usually function within a multidisciplinary team model and are often supervised by nurses or other health professionals. At the informal end of the continuum is the unpaid *natural helper* CHW. They may be appointed by their communities on the basis of their reputations of having a caring attitude, discretion, and good judgement (Werner, 1981; Eng and Young, 1992). South African programmes include both ends of the paid worker-volunteer spectrum, but government guidelines recommend adequate renumeration for CHWs, with funding from district and provincial levels dispersed by NGOs. The national government's 1996 decision to delegate CHW programmes to provinces and districts has resulted in significant disparities, with only KwaZulu-Natal, Eastern and Western Cape committed to establishing and maintaining a network of paid workers. In the remaining provinces, CHWs generally receive "incentives" rather than salaries (Friedman, 2002).

health care approach (Walt, 1990, 1993; Folala and Ityavyar, 1992; Feierman and Janzen, 1992). By discussing the roles and functions of the IFCH health educators, this study presents antecedents for CHWs that may prove illuminating.

2.6 Health Education

Literature on health education may be divided into two broad categories: taxonomies of health education models; and attempts to clarify the conceptual contributions from various disciplines including psychology, education, epidemiology and sociology.[54] Examples of the former category are considerably more prevalent than the latter. As the editors of a seminal collection on theoretical developments and debates in health education admit, "there has been little concern for the nature of the knowledge base being drawn upon" by health educators and researchers (Bunton and MacDonald, 1992:62). Representative taxonomies of health education models include Beattie (1980); Tannahill (1985); Rawson and Grigg (1988); Downie et al (1990), Tones et al (1990); Glanz, Rimer and Lewis (2002).[55] So prolific are health education models that some analysts have attempted to reduce their number by identifying areas of linguistic, thematic and methodological overlap. One such study is by French and Adams (1986), which groups health education models by aim, corresponding theories of health and education, and underlying assumptions about humanity and society. Another is by Caplan (1990), who dissects the theoretical basis behind different variants of health education,

[54] Other disciplines that have influenced health education are economics, marketing, and philosophy.

[55] These sources give examples of health education models in developed industrial nations. However, both the form and the content of these models may need modification for use in developing countries, a requirement that the literature seldom recognises (see for example Glanz, Rimer, and Lewis 2002).

from "radical" to "humanist" to "structuralist", and outlines their respective core views, goals, and explanations of the source of problems requiring health education. (See Appendix 5).

Health education theories and models vary in their emphasis on individual—as opposed to social and environmental—factors that influence health. Reviews of health education programmes over the last several decades show an increasing shift away from individually-focused explanations of health behaviour and beliefs to models espousing social and environmental influences—the "ecological model" (Merzel and D'Affliti 2003). As a community-based intervention that stressed the importance of socio-economic and cultural factors at the interpersonal, community and policy levels, the IFCH embodied the ecological approach.

Health education's preoccupation with models gives rise to a caveat: explanatory equations seldom translate tidily from the page to "real life", where people's knotted attitudes and actions are not so readily discerned or directed. For both health educators and their audiences, the pristine connections outlined in models may have little bearing upon how health education messages are given or received. This study seeks to redress this imbalance by ascertaining how one group of health educators transmitted their messages, and how they perceived the reception of their efforts. An important point is that the IFCH HEs' aims and methodology were trailblazing, and not sufficiently routinized to lend themselves to easy extrapolation.

As an intrinsic feature of primary health care (PHC) in developing countries, health education is often incorporated into surveys of PHC and its variants (Sidel and Sidel, 1977; Werner, 1982; Bender and Pitkin, 1987; WHO 1988; Love et al, 1997).

Reviews of specific programmes tend to focus on the "disease prevention" guise of health education rather than "health promotion" (Sutter, 1979, 1984; Heggenhoegen et al, 1987). With the onslaught of the HIV/AIDS epidemic, the preventive element of health education gained greater urgency, and a growing body of research is devoted to evaluations of programme format and impact (Kelly, 1998; Nduati and Wambui, 1997). Yet the demands of the current crisis appear to crowd out historically-based considerations that may provide useful analogies for health education programmes.[56] Historians of health services in South Africa (not an extensive field to begin with) are largely silent on the topic of health education, with the exception of Alan Jeeves (Jeeves 1997; Jeeves 2001*b*).[57] Apart from a mention in most discussions of the NHSC, one would have little idea that health education existed in South Africa until later research includes it as part of a broader PHC mandate.[58] Yet from the 1930s onwards, various forms of health education were promoted in South Africa which reflected contemporary international trends in media-driven "health propaganda" campaigns. The DPH contracted the South African Red Cross to carry out a number of such efforts under the aegis of the National Health Education Committee. The latter body defined its scope as

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[56] Only recently have scholars begun to explore the historical dimensions of the HIV/AIDS pandemic, looking at issues such as changing patterns of sexual socialisation. For a comprehensive survey of historical scholarship on AIDS in South Africa, see special issues of the *South African Historical Journal* (Jeeves 2001*a*) and *African Studies* featuring papers from the 2002 "AIDS in Context" conference (Delius and Walker 2002).

[57] In his examination of syphilis and public health in the 1930s and 1940s (Jeeves 2001*b*), Jeeves discusses two "health propaganda" films the Red Cross produced for the DPH. Intended for African audiences, the films graphically depicted the perils of VD and malnutrition. While proselytising against traditional medicine, the films "falsely impl[ied] that modern medical treatment was available to everyone who sought it" (Jeeves 2001*b*:12). See also Jeeves' treatment of "malaria assistants" in Zululand during the 1930s, whose preventive work included "dissemination of information" (Jeeves, 1997). Malaria assistants are discussed more fully in Chapter 4.5.

[58] See for example Van Rensburg et al, 1986; and Torkington, 2001.

"all forms of health promotion excluded from the sphere of action of the NHSC", in an ostensible attempt to avoid overlap.[59] Given the breadth of the NHSC definition of health promotion/education (see Appendix 2), such overlap would have been inevitable if NHSC proposals had actually been implemented. As it was, health education activities carried out by various government departments and voluntary organisations were sporadic and uncoordinated.

[59] VWN 1006, SW 430/15-1. Minutes from the first meeting of the National Health Council, 11 Aug 1947.

CHAPTER THREE: METHODOLOGY[60]

3.1 SCOPE OF RESEARCH

The scope of research in this study took into account the nature and availability of the subjects (retired IFCH health educators who shared their stories); the nature of the data (i.e. verbal accounts gathered by oral history techniques); and the need to fill gaps and enlarge the extant scholarship about the IFCH.

3.2 RESEARCH DESIGN

The research uses elements of a case study design. Two definitions of case study are here applicable: a detailed analysis of a person or group (i.e. the IFCH health educators) as a model of medical, psychological or social phenomena; and an intensive study of a unit (i.e. the IFCH) that stresses factors contributing to its success or failure (Denzin and Lincoln, 2000). This design was chosen as the most appropriate means of examining the role of health educators within the IFCH and of exploring the IFCH itself, within its historical and political context.

3.2.1 Definition and justification of qualitative research

Qualitative research examines the personal meanings of individual experiences. The data-gathering approach is holistic, with data consisting of detailed descriptions recorded in a naturalistic setting chosen by the research subjects themselves rather than

[60] The presentation of methodology in this chapter follows guidelines suggested by the Department of Community Health, Nelson R. Mandela Medical School of the University of KwaZulu-Natal.

inside a controlled laboratory environment. Qualitative research also employs inductive reasoning techniques seeking to understand individual experiences in specific historically-bounded social and cultural settings. One of the goals of this thesis is to conduct an inquiry guided by explicit methodological and theoretical principles that define problems and formulate frameworks for collecting and analysing evidence (Creswell, 1994; Denzin and Lincoln, 2000).

Academic fields that provide conceptual models for qualitative research include philosophy and social psychology. From the former discipline comes phenomonology, and from the latter, symbolic interactionism. A phenomenological approach (articulated by Hegel, Husserl and Heidegger, among others), aims to describe the essences of pheonomena as filtered through human consciousness, without recourse to assumptions from the natural sciences. Phenomenology seeks to understand how the mind constructs meaning as it encounters objects and experiences, but also explores the nature of "the mind" itself, as constituted through conscious acts (Merleau-Ponty, 1962). A complementary theoretical domain that also provides qualitative research with valuable paradigms is symbolic interactionism as articulated by Blumer (1969) and Denzin (1978). Symbolic interactionism examines how individuals create meaning through exchanges with other people, in relation to collective groupings and social structures. People may create shared meanings through mutual ties which in turn comprise a crucial part of their daily reality. These concepts have been useful in framing the research and guiding the methodology of this study.

3.3 SELECTION CRITERIA

Interview subjects were selected on the basis of their former employment as health educators at the IFCH. Convenience and snowball sampling techniques were used to yield potential participants.

3.4 STUDY SAMPLE

The research sample comprised twelve former IFCH health educators. In addition, two informants who were close to Sidney and Emily Kark were interviewed for background material about the IFCH and the Karks.[61] The majority of these individuals had responded to numerous radio and newspaper advertisements that appeared in English- and Zulu-language media in KwaZulu-Natal which over the months of May and June 2000, inviting anyone who had worked with Drs. Sidney and Emily Kark in the Durban or Pholela area to contact Dr. Catherine Burns, the organiser of an International Workshop on Social Medicine held at the University of Natal in July 2000.[62] In some cases, respondents referred the researcher to additional potential informants ("snowball sampling"). Other research methods used in the search for additional participants included archival evidence and telephone inquiries to various individuals, libraries and government health departments. Unfortunately these avenues did not yield additional interviewees. The difficulty in locating former IFCH health educators may derive from

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[61] The two "background" interview subjects were Mrs. Pauline (Pondy) Morrell and Dr. Jack Geiger. Pondy Morrell was the sister of Helen Cohn, the first IFCH nursing director. Pondy was also principal of Dartnell Crescent Girls' High School and was cited as an important figure in the lives of many of the Indian female HEs interviewed. Dr. H. Jack Geiger is a prominent American COPC advocate who as a young intern in the late 1940s trained with the Karks at Lamontville and Pholela.

[62] I thank Dr. Catherine Burns for providing me with the initial list of respondents. I also thank Dr. Alan Jeeves, with whom I conducted the first set of interviews.

the half-century that has elapsed since their IFCH employment and to the lack of professional or institutional affiliations for health educators in South Africa.

The pool of interviewees included five Indian women, one Indian man, two African women, five white women, and one white male doctor. This cluster represents a convenience sample. It is not representative of the racial composition of South Africa nor of the IFCH health educators as a whole, a preponderance of whom were African males, with significant numbers of Indians and a sprinkling of Coloureds and whites.[63] The small number of African respondents indicates that they might have less access to media outlets that advertised the workshop, or if they were aware of the public announcements, they might have had too many obstacles to surmount such as no telephones or inadequate transportation. Another salient explanation is suggested in statements of several interviewees, who pointed out that their African colleagues tended to be older than the white and Indian HEs, so there may be fewer surviving African HEs. This is corroborated by the respective ages of the HEs interviewed: the white and Indian HEs were in their 70s, whereas the African HEs interviewed were in their mid-90s. The taped discussions were conducted in English, by choice of the interview subjects.[64]

In terms of socio-economic class background and outlook, the interview subjects represent a range of income and educational levels, though as trainees at the IFCH all had fulfilled the prerequisite of completing a junior certificate (equivalent to Grade 10), matriculation (Grade 12), or earned a professional qualification such as a teaching

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[63] See for example GES 2727 1/70, Health Centre Newsletter No. 1, by Dr. David Landau, Oct 1947, p. 4; also Kark and Kark, 1999:243.

[64] The African HEs were offered the services of a Zulu translator, had they wished to conduct their interviews in isiZulu. They opted instead to speak in English.

certificate. In the period under study—mid-20th century—Indian, African and Coloured secondary school graduates came from an embryonic educated elite. Several of the Indian HEs, for example, recounted how their education and health work elevated them above the educational and financial level of their families.[65] The white female health educators were university graduates and were thus poised for a commensurate income bracket, albeit, in most cases, the modest salary of a social worker. Yet like the African and Indian HEs interviewed, some of them also cited financial necessity as a motive in their applications to the IFCH. Following their employment at the IFCH, all of the white HEs and some of the Indian HEs continued their climb up the professional ladder in the fields of social work or health, with several attaining advanced degrees (see Appendix 7 for biographical sketches). Of the two female African HEs interviewed, one had remained working in the health field as a nursing assistant, and the other had "retired" in the late 1950s to stay home with her young family.

3.5 TYPE OF DATA

The initial selection interviews took place through telephone channels and generally lasted up to 30 minutes. The duration of subsequent in-depth interviews was between 90-180 minutes. In several cases, the researcher conducted two to three extensive interviews with the same interview subject. The bulk of the data collected consists of transcribed interviews and notes, as well as general information questionnaires that confirmed HEs' biographical dates and location(s) of IFCH employment.

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[65] See final chapter for an exploration of typical educational levels among different racial groups in the 1940s.

3.6 DATA GATHERING

The first phase of research entailed identifying health educators who had trained and worked at the IFCH in Durban in the 1940s and 1950s. Subsequent contacts were drawn from a list of health educators and other individuals who had responded to public advertisements. The names of other possible interview subjects came from respondents. The researcher called potential participants by phone to inform them about the purpose of this thesis project, invited them to participate as interview subjects, and verified their suitability as informants.[66] If they agreed to participate, the researcher set up an in-person interview that also functioned as an informational session, explaining her objectives, procedures and protocol (i.e. consent forms). The researcher later mailed participants a) an informed consent document and b) a questionnaire. The latter document included items such as participants' dates and location of training/work at the IFCH, descriptions of their activities as HEs, total number of families served, post-IFCH career, etc.

The second phase began with the task of transcribing interviews; this exercise was followed by fact-checking. The transcriptions were sent to interview subjects for review. Several interviewees corrected spelling of names where applicable, requiring elisions and amendments to their testimonials. The final leg of research focused on analysing the transcribed interviews for thematic content, dividing into the sections outlined in Chapter Six. To ensure academic rigour in the usage and interpretation of interview material, the data was triangulated with information contained in archival, scholarly, and other published sources including memoirs. Such cross-checking corroborated certain details,

[66] Respondents were also invited to publicly recount their experiences as IFCH HEs during a special "Witness Session" of the International workshop on "Social Medicine and Report of the Health System 1940-2000".

such as dates or names. However, given the subjective nature of oral history, some details or memories are not fully verifiable, as they are in the realm of perception.

3.7 LIMITATIONS OF DESIGN AND METHODOLOGY

In evaluating potential outcomes of the study, the researcher anticipated certain methodological limitations which could affect the validity or interpretation of results. As a qualitative study, the data is more vulnerable to personal, intellectual, and cultural biases (Denzin and Lincoln, 2000), including observer bias and self-selection bias (e.g. only those health educators who viewed their experiences positively may have responded to the original request for contact.) Similarly, the perceptions of the interview subjects are entirely subjective, and may misrepresent actual conditions at the IFCH. Interviewees spoke five decades after their IFCH experiences, and thus memory lapses or inaccuracies must be expected. These limitations will be discussed more fully in the study's conclusion.

Finally, the study sample's composition reflects certain race and class elements that tilt the data in a particular direction. The absence of African male participants is a regrettable lacuna, and the small number of African female participants may lead to their voices being overshadowed. The relatively large number of white women in the sample corroborates a trend in exploratory studies employing volunteer subjects, which are more likely to elicit participation from white middle class women (Cannon, Higginbotham and Leung, 1988).

The study has low generalizability, due to the small sample size and convenience sampling methods. It is likely that the context-specific and interpretative nature of this study precludes the possibility of another researcher arriving at exactly the same results.

3.8 ETHICAL CONSIDERATIONS

3.8.1 Consent:

Before being interviewed, the retired HEs were notified that they would have an opportunity to participate in a study of IFCH HEs. Those who elected to be interviewed were mailed self-stamped envelopes containing informed consent forms. This study was approved by the Research and Ethics Committee of the Faculty of Health Sciences, University of KwaZulu-Natal; procedures for the protection of human subjects were followed.

3.8.2 Confidentiality:

HEs were assured of confidentiality before conducting interviews. Permission was requested to identify interview subjects either through initials or full name (see check box on Informed Consent document). If permission was not granted, neither the subject's initials, name or any other personal identifiers would have been recorded: subjects would have been given an alias as a personal identifier. However, all subjects in this thesis formally indicated that they wished to be identified by full first and last name, as well as by a brief biographical description (See Appendix 7).

CHAPTER FOUR: HISTORICAL CONTEXT OF THE IFCH

As suggested in Section One of the Literature review, the early 1940s was a period of mounting tensions between segregationists and liberal reformers. Increasing African urbanisation and labour militancy, as well as growing impoverishment in both townships and African reserves, galvanised reformers to press for the extension of social services to Africans, Indians and Coloureds. The demands included better provision of housing, medical and sanitation services, welfare programmes such as school feeding schemes, and recognition of black workers' rights. To a limited extent, the Union government—particularly General Smuts' liberal-minded deputy Jan Hofmeyr—attempted to answer these needs, but reformist individuals and institutions insisted on greater interventions.[67] For example, in 1942 the South African Trained Nurses' Association passed a unanimous resolution deploring the inadequate provision of health services for non-Europeans and urging joint pressure on the government to rectify this immediately (Marks, 1996). Such calls consistently came from the Union Departments of Public Health and Native Affairs during the early 1940s as they endeavoured to publicise the severity of the crisis in African health and welfare (Jeeves, 2001*b*).

These protests and reforms did not occur within a vacuum, but were a reflection of international post-World War I trends that witnessed the creation of social welfare systems throughout western Europe, the United States and the USSR.[68] The influential but doomed 1919 Dawson Report in Britain recommended a state-organised

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[67] The Union government during the 1930s and '40s was led by Prime Minister Hertzog, with General Smuts as Deputy Prime Minister. Jan Hofmeyr was appointed by Smuts to head the Ministries of Interior, Education and Public Health. In 1945, the Department of Public Health received full departmental status and its own minister.

[68] In contrast, most colonial governments retained a paternalistic model of health care (Vaughan, 1994).

rationalisation of health services based on primary health centres, a blueprint later evoked by the National Health Services Commission in South Africa.[69] The Dawson Report viewed preventive and curative care as inextricably linked, exemplifying the "holistic" trend that commenced in the early decades of the twentieth century. Medical holism countered the Kochian bacteriological paradigm that dominated medicine since the late nineteenth century. Advocates of medical holism such as Charles-Edward Winslow of the Yale School of Public Health, maintained that ill health could not simply be understood at the individual or clinical level; rather, illness was an indicator of the well-being of a society (Porter ,1998; Fee and Porter, 1992). However, it must be emphasised that the holistic attempt to relate health to the larger social environment was a minority view, with far more doctors, epidemiologists and bacteriologists following Koch's injunction to concentrate on specific disease-causing organisms and the individuals who harboured them.

In the 1930s, as the field of health education solidified, it adopted various strategies to prevent disease and promote health. Many of these initiatives were aimed at women and children, instructing them in the principles of hygiene, nutrition and "domestic science" (Aita and Crabtree, 2000; Lupton, 1995). Other programmes were tailored to the needs of workers; health education was one of the roster of services delivered by the Peckham Health Centre in London, an institution that embodied the

[69] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944), 66. See also Kark and Kark, 1999:88. In turn, the NHSC plan served as the inspiration for the Beveridge Report which established the NHS in Britain (Gluckman, 1970; Marks, 1997).

1930s ideal of democratic health care by providing free clinical care along with leisure and educational facilities to a working-class community.[70]

Divided into five sections, this chapter explores how these international models and their underlying concepts inspired the originators of the National Health Services Commission and the IFCH.

Section 4.1 defines social medicine, one of the pillars of the IFCH approach. It traces how social medicine functioned in the South African context.

Section 4.2 outlines the objectives and outcomes of the 1942 – 44 National Health Services Commission (NHSC).

Section 4.3 provides a brief history of the IFCH, its relation to the health centre plan and its affiliation with the Durban Medical School.

Section 4.4 summarises the role of health educators within the IFCH structure and compares them to other historical South African and international examples.

Section 4.5 sketches the history of international health education.

4.1 Social Medicine

Social medicine refers broadly to a model that views sickness as the product of a complex web of interactions—economic, social, environmental, and political and biological. The model's nineteenth-century founders, Rudolf Virchow and Frederick Engels, analysed the distribution of illness, linking it to social and political forces.

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[70] In various publications, Sidney Kark cited the Peckham Health centre and similar initiatives in the USSR as historical predecessors (Kark, 1951:662). See also TES 56/157 Department of Public Health. 1) Institute of Hygiene.

Although the revolutionary changes in political economy advocated by Virchow and Engels were later diluted by followers into "reform" of existing structures, what remained was the correlation of morbidity and mortality statistics with variables such as income, education, class, diet and housing (Porter and Porter, 1988; Porter, 1997; Trostle, 1986).[71] Twentieth century champions of social medicine such as Sidney and Beatrice Webb in England, Henry Sigerist in the United States and Salvador Allende in Chile, urged the widest possible dissemination of health-promoting knowledge, services, and resources.[72]

Another important figure in social medicine is John Ryle, the first professor of social medicine at Oxford, who urged the extension of public health's traditional concerns—issues such as drainage and water supply—to encompass the economic, nutritional, occupational, educational, and psychological needs of the individual and the community (Porter, 1992). Ryle played a significant, if ultimately, damaging role in social medicine in South Africa when he released a disparaging assessment of South Africa's nascent health centres in 1948.[73]

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[71] Other nineteenth-century pioneers included Jules Guérin (who coined the term "social medicine") and Réné Villarmé in France; William Farr in England, and Neumann and Leubusche in Germany (Hamlin, 1992; Waitzkin, 1981). These figures represent a wide range of attitudes towards the social determinants of disease. Villermé and Farr, for example, advocated the moral regeneration of the poor as opposed to state intervention which might, as Farr wrote, "be expended indiscriminately upon the idle, reckless, vicious as well as the good but unfortunate" (cited Porter, 1997:408).

[72] These figures' understanding of "health-promoting factors" encompassed nutrition, housing, sanitation, and environmental safety. The American social medicine doyen Henry Sigerist was particularly influential in South Africa through his 1930s seminars at Wits which the Karks attended and cited as a lasting influence (Marks 1997 quoting 1992 interview with Sidney Kark). Salvador Allende's work in social medicine offers a relevant parallel because he specifically addressed the role of underdevelopment in health problems. For a review of social medicine in South America, including the key role played by Allende between the 1930s to his death in 1973, see Waitzkin et al, 2001).

[73] There are many similarities between the respective views of social medicine held by John Ryle, on the one hand, and Sidney and Emily Kark on the other. For example, they all insisted on the integration of medical and social science; called for research that examined how social change affected health; and emphasised that epidemiological data provided the necessary foundation on which to build and monitor a health service. The Karks and Ryle also shared a desire to combine preventive and clinical practice, and abhorred the increasing specialisation of medicine (Jeeves, 2000; Porter, 1992). Given these parallels, it is

Through advocates such as Ryle and Sigerist, the 1940s saw a renewed interest in social medicine. The Cold War was just brewing and the paranoia that would demonise "social medicine" as "socialized medicine" was not yet dominant. Writing in 1947 and 1952 respectively, George Rosen and Réné Sand chronicled the history of social medicine and sanguinely predicted its ascendancy in the future (Rosen, 1947; Sand, 1952). Furthermore, philanthropic institutions such as the Rockefeller Foundation and its programme officer John Grant funded international projects that unabashedly drew on precepts of social medicine, including the IFCH (Grant, 1963).[74] Grant visited Pholela in 1947 when the Rockefeller Foundation was considering offering a grant to the IFCH. The Karks and George Gale acknowledged Grant's pioneering efforts to integrate preventive and curative health care in China and India.[75]

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surprising that Ryle so disapproved of the ways in which South African health centres attempted to practice social medicine: GES 2958, PN6/2, John A. Ryle, "A Report on the Health Centres Service of the Union Department of Health", p..3. His tour of these centres in late 1947 was cursory: of 20 extant sites, he visited only ten (Grassy Park, Knysna, Walmer, Thaba 'Nchu, Alexandra Township, Lady Selbourne, Springfield, Polela and Tongaat). At Springfield, then the IFCH headquarters, he spent only two hours on site, and met very briefly with Secretary of Health George Gale, Minister of Health Henry Gluckman, and David Landau, head of the IFCH while Sidney and Emily Kark were abroad, studying at Ryle's Oxford-based Institute of Social Medicine: GES 2958 PN6/2, Confidential Memo by George Gale, 24 Dec 1948. In his report, Ryle asserted that the health centres attempted "to cover far too wide a range of interests—particularly on the investigatory side—having regard for the relatively primitive conditions under which the centres have at first been compelled to work...." Ryle lamented the paucity of public health services and inadequate government support for a national health service, which prevented the centres from truly fulfilling their mission. In raising these issues, he seemed oblivious of how familiar they would seem to beleaguered defenders of the health centre movement such as Gale. A strict idealist, Ryle contended that practice and research should remain separate and unadulterated, the latter ensconced within an independent academic institution. Similarly, he argued, no attempt could be made to implement social medicine without poverty-reduction policies as well as functional environmental and welfare services. Such concerns, however well-conceived, belied an "all-or-nothing" approach. Ryle appeared unwilling or unable to fully appreciate the actual political, economic and racial order of South Africa. For more on Ryle's criticisms of health educators, see Chapter 4.4.

[74] The Rockefeller Foundation's mandate and methods have generated a number of critiques, including those by Brown (1979) and Solorzano (1992). These scholars argue that the Rockefeller Foundation's agenda supported capitalist designs, and its association with social medicine was superficial at best.

[75] During Grant's 1921- 23 tenure as director of the department of hygiene at the Peking Union Medical College in China (a Rockefeller-funded institution), Grant had developed a "demonstration health station" which taught the principles of health promotion, prevention and curative care to medical school students

Social medicine was integral to the 1942-44 NHSC and remained sufficiently acceptable that in 1946 the Department of Health (DOH) formed a Division of Social Medicine, headed by Dr. David Landau. However, after the 1948 Nationalist Party victory, "social medicine" became such a term of opprobrium that Secretary of Health George Gale was forced to disavow its influence:

> In view of the ambiguities, misunderstanding and controversies which have arisen from the use of the term social medicine, it has been decided, by the present Minister of Health himself, to discontinue its use in connection with Government Health Centres. Henceforth, therefore, the term used will be simply 'Health Centre practice'(Gale, 1949).[76]

Despite such perfunctory recantations, the idiom of social medicine lingered for several years in departmental correspondence and publications written by a dwindling group of stalwarts that included Gale, the Karks and former Secretary of Health E.H. Cluver, who in 1951 defiantly titled his edited volume *Social Medicine*.[77] However, by 1962, when Kark and Steuart published *A Practice of Social Medicine,* they, like most of its contributors, had emigrated in response to the apartheid state's increasing hostility to their reformative vision. Set in various IFCH centres, the book vividly illustrates many of

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and public health nurses. In 1944, Grant had established a similar health centre in Bengal, the All-India Institute of Hygiene and Public Health. The sphere of influence between the Karks, Gale and Grant was reciprocal; in 1947, when Grant was advising the Bhore Commission in India about setting up health centres in India, he drew inspiration from the NHSC report, and subsequently reported to Gale that "the members of the Bhore Commission had been greatly stimulated by the recommendations of the Gluckman Commission" (Kark and Kark, 1999: 179). Grant facilitated Sidney Kark's first visit to the USA in 1947, and through Gale, arranged the Foundation's 5-year joint sponsorship with the Durban Medical School for an IFCH-based teaching program in family practice and community medicine. UKP H6/1/1 George Gale. "The Story of the Durban Medical School", 25 Jan. 1976, p.6.

[76] In a later document, Gale was openly sarcastic about the diluted language: "...the teaching of social medicine—or, to use terminology which they favour, teaching in health centre practice...": UKP H6/2/3, Durban Medical School Project for a Department of Family Medicine, p. 6.

[77] See also a 1951 report compiled for the Dept. of Health on "Social Medicine in South Africa": GES 2704 1/62 Medical and Health Services for the Union.

social medicine's fundamental premises: poverty and class are important determinants of health; cultural change affects transmission of illness; and collective interventions are as critical as individual actions in preventing disease.

The emphasis of social medicine on the group was also a feature of African concepts of vitality and morbidity, a congruence noted by the Karks and their associate, anthropologist Hilda Kuper. In a 1947 article exploring the applicability of social medicine to a "Bantu" context, Kuper contended that African interpretations of disease share with social medicine a belief that sickness could be attributed to myriad "indirect" factors ranging from the natural to the man-made, rather than merely biological causes.[78] Yet this common focus on the environmental and social setting existed alongside a major difference: African notions of etiology included "such mystical notions as witchcraft and pollution", which were "rooted in the pattern of Bantu tribal society, the political and kinship structure, the legal code and the religious beliefs"(Kuper, 1947:66). Kuper urged the Karks and their colleagues not to impose "the European concept of social medicine" which was, after all, "a historical development in a particular sociological setting". Any attempt to fuse African and scientific approaches must first accept that "notions of witchcraft—intellectually a perfectly coherent system…[are not due to] any innate differences of mentality, but because of different social conditioning".[79] Persuaded, Sidney Kark argued that "witchcraft thinking is social thinking: a man examines his relationships with other people: and the diagnosis and treatment are also in social

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[78] Kuper used particular examples from Swazi concepts and social structure to illustrate her points, but extrapolated from the Swazi to other Bantu-language groups such as the Zulu.

[79] Kuper's willingness to regard witchcraft beliefs as a legitimate expression of "African institutions" (Kuper, 1947:66) was shared by the Karks and other anthropologically-minded IFCH staff, a point which will be developed in Chapter Five. See also chapters by Chesler and Cassel in Kark and Stueart (eds.) 1962.

terms...such an attitude to ill-health comes very close to our Western concept of social medicine" (Kark,1957:11).

In one of his many definitions of social medicine, Sidney Kark cast a wide net: "Social Medicine means the practice of medicine which, both in diagnosis and therapy, takes into account all the factors extrinsic (including social and environmental) as well as intrinsic that make for the health or ill-health of the individual. It is holism applied to health services" [emphasis original].[80] Although Kark alluded to the structural nature of "extrinsic" factors, such as the migrant labour system which spawned the "social pathology" of syphilis (Kark, 1949), the Karkian model as it was implemented in South Africa remained resolutely embedded in quotidian relationships rather than the political and macro-economic analyses that underpinned revolutionary strands of social medicine.

4.2 National Health Services Commission (NHSC)

Debates over health care and medical personnel in under-served populations took diverse expressions throughout the 1920s to the 1940s.[81] Many voices chimed in—

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[80] TES 6902 56/157 Dept. of Public Health. 1) Institute of Hygiene. 2) Family and Community Health.

[81] See Chapter 1.3 of the literature review for scholarship about the NHSC. Important milestones in debates about health services for Africans include the 1928 "Loram" Committee: *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health* (Pretoria, Government Printer 1928, U.G. 35-1928 and the 1933 'Thornton Committee": *Report of the Interdepartmental Committee on 'Native Medical Education' 1933* (unpublished, cited Shapiro 1987:251). Whereas Thornton adamantly opposed the concept of identical medical training for black and white students and proposed a category of black medical auxiliaries (along lines developed in colonial West Africa), the Loram Committee instead counselled against a dual standard in which blacks would receive inferior qualifications. Yet Loram did insist on separate training facilities for blacks through in a segregated division of the Wits medical school. Like the NHSC later, the Loram Commission concluded that that the best way to combat disease in the "native territories" was to establish a government medical service featuring team of doctors, nurses, and particularly "health assistants", skilled in preventive work and hygiene. See also GES Vol. 2957 Ref. PN 5, Native Medical Aids. Report of the Committee of Enquiry on the Medical Training of Natives to the Minister of Public Health, 15 June 1942). In the end, it was Thornton's conception of Medical Aids which won the support of Minister of Education and Public Health Jan Hofmeyr and thus became government policy, implemented through the Fort Hare training programme.

doctors, government committees and departments, especially the DOH and DPH, the general public and "special interest" groups such as the South African Institute of Race Relations (SAIRR) and the Chamber of Mines.[82] Myriad questions needed answers: Would there be a central health authority? A national insurance scheme? Expanded free hospital facilities with black medical and paramedical personnel?

One proposal regarding the inclusion of black male paraprofessionals found ill-conceived expression in the Medical Aid training scheme at Fort Hare (1936-46). The category of medical aids cobbled together three competing visions: the Thornton concept of a medical auxiliary, the Loram idea of a health assistant, and a diluted version of Dr. James McCord's ambitious plan to create a coterie of black doctors. Funded by the government and the Chamber of Mines, the Fort Hare program aimed to educate African men to deliver basic health services in rural areas. Between the first and fourth years, candidates studied natural science, anatomy, biology, public health and laboratory procedures. In their final year, they moved to McCord Hospital in Durban to gain practical medical and midwifery experience. The five-year course was almost as long and rigorous as a full medical school qualification, but medical aids were not allowed to prescribe drugs and could only participate as assistants in poorly-paid government service under the supervision of a white doctor. If a medical aid left the public sector, he was disqualified from further practice. As the 1944 NHSC Report pointed out, under the terms of Section 34 of the 1927 Medical, Dental and Pharmacy Act, "unfortunately

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[82] In 1934 the SAIRR convened a number of regional conferences on "Non-European Health Assistants" as a possible solution to what SAIRR designated "important questions of racial policy and the coordination of welfare work among the Bantu, Indian and Coloured communities." NAD 3PMB 4/3/153, Medical Officer of Health Minute Paper, 15 Sept. 1934. An example of the Chamber of Mines' efforts to monitor the health of its actual and potential workers was the 1938 nutrition survey by Fox and Black; see Packard (1989). For discussions within the Medical Association of South Africa (MASA) about national insurance and centralised systems, see Harrison (1993).

Medical Aids had been trained for clinical work which they were not permitted to do".[83] Not surprisingly, the program soon floundered under criticisms from medical aids themselves, who felt gypped. Former trainers like George Gale also protested that the Medical Aid Training Scheme provided neither qualified medical practitioners nor sufficient numbers of paraprofessionals to address the health needs of Africans (Shapiro, 1993; Marks and Andersson, 1992:148).

Although groups representing liberal, professional and industrial interests were concerned with the increasingly dire welfare of Africans in remote reserves and teeming slums, their intentions were by no means wholly altruistic. The debates about African health involved two opposing camps: reformers who wanted to heal the wounds of racial inequality versus defenders of the status quo who sought to preserve African vitality for the colonial order. The latter motive contained a number of self-interested priorities: reproduction of the labour force; protection of whites from the threat of contagious disease; appeasement of African militants demanding better social services; and minimal expenditures for a cash-strapped government (Marks and Andersson, 1992; Marks, 1997; de Beer, 1986:23).[84]

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[83] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944), p. 90.

[84] An alternative perspective presented by black nationalists argued that liberal reform also reflected narrow white interests. By the early 1940s, ANC leader A.B. Xuma was becoming increasingly critical of liberal bodies such as the SAIRR for their paternalistic dominance over the black intelligentsia and their belief in government "trusteeship" of Africans. An Africanist challenge to white liberalism crystallised in 1943 with the emergence of the ANC Youth League. Its leader, Anton Lembede, in the 1944 Youth League Manifesto rejected the notion of collaboration with white liberals, who "bluff" Africans in order to "consolidate... "[their] position at the expense of the African people". White-elected Native Representatives were singled out for they "have been very vocal in their solicitations for the African while their deeds have shown clearly that talk of Trusteeship is an eyewash for the Civilised world and an empty platitude to soothe Africans into believing that after all oppression in a pleasant experience under Christian democratic rule." Alfred Xuma papers, ABX 326329 (68), Congress Youth League Manifesto, 31 March 1944, cited in Rich 1984:84. See also Gerhardt (1978), Rich (1993), and Dubow (1989; 1995).

In 1939, these "cost-saving" arguments gained ground with the creation of a separate health service for blacks, administered jointly by the DPH and the Department of Native Affairs. It was under the auspices of this "Native Health and Medical Service" that three health units in African reserves were to be launched, but under war-time constraints only one was actually established. This was the Pholela Health Unit, founded in 1940 under the direction of Sidney Kark.[85]

The formation of the NHSC in 1942 represented a counter-strike by a reformist faction that appealed for a "unitary" (i.e. non-segregated) health service in South Africa. More than 1000 witnesses testified before the 10-member Commission, headed by Dr. Henry Gluckman, who at the time was a member of parliament and would soon to become Minister of Health.[86] The Commission aimed to "enquire into, to report and to advise upon the provision of an organised national health service in conformity with the modern conception of 'health', which will ensure adequate mental, dental, nursing and

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For an example of "African militancy", see the ANC's 1943 document *African Claims*, which called for a welfare state programme including free education for African children, free public health and medical services, industrial welfare legislation, and unemployment, sickness and old age benefits. African National Congress, African Claims (Johannesburg, 1943), cited Rich (1984:85).

[85] Pholela, a rural area in southern Natal about 135 km (80 miles) from Durban, was chosen primarily because it was one of the "Betterment Areas" designated by the Native Affairs Department (NAD). In theory, a "betterment area" was supposed to be a site of intersectoral cooperation between the departments of agriculture and the NAD, specifically efforts to improve land use. However, in Pholela such coordinated services never materialised (Jeeves 2001*b*). As George Gale observed, "the NAD was so denuded of staff during the War that little or no progress was made in land use, other than that stimulated at the domestic level by the Unit's health assistants." UKP H6/1/1, George Gale, "The Story of the Durban Medical School", 25 Jan. 1976, p. 4. Members of the NHSC visited the Pholela Health Unit in 1943, and were so impressed by the ideas and methodology of the Karks and their staff that Pholela became the model for all other health centres set up by the NHS in South Africa.

[86] Gluckman was South Africa's first and only Jewish Minister of Health. The Jewish identity of Gluckman, the Karks, and so many of their IFCH colleagues is a fascinating issue that deserves consideration but cannot be explored here due to space constraints. See Scholtz (1999) for a discussion of Jewishness as an orienting factor in the medical activism of Mervyn Susser and Zena Stein as well as the Karks; see Shain (2001) and Suttner (1997) re: the prominent role of South African Jews in the struggle for democracy.

hospital services for *all* sections of the people of the Union of South Africa [emphasis in original]".[87] The sweep of its radical inclusiveness still startles: "the ultimate aim of our recommendations is to bring these services within reach of *all...according to their need, and without regard to race, colour, means or station in life*" [emphasis original].[88]

The NHSC set forth administrative, legislative and financial measures necessary to implement its proposals, stipulating that its task "was not merely one of offering suggestions for the improvement of a superstructure built upon foundations already laid", but rather "the reconstruction of the foundations themselves".[89] This overhauled system aimed to balance the distribution of services for all races and classes and centralise them under a single authority, the DOH (see Chart 1 in Appendix 2 for chain of command). The NHSC sharply criticised the existing "disjointed and haphazard" health services that scattered responsibilities between local, provincial, and national authorities so that "services [were] distributed mainly among the wealthier sections who, on account of their economic potentialities should need them least; they [services] are but poorly supplied to the under-privileged sections who require them most".[90] The Commission exposed a ratio of one hospital bed for every 304 whites, but only one bed per 1198 blacks. Similarly, it found that the doctor-to-population ratio was grossly skewed: 1:308 (whites) in Cape Town to 1:22 000 (blacks) in Zululand and 1:30 000 (blacks) in the Northern Transvaal.

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[87] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944): 1.

[88] ibid., 121.

[89] Ibid, 90. Although many of these measures were never effected, there were several superstructures established through legislative action between 1945 and 1946: 1) The NHS Advisory Committee; 2) the Health Centre-Advisory Committee and 3) Central Health Services and Hospitals Coordinating Council.

[90] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944):100.

Private practice entrenched these disparities, with most doctors clustering in cities where there were greater numbers of paying customers.

The profit motive also led doctors to be more interested in treating sick patients than in teaching them how to avoid illness. In contrast, the Commission wished to inculcate a "modern conception of health" in which "the main object will be to prevent ill-health rather than merely to cure or alleviate already-established disease".[91] In its "modernity", the NHSC anticipated by several years the WHO's famous 1947 definition of health as "the state of complete physical, mental, and social well-being, not merely the absence of disease."

The NHSC systematised the distinction between "non-personal" health services (such as housing, sanitation, water supply and food handling) and "personal" services, comprising promotive, preventive, curative, and rehabilitative functions (see Chart 3 in Appendix 2). The promotive arena included wage regulation, education and nutrition, while preventive care encompassed periodic medical examinations, antenatal- and infant welfare clinics, immunisations, health education, and school and worker health programmes. Health centres would be the main delivery unit for such "personal" services, with "non-personal" services remaining the statutory responsibility of local authorities.[92]

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[91] ibid, p. 22. See also a memo that the DPH circulated to all magistrates to explain the concepts and recommendations of the Commission. GES 2727 1/70. Circular No. 1/70 of 1946 to All Magistrates in the Cape, Transvaal, Orange Free State and Natal Re: Health Centres.

[92] Municipal authorities were generally reluctant to extend sewerage, waste removal and water services to black communities, which consequently suffered "a holocaust of insanitation", as Dr. Park Ross described the black township of Edendale. Health centres aimed to improve environmental conditions through a two-pronged campaign: pressuring municipalities to extend sanitation to under-served areas, as well as guidance by health educators on do-it-yourself sewerage with buckets or pit latrines. GES 2752 105/70. Advisory Committee on Health Centre Practice. 9 June 1949. Re: "holocaust of insanitation": NAD 2PMB 3/1/1/2/5, Report by G.A. Park Ross and B.A. Dormer on a health survey in Edendale, 1938.

Despite assurances by the NHSC that private practitioners would not be forced into public service, the medical profession expressed misgivings and hunkered down to protect its turf.[93] The main NHSC proposal—reorganisation of health services along more "rational" (centralised) lines—faced adamant resistance from sources such as the provincial authorities, who insisted that their command over hospitals was constitutionally ordained.[94] Disputes over control foiled complete implementation of the health centre plan. A 1947 DOH memo remarked on these difficulties: "[It is] impossible to proceed with the development of national health services until there is a clear demarcation of respective responsibilities, financial and executive, of local authorities and the Central Government in the sphere of personal health services".[95] While parliament did pass the NHSC recommendations in 1944, two reservations remained which turned out to be fateful:1) the retention of provincial control over curative medical services, i.e. hospitals; and 2) the rejection of a 4% national health tax, to paid by "each according to his means". By eliminating taxation as the primary means of financing the plan, the government consigned health centres to a state of chronic and eventually fatal under-funding. A statement by Prime Minister Smuts exemplifying the government's lack of serious commitment referred to the "scheme…as more than an ideal which could

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[93] The NHSC was careful to seek advice from the Medical Association of South Africa (MASA) which responded by making a disingenuous pledge of support for the NHSC plan contingent on certain conditions such as no cap on fees for service. MASA further hedged its bets by recommending "additional consultations with interested bodies." (Gluckman, 1970: 465).

[94] The South Africa Act of 1909, merging the four colonies into one Union, did not specifically deal with health care but simply transferred administrative powers and functions to four provincial governments, which autonomously provided curative services through general hospitals, funded by the DOH.

[95] GES 2958 PN6/1 National Health Centres. Notes on Discussions between Minister of Health Gluckman and Dr. JH Holloway, Sec. for Finance, 26 Feb. 1947.

in any case, only be reached in a series of stages. Its adoption as a whole would necessitate far-reaching changes for which the country is not ready".[96]

The NHSC called for the construction of over 400 health centres as the cornerstone of its overhauled system. Given the paltry budget allocated to health centres (£240,000 or about 2.6% of the overall health budget), it is not surprising that only one-tenth of the hoped-for 400 centres were built.[97] Between 1945 and 1952, approximately 44 health centres set up operations, often in dilapidated, inadequately renovated buildings (see Appendix 1 for locations).[98] As health centres could only offer low to modest salaries, they competed at a disadvantage with provincial and private health sectors for personnel.[99] Thus the NHS attracted mainly the most idealistic professionals or candidates who could not advance in other medical settings.[100] Bureaucratic red tape was another disincentive for potential and actual staff, with Secretary for Public Health Peter Allen lamenting in 1946: "Between the date of their application and the receipt of a letter

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[96] GES 2958, PN6,1 Extract from Rand Daily Mail 10.10.1944 which refers to a statement released by Prime Minister Smuts 9 Oct. 1944. Like Smuts, few white South Africans would have embraced the multiracial ramifications of the plan. Yet archival evidence demonstrates that there were pockets of passionate support for the provision of health care to African, Indian and Coloured communities. Dozens of letters to the Ministry of Health written by voters' associations, women's groups, private doctors and African community representatives, pleaded for a health centre for their respective districts, testifying to a groundswell of positive interest in the NHS. Many of the letters authored by whites advocated on behalf of African communities: GES 2727 1/70 Letters to Minster of Health.

[97] Re: 2.6% of budget: GES 2752 105/70, Minutes of the Advisory Committee on Health Centre Practice, 18 Aug 1948.

[98] The Karks gave the total number of health centres as "some forty" (Kark and Kark, 1999) and elsewhere, exactly forty-five (Interview of Emily and Sidney Kark by Prof. C.C. Jinabhai and Dr. Nkososana Zuma, Durban 1992, p. 17). Subsequent scholars usually cite the number as "forty odd". Archival searches yielded an exact number of only 37 as of 1952 when construction had fully ceased. However, there may have been additional sub-centres not mentioned in these documents: GES 2957 PN5 "Native Affairs Fact Paper VIII, Social Medicine in South Africa", March 1951; and GES 2957 PN5, Letter from Sec. of Health Feb. 1952.

[99] GES 2958 PN6/2 Letter to the Treasury from the Sec for Health, 14 Dec. 1950

[100] GES 2958 PN6/1 Notes on Discussions between Min of Health Gluckman and Dr. JH Holloway, Sec. of Finance, 26 Feb. 1947.

of appointment several months elapse...[and] during the interval many of the applicants have come to the conclusion that they are not wanted....Sometimes they have been so irritated by the delay...that even if free to do so they are unwilling to enter the service".[101] A proposed Health Services Personnel Commission to determine conditions and length of service never materialised, so that most job applicants accepted into the NHS ranks were only offered temporary contracts. Indeed, one DOH report noted that African nurses at a health centre in Cradock in the Cape had been waiting several months for their contracts—and their pay![102] The department's glacial pace and inefficiency annulled an initial advantage conferred by war-time conditions in the early 1940s, when one-third of the total number of doctors and nurses in South Africa were seconded to the state-run South African Medical Corps. The failure to retain this personnel upon demobilisation in 1945 entailed the loss of what Henry Gluckman called a "great national opportunity...forced upon us by abnormal circumstances"(Gluckman, 1970: 422).

The NHS was also bedevilled by the issue of a means test to determine eligibility for fully subsidised treatment. While the Commission originally declared that free services to be available to all, Parliament's rejection of a national tax to finance the system, combined with the Medical Association's anxieties that health centres would "steal" paying customers, forced the DOH to alter this policy in order "not [to] cause the local medical practitioners any concern, as the health centre service is intended only for

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[101] GES 2958 PN6/1 Letter from Secretary for Public Health Peter Allen to the Chairman of the Public Service Commission. 14 Feb 1946.

[102] GES 2727 1/70D. Notes on the Health Centre Scheme, Report by Dr. David Landau. 20 May 1947, p. 5.

those who are so poor that they rarely, if ever, go to private practitioners"[103]. The difficulties in applying a means test created public confusion and resentment over whom would be eligible for services, and in the end, the test was rarely given.[104] Nonetheless, the damage was done; the DOH had been compelled to confine health centres to "those who were too poor" to access private doctors, i.e. Africans, Indians and Coloureds, thus assuring the scheme's marginilisation (Marks, 1997; Phillips 2000).[105] Ultimately, the result was very similar to the segregated "Native Health and Medical Service" devised in 1939 which the NHSC had hoped to challenge.

Another innovative (and to some doctors, threatening) aspect of the NHSC's "modern conception of health" was the "health team", a coalition that would mitigate the "individual-isolationism in private medical practice".[106] On the team were doctors, nurses, medical aids, health assistants (health educators) and other auxiliaries. The health assistants, in particular, would engage with the community at the grassroots level where closer observation of the social causes of disease was possible. George Gale elaborated on the health team concept:

> Its approach to health needs is entirely different from that of ordinary private practice. It places in the field not an individual medical practitioner, but a team...They are trained to observe, in the homes of the people, the environmental, including the social, factors which are working for or against health. These they

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[103] GES 2727 1/70 Letter from the Medical-Officer in Charge, Alexandra Government Health Centre, 3 May 1948.

[104] ibid. Also GES 2745 65/70, Letter from Sidney Kark to George Gale 18 Jan. 1951.

[105] The only health centre that was attended by a large number of "Europeans" was Knysna, whose "poor white" population was soon to be uplifted by Nationalist Party policies: SAB GES 2727 1/70A C.T. 71 (P.Q.1) Reply to Mr. Sullivan in the House of Assembly 20 Jan 1948.

[106] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944):16.

> record, and the record is available to the team at the health centre when dealing with individuals from these homes (Gale, 1946:326).

The actual number of staff would be "very elastic...as the size of the Health centre would be adjusted to the needs of the community". There was to be a health centre for every 25,000 people, served by six to eight doctors and other health team members. Despite a stated desire to equalise urban and rural services, the Commission recognised that it would be difficult to attract personnel to "native" reserves, so for these territories it recommended a team of at least two doctors, one medical aid, seven health assistants, one nursing supervisor, seven midwives as well as dental, clerical and laboratory workers. In actuality, most health centres averaged two doctors, two to four health assistants, and one nurse, and rarely managed to secure the recommended numbers of auxiliary staff. These personnel shortages continually plagued operations and led to a reduction in the range and adequacy of services, as noted in various evaluations.[107] Ideally, to fulfil their mandate to cure, prevent and promote, health centres would cater to a "defined population" of no more than 10,000 people, the size of Pholela's "intensive family service" at its largest, in 1957. In contrast to health centres elsewhere in South Africa, the staff at Pholela and the IFCH centres in Durban were sufficient in both quantity and quality to enable them to achieve their aim to not only treat the sick but to create data-based health education and research programmes.[108] In 1951, Pholela had one Medical

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[107] GES 2958 PN6/2, Report on the Health Centre Service of the Union Department of Health, by John Ryle, 1948; GES 2727 1/70D Notes on the Health Centre Scheme, by David Landau, 1947; GES 2727 1/70A, Letters from A.W. Harding le Riche, M.O.-in-Charge, Knysna, to Secretary of Health George Gale, 30 Jan 1947 and 17 Feb 1947.

[108] Yet the IFCH also suffered from dwindling government support and budgetary constraints, evidenced by a hiring freeze from the early 1950s onwards. By 1954, the seven IFCH centres in Durban had only ten doctors between them to serve a population of 35,000, a 1:3500 doctor-to-population ratio far in excess of the 1:2000 proscribed by the British National Health Service as an optimum ratio, and even in excess of the

Officer in charge, two other doctors and a dentist; five African nursing sisters, two African staff nurses, five Medical Aids; and nineteen health assistants (twelve male and seven female).[109]

Lacking this extensive cast as well as the inspired direction of Sidney and Emily Kark, the majority of health centres scattered throughout South Africa struggled to reach "the Promised Land of Social Medicine" wistfully evoked by one health centre director, which he attributed more to systemic inequality rather than to any deficiency in health centres' principles or practices: "There are only a few places in this country where it will be possible usefully to apply the techniques of Social Medicine. This is not a reflection on Springfield [the first IFCH training site]—it is a reflection on backward South Africa. Health Services cannot increase the yearly national income of about £35 per head." [110] To the cumulative weight of various handicaps—health centres' "poor cousin" status, shaky parliamentary backing, the antipathy of provincial authorities and a sclerotic medical

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1:3000 described by the S.A. Ministry of Health as an "under-doctored area". UKP H6/2/3, Letter from George Gale to Secretary of Health le Roux, 28 Oct. 1954.

[109] GES 2704 1/62 Social Medicine in South Africa, 1951.

[110] GES 2727 1/70, Letter from Dr. W. Harding le Riche, Medical Officer in charge of Knysna Health Centre, to Secretary for Health George Gale, 17 February 1947. David Landau, then Director of the Division of Social Medicine for the Department of Health, shared le Riche's dismay but pointed to institutional as well as systemic causes. In May 1947 Landau toured eleven of the thirteen NHS health centres set up by that point throughout the country. What he saw depressed him: only three centres—Pholela, the IFCH at Springfield, and Thaba 'Nchu—were doing "work of good quality". Other sites that were doing "work of poorer quality, but still recognisable as the type of work which a health centre is required by definition to carry out" were Tongaat, Newlands, Knysna, and with reservations, Grassy Park, Cradock and Grahamstown. At the remaining locations, the problems that beset health centres generally were even more dire. Landau summarised the "causes of these defects": staff demoralisation, particularly of Medical Officers-in-Charge (M.O.s) due to low pay, lack of interest and guidance from the DOH, inadequate training in social medicine principles, severe staff shortages, particularly of health educators, and shoestring budgets that compelled one M.O to operate his health centre out of a garage!: GES 2727 1/70D, Dr. David Landau, Notes on the Health Centre Scheme, 20 May 1947. Among Landau's recommendations was a suggestion that HEs be trained to give injections for immunisations and vaccinations, which they were not legally allowed to do, and to be trained as midwives. The DOH, unwilling to challenge existing legislation, rejected this proposal: GES 2727 1/70 D, Letter from N. Reeler to David Landau, 30 Sept 1948, p. 4.

establishment—was added a decisive shift away from the moderate reformism of the early 1940s. The 1948 Nationalist party victory exacerbated these obstacles, and by 1949 the retreat from many of the Commission's recommendations was well underway. A curt memo from Secretary of Health George Gale conveys his diminished hopes for transformation: "Provincial control of hospitals: No Change. Health functions of local authorities: No change".[111]

From its inception, the NHSC incorporated dual (and duelling) obligations to save money as well as lives. Gluckman summarised these ideas: "Health…is no longer accepted as purely the private concern of the individual but of the community as a whole, for both humanitarian and economic reasons" (Gluckman, 1970:359). It must be noted, however, that early attempts to gain support for the plan emphasised the latter aim, expressed succinctly by E.H. Cluver in a letter to the Treasury Department: "In order to control expenditure on Native hospitalisation and to reduce the demand in a manner which will ultimately result in a considerable saving…a scheme has been evolved to establish inexpensive clinics to the early treatment of disease among Natives."[112] Even an ardent advocate for social medicine such as George Gale, aware that the democratic implications of a nationalised health service might provoke alarm, at times emphasised that health centres provided an economical alternative to hospitalisation, with the comprehensive health centre service costing about £1 per head of the population per year as compared to about double this expense for government hospital costs.[113] Despite the

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[111] GES 2958 PN6/2 Memo from Secretary of Health George Gale: "Policy and Programme Regarding National Health Services", 28 April 1949.

[112] GES 155 1/62 Letter from Secretary of Health E.H. Cluver, 4 Feb. 1939.

[113] GES 2958 PN6/2 Memo from Secretary of Health George Gale: "Policy and Programme Regarding National Health Services", 28 April 1949. Yet Gale was also wary of placing too much emphasis on the

NHSC's cost-cutting objectives, it is remembered today for its humanitarian aspirations and a prophetic, universalist vision that saw health services as a citizen right in a society in which citizenship itself was confined to the privileged few.

4.3 Institute of Family and Community Health

The members of NHSC realised that for the plan to be effective, they had to instruct health care providers in the cardinal tenets of social medicine. Accordingly, they set out what was originally called a Training Scheme for Health Personnel, also known as the Institute of Hygiene. In the late 1940s, the term "Hygiene" was dropped and the title was changed to the Institute of Family and Community Health.[114] Initially, doctors, nurses and health educators—the latter identified in a DPH memo as "the most urgently required. Without them it is impossible to establish health centres in the true sense. They represent the front-line troops in the attack on ill-health and in the guardianship of health"—were sent to Pholela to observe and learn from the health team there.[115] However, the area's remoteness and the cramped clinic quarters soon necessitated finding another location.[116] Durban was thus selected as the most advantageous place, reflecting concerns that Vanessa Noble elucidated in her study of the Durban Medical School (Nobel, 1999): the accessibility from Durban of a rural hinterland containing the

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cost-effectiveness of health centres, fearing that this would make them even more vulnerable to budget cuts.

[114] Sidney Kark wanted to name it the Institute of Social Medicine, but was dissuaded by Gale, who pointed out that such a title would be "like a red flag to a bull" for their political opponents. Interview of Emily and Sidney Kark by Prof. C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992, p. 12.

[115] TES 6902 56/157 Dept. of Public Health. 1) Institute of Hygiene. 2) Training of Personnel for Health Centres. 3) Institute of Family and Community Health.

[116] Pholela remained the rural training site for the IFCH, and personnel were sent there for a portion of their training.

environmental conditions and range of pathologies that health centres' personnel would encounter, and the presence of various race groups (as defined by the Union government) who would be the IFCH patients. Another compelling argument in favour of Durban owed to the legacy of medical missionaries such as McCord and Taylor, who had long advocated for a black medical school in Durban.[117] After much debate, Springfield was selected as the initial training site.[118]

The Karks left Pholela for Durban in December 1945 after designating Dr. Dorothy Ryan as acting director of the Pholela Health Center.[119] The then-Institute of Hygiene was established the following month in temporary accommodations provided by Dr. B.A. Dormer, director of the King George V Tuberculosis Hospital in Springfield, but soon moved to an adjacent building that had served as a military hospital. Sidney Kark was in charge of training, practice, and research, while Emily was appointed chief Medical Officer. The Springfield health centre's first clients were drawn from the nearby

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[117] The IFCH preceded by five years the 1950 founding of the Durban Medical School, but the latter institution had undergone a 40-year incubation period as the indefatigable James McCord and his successor Alan Taylor strove to realise their dream of training black doctors. As Taylor and other members of the medical school's planning committee sought to convince the government that Natal's major city was the best possible site for the medical school, "one of the principal arguments used in support of Durban...was the availability of the Institute for training in practice outside hospitals." UKP H6/2/3 George Gale, confidential memo: History and Future of the Institute of Family and Community Health. 1 June 1954. However, advocates for the Durban location (for both the IFCH and the Medical School) had to overcome the resistance of apartheid politicians who, according to George Gale, "felt that all big towns were 'bad' in their influence upon the Bantu. [Black medical] students in Durban would be exposed to the baleful influence of far too many 'liberals' in both the University and the town, and the IFCH had long been reported by spies as a 'nest' of liberals, even 'communists' according to the Nationalist definition." UKP H6/1/1, The Story of the Durban Medical School, by George Gale, 25 Jan. 1976.

[118] Alternative locations in Natal suggested for the IFCH: Umlazi, Dalemeny Farm, Ilfracombe, Marianhill, and Adams College. All these sites were eventually rejected on the grounds that they were too far from Durban, did not share Clairwood or Springfield's access to different racial groups, or did not have the advantage of donated or cost-reduced land and facilities. TES 6902 56/157, Department of Public Health. 1. Institute of Hygiene 2. Family and Community Health. Note Re: Sites, 8 Oct 1945.

[119] Dr. Ryan stayed in this position until 1948, followed by Dr. Bert Gampel for a brief period and Dr. John Cassel from 1948 to 1953.

Indian municipal housing section and later from the adjacent Coloured areas of Sydenham and neighbouring African locations. An additional health centre was set up later that year in the Friends of the Sick Association (FOSA) TB site in Newlands, serving Indian and African families.

Within a couple of years, the training programme outgrew the Springfield site (though it was retained as a health centre) and in 1947 the Institute, now renamed the Institute of Family and Community Health, relocated to another former military hospital in Clairwood.[120] Besides being larger, the Clairwood facility was within closer proximity of different racial groups who lived in the surrounding areas of Lamontville (African), Merebank (mainly Indian, some Coloured and Africans), Woodlands (white), and Mobeni (African, Indian, Coloured and white factory workers). By 1950 the IFCH operated a total of seven centres in these neighbourhoods, while maintaining strong links with Pholela as a field unit. Later Tongaat, a small village on the north coast of Natal with a population of Indian and African sugar cane cutters, was added to the IFCH roster.[121]

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[120] The land and buildings that the IFCH bought in Clairwood were sold at "half their value" by the Durban City Council, with Minister of Health Henry Gluckman personally conducting the negotiations: UKP H6/2/3, George Gale, History and Future of the Institute of Family and Community Health, 1 June 1954. Clairwood was part of Durban's "black belt", a dense concentration of Indians on the city's southern periphery. Since the turn of the century, Clairwood attracted indentured Indians who had completed their labour contracts and chose to settle permanently in Natal (Swanson, 1983). Clairwood's flat alluvial soil and the absence of restrictive municipal regulations made the area suitable for both residential dwellings and small-scale agriculture: it boasted the largest acreage of market-gardens in the Durban area (Freund, 1995). A number of early Indian pioneers in Clairwood purchased properties; subsequent arrivals lived as tenants of these Indian landowners. Informal settlements soon sprawled beyond the original nucleus of pioneers. Although shack settlers leased their property from the state, they retained strong communal links with Clairwood centre (Scott, 1999). Until the 1956 re-classification of Clairwood from a residential area to an industrial zone, Clairwood was the last remaining island of privately-owned Indian land in the southern corridor. The process of removing informal settlements had already begun in the 1940s, intensifying between the 1950s and the 1980s, during which time at least 40 000 people were removed from Durban's black belt (Surplus People's Project, 1983 cited Scott, 1999:118).

[121] The IFCH also offered some services in Umlazi, a black township south of Clairwood.

The eight centres, including Pholela and Tongaat, which between them covered about 30,000 people, served a total population of 65,000 to 70,000 people, disaggregated into 3500 whites, 5200 Coloureds, 13 350 Indians and 47 000 Africans (Kark 1951:870).[122] Without the Pholela and Tongaat centres, the Durban centres handled about half the case load, a pool of 35,000 to 40,000 people.

Doctors and nurses assigned to health centres across South Africa came to the IFCH for periods of several weeks to months, to be immersed in the principles and practices of social medicine. The course for health educators was originally half a year, but by 1949 it had expanded to three years. Other trainees included social workers, midwives, psychologists, even a few dentists. As director of the institute, Sidney Kark designed a programme that conveyed his and Emily Kark's interpretations of social medicine, with significant intellectual contributions from George Gale and David Landau, who took over as director when the Karks were in England in 1947.[123] One of the first lessons taught was that patients were not merely isolated individuals with biomedical conditions. Rather, they lived at the epicenter of a series of concentric circles: their family situations, their families' life situation within the local community, and

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[122] See also UKP H6/2/3, Enclosure sent by DCHO to Sec of Health 1 Oct. 1954.

[123] Sidney Kark evinced great admiration and affection for David Landau, who died prematurely in 1948 of a heart attack. In particular, Kark cited the influence of Landau's work as Medical Officer of Health for the Local Health Commission in Edendale, a view shared by at least two of the health educators interviewed, one of whom (Bala Govender) had worked with Landau prior to joining the IFCH. Kark recounted, "[Landau}used to come out to Pholela and see what we were doing and we used to go to Edendale to see what he was doing...Eventually we ran similar services. His programme in Edendale and his earlier reports in Edendale read very much like reports on Pholela except that they deal with a different community and he began training health assistants similar to ours, began realising that doctors and nurses need to fulfil different roles, and would have spread this very far...I think David had a lot to do with influencing the Gluckman commission together with George Gale because he and George were very close": UKP H6/1/1 Interview with Professor. S.L. Kark and Professor Gordon on Some Facts and Aspects of our Medical School Which Are Not Recorded, p. 15
Re: Sidney Kark's appreciation for Gale's contributions to social medicine, see Kark and Kark (1999) and Marks (1997; 2000).

finally the way of life of the community itself in relation to the social structure of South Africa.

Epitomised by the democratic health team, the IFCH approach challenged the hierarchical and authoritarian relationships inherent in the usual health care model (doctor-nurse, nurse-health educator, professional-auxiliary).[124] At the IFCH, this team usually comprised one doctor, two nurses and two health educators, with health recorders, laboratory workers and midwives occasionally in attendance.[125] At weekly health team meetings, an informal atmosphere prevailed and dialogue was encouraged along with an insistence on patient confidentiality outside of the health team meetings. Team members studied family cases through the prism of socio-economic influences on health (though patient confidentiality was emphasised), reported demographic and epidemiological information, commented on progress and levels of participation in various community programmes, and engaged in more personal sharing. For Eva Salber as for others, "Our team meetings became times of very frank discussion and camaraderie..." (Salber, 1989:95). The amicable exchange of perspectives and experiences not only bridged gaps between individuals but also helped synchronise white doctors' "Western" biomedical model with an array of different cultural outlooks—traditional, urban, Christian, Hindu, etc.—held by their African and Indian colleagues and patients (Kark and Steuart, 1962; Kark and Kark, 1981; Kark and Kark, 1999). Yet the openness of health team meetings could also be "a source of irritation to some staff

[124] So embedded is the hierarchy of the doctor-nurse-HE-patient nexus that a complete transcendence of these boundaries would be unlikely (Glazer, 1991). According to some of the HEs interviewed, certain aspects of the hierarchy did remain intact and beyond question. See Chapter Six, Section 2.7.

[125] Health recorders and lab technicians were health educators who had received special training in those fields. See Appendix 3 for final "clinical sideroom" exam taken by the lab technicians.

members and trainees, as well as to a number of visitors". Indeed, the Karks "were subsequently castigated for this policy" on both racial and professional grounds (Kark and Kark, 1999:111). They defended health teams for providing an occasion for collegiality, a forum for intercultural dialogue and a symbol of restructured attitudes and relationships, not just within the team but with patients as well: "[medical staff] had to give up the assumed 'right' of authority of professional[s]...who have been trained in hospitals. [Their] approach required modification if [they] were to become the confidants of the individuals and families under [their] care"(Kark and Kark, 1999:119).

In conceptualising the functions of the IFCH, Gale, Gluckman and Sidney Kark foresaw its value as a site not only for government health workers' training but for medical students as well. Just as doctors needed to anchor their family practice in the wider environment, Sidney Kark asserted, so too did medical students require "experience in the laboratory of human relationships, namely, the community".[126] As George Gale explained, "no amount of teaching within the hospital, or even at its outpatient department, where patients are seen divorced from their normal physical and social environment, can ever be an effective substitute for the training which could be given through the health centres".[127] Accordingly, in 1955 the IFCH became a satellite department of the University of Natal's newly-founded Durban Medical School, a link that lasted five fruitful years before both the university department and the IFCH closed down. [128] The Department of Social, Family and Preventive Medicine formed one of the

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[126] UKP H6/2/3, "Family Health and Medical Care", by S.L. Kark. 26 May 1954

[127] UKP H6/2/3 Confidential Memo by Dr. George Gale, "History and Future of the Institute of Family and Community Health", Jan 1954, p. 2.

[128] The division was also known as the Department of Family Practice. I am indebted here to Vanessa Noble's scholarship on the history of the Durban Medical School and its links with the IFCH through the

cornerstone clinical divisions of the medical school, alongside Medicine, Surgery, Gynaecology and Obstetrics. IFCH leaders appointed as professors or lecturers included Sidney (head of department) and Emily Kark, Drs. John Abramson, Julia Chelser, and Bert Gampel as well as Guy Stueart, Helen Cohn and Nancy Ward.[129]

The impresario of the IFCH-Medical School connection was George Gale, Dean of the Medical School from 1952 to his departure from South Africa in 1955. In the late 1940s, Gale laid the groundwork for an alliance when he and Sidney Kark were active members of the initiating committee of the medical school. A deciding factor in the affiliation was the sponsorship of the Rockefeller Foundation spanning the years 1955 to 1960, secured by Gale after protracted negotiations. As early as 1946, the Rockefeller Foundation had expressed interest in the IFCH; the 1947 visit to Pholela by Dr. John Grant, an officer of Rockefeller's International Health Division, cemented the constructive relationship between the American philanthropic organisation, the Karks and Gale. In keeping with Rockefeller's tradition of supporting medical education in developing countries such as China and India, Grant insisted that the IFCH be formally linked to the Medical School, cautioning that "an Institute...which was not integrated with a University Medical School would become a second rate institution and was doomed to fail in the end. Divorced from an institution of higher learning it would tend to

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sponsorship of the Rockefeller Foundation (Noble, 1999). From the Durban Medical School's founding in 1951 until 1976 (when Medunsa was established), it was "the only tertiary institution in South Africa whose main concern was providing medical training for black students" (Noble, 1999:5). The inception of the Durban Medical School sparked debates about whether its status as a black institution was an advantage or disadvantage, as was argued by progressive student organisations who objected to another segregated educational institution (Susser, 1993:1040). Under such pressure, the segregation practised at the Durban Medical School was not de jure but de facto.

[129] Salaries for these staff were paid jointly by the University of Natal (through the Rockefeller Foundation grant) and the Natal Provincial Association: UKP H6/2/3, Letter from Flora M. Rhind, Secretary Rockefeller Foundation to Dr. Malherbe; also UKP H6/2/3, Letter from G.W. Gale to Dr. le Roux, Secretary for Health 8 Nov. 1954.

be actuated by a spirit of narrow occupationalism and would become intellectually isolated....[130] Grant presented his view of preventive medicine along lines familiar to the Karks and Gale: "A strong department of Social Medicine within a Medical School would be one of the best ways of ensuring that doctors who qualify in that school are imbued with the right outlook...[i.e.] that they should deal as much with the promotion of health as the prevention of disease".[131]

To strengthen the connection between the IFCH and international currents in social medicine, the Rockefeller Foundation granted U.S. Travelling Fellowships to several IFCH leaders, among them Sidney Kark (late 1947), John Cassel (1951), Guy Steuart (1952) and Helen Cohn (1953), enabling them to study epidemiology and social sciences at institutions such as the Harvard and Yale Schools of Public Health.[132] The retention of these scholarship recipients later became one of the conditions for Rockefeller funding.[133]

Rockefeller sponsorship and affiliation with the University of Natal offered a degree of security to the IFCH, acting as a buffer against mounting Nationalist government antagonism by the early 1950s. The state's repudiation of the "health centre

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[130] cited in Noble, 1999:115.

[131] ibid.

[132] After Sidney Kark finished his fellowship at Oxford in 1947, where he and Emily were funded by the Nuffield Foundation to study social anthropology and epidemiology, Grant arranged for Kark to visit the United States. Cassel took a leave from the Pholela health centre in 1951 to study there as well. Guy Stueart (director of health education at the IFCH) was funded by Rockefeller to study at the Yale School of Public Health; Helen Cohn was the IFCH's first chief nurse and head of nurse training, who completed a MPH at Harvard. George Gale also travelled to the U.S. in 1950 on a Rockefeller fellowship.

[133] The other two conditions required by the Rockefeller Foundation were 1) written support from the DOH for the IFCH-Medical School affiliation and 2) clarification regarding whether students from other parts of Africa could attend the Medical School: these conditions were met. UKP H6/2/3, Letter from George Gale to Dr. Andrew Warren of the Rockefeller Foundation, 2 Aug. 1954.

movement" took two forms: passive—a reduction of financial support to existing health centres—and aggressive—open criticism of both the philosophy of social medicine its practitioners like Sidney Kark. In 1950, while Gale was in the U.S. on a Rockefeller fellowship, his temporary replacement, the chief medical officer Dr. H.F. Anecke, appointed a hostile committee of enquiry to assess the IFCH. Kark found the committee's so venomous that he considered suing for defamation of character (Marks, 1997: 457, 459).[134]

Although the first two Nationalist Ministers of Health, Drs. Stals (1948-51) and Bremer (1951-52) cautiously supported the IFCH, they could not curb the escalating animosity of dominant politicians and the apartheid-era medical profession for the "liberal, as opposed to authoritarian, methods..." of the Karkian model.[135] After Stals' untimely passing in 1951, Gale "had no difficulty in persuading [Stals' successor Bremer] too to give support to our main objective [support for the IFCH and the Medical School]". However, when Bremer too died the following year, the IFCH lost the last moderately sympathetic figure in the top echelon of the DOH. Subsequent ministers of health showed themselves reluctant to "distinguish between social medicine and socialism", caving into the "pressure from ...rank-and-file supporters to abolish, or profoundly modify, the health centres and IFCH".[136]

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[134] The report was recalled by the Minister of Health, Dr. Karl Bremer, as he deemed it unsuitable for doctors to publicly cast aspersions on their colleagues (Noble, 1999:206).

[135] Gale described Stals as "both modest and open-minded" and lauded him for withstanding "complaints made to him by politically-minded opponents of the whole health centre scheme". Stals authorised Gale to "maintain the Institute and even to establish one or two more health centres". UKP H6/1/1 The Story of the Durban Medical School, by George W. Gale, 25 Jan 1976, p.13.

[136] ibid, p. 16.

By late 1952, these conservative forces were beginning to gather greater force. A crusading Gale struck back, seeking to repulse what he envisaged as a government mob intent on "murder[ing]...the Health Centre scheme...a murder of its finest effort (carried out with real devotion, under a perpetual cloud of insecurity and malevolence)..."[137] Writing with candid fury to the Secretary for Health J.J. du Pre le Roux, Gale excoriated the DOH's 1952 plan to terminate HE training and phase out the position, replacing them with "nurse-aides" with lower educational credentials and far less training.[138] Gale pointed to the measurable successes achieved by the HEs: "What puzzles me is how you or anyone, can suppose that the integration of the health centres service can be aided by destroying the class of personnel (health assistants) who are distinctive to health centres and have played a vital part in achieving their excellent results (diminished mortality and morbidity rates) and substituting for them a hopelessly inferior class. This is not integration, but reduction of the health centre to the lowest common denominator of health services...."[139]

Admitting that nurse-aides "might be useful in curative work", Gale nonetheless argued that they could not "make any significant contribution to the preventive and health educational side of health services [and] will never be able to accomplish what health

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[137] UKP H6/2/3, Confidential Letter from G.W. Gale to Dr. J.J. du Pre le Roux, 5 Nov. 1952, p.6.

[138] Nurse-aides had only a Junior Certificate (equivalent to Grade 8) as opposed to HEs' matric (Grade 12). They would receive only one year of training, compared to HEs' three years. Gale summarised the Dept. of Health's rationale for lowering the educational and training requirements: "The object in taking girls of this educational standard is to ensure that they will be of a type who will content to go back, after this simplified type of training, and live among their own people". He derided the "the a priori assumption that too much education is bad and dangerous – for non-Europeans" and the related "supposition...that the more highly educated a Native woman is, the less willing she is (if a nurse or nurse assistant) to live among her own people...in general the supposition is quite incorrect, taking in account of the very numerous other and more important factors which influence Native attitudes in this matter": UKP H6/2/3, Letter from G.W. Gale to the Department of Health, 5 Nov. 1952. p.8.

[139] ibid. p.6.

assistants have accomplished in field work".[140] He brought to this assessment his vast experience in community health: "After well over twenty years of constant personal observation, I have not come across any other results anywhere near those which have been achieved by the use of health assistants, as trained by Kark and his associates. The result I have in mind are the changes in the ways of living of entire communities...behind all these lie changes in concepts, due to health education carried out by health assistants – not in isolation, but as members of the health centre team [emphasis original].[141] Finally, Gale reminded le Roux that "the work of the health assistants has been widely publicised abroad...as evidence of progressiveness in social services for non-Europeans", and their replacement would jeopardise the support of international funders like the Rockefeller Foundation and the Nuffield Foundation. He raised these issues "as a citizen jealous for the reputation of my country abroad" and warned that "when health experts in many countries, who appreciate...the significance of what has been accomplished in Health Centres in South Africa, hear that the service is being emasculated, on the recommendation of the senior health officers of the country they will doubtless feel that reaction and repression have now invaded the health field also [emphasis original]". [142]

By the end of 1952 Gale had to fight off an even graver menace: the potential closure of the entire IFCH. He was able to prolong its survival by arranging its transfer from the central DOH to the Natal Provincial Administration (NPA).[143] As the Karks

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[140] ibid, p.1-2.

[141] ibid.

[142] UKP H6/2/3, Personal letter from Gale to Dr. J.J. de Pre le Roux, 10 Nov. 1952, p.2.

[143] However, the full transfer of control from the central DOH to the NPA took several years and was not finalised until 1955 (Noble 1999:151).

later commented, this was an unusual step as the NPA was only responsible for hospitals, not for community based health centres (Kark and Kark, 1999:194).

Government threats against the IFCH did not cease with the provincial takeover. Gale managed to get another reprieve by obtaining the Rockefeller funding, which "knit the IFCH to the Medical School", thus ensuring "its preservation...from extinction".[144] The Rockefeller Foundation agreed that "the step...is timely, for the Medical School is now in its formative period, and the Union Government may otherwise discontinue support to [the IFCH]...the rescuing of this Institute is an urgent consideration".[145]

The Department of Social, Preventive and Family Medicine aimed to inspire medical students to integrate curative and preventive work into their general practice. The syllabus covered family care, epidemiology, public health administration and health education (Stueart, 1962). In addition to lectures and seminars, medical students were required to do weekly "clerkships" (internships) at IFCH centres during their last three years of study. Working in conjunction with a "clinical tutor", usually an IFCH doctor, as well as nurses and health educators, students conducted a long-term family study, examining individuals and families on a regular basis at the centre and during house calls. Sidney Kark remarked that caring for "the sick at home...would be complementary to [the medical student's] case studies in the hospital ward or out-patient department".[146] Students were urged to consider the epidemiological significance of disease and to relate

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[144] UKP H6/2/1. Correspondence of Prof. I. Gordon, Faculty of Medicine, 1954-57. Letter from Dr. G.W. Gale to Dr. Gordon, 21/5/55, p.3.

[145] UKP. H6/2/3, Letter from the Regional Directory of the Rockefeller Foundation, Africa. W.A. McIntosh to Dr. G.W. Gale, 17 May 1954.

[146] UKP H6/2/3, S.L. Kark, "Family Health and Medical Care: the Need for Training a Family Doctor." 26 May 1954. p.9.

the patterns of health in a family to determinant factors such as diet, income, and environment. Using statistics that the IFCH compiled on morbidity and mortality rates in communities served by health centres, students learned to analyse field data and make comparisons with other communities in South Africa and elsewhere. Students also engaged in short-term investigations that provided a window into family practice, exploring among other themes hygienic conditions in homes and neighbourhoods, storage and preparation of food, as well as more intangible elements such as health concepts and knowledge; and social integration or isolation.

The content taught in courses given through the auspices of the IFCH and in the Department of Social, Preventive and Family Medicine appeared on final examinations as a mandatory qualifying subject. Thus the Department's orientation in social medicine put the Durban Medical School in the vanguard of medical training in South Africa. But not all faculty and students embraced this innovation, Sidney Kark admitted: "[R]ight from the beginning we had our students questioning why they should have to do something different from the leading schools in the country, and there were arguments all the time...there was bitterness that they had to go through this extra year with extra subjects that the well-established school didn't want".[147]

Beyond the Durban Medical School, the IFCH also sealed an alliance with the Council for Scientific and Industrial Research (CSIR). In 1948, the chairman of the CSIR's Medical Section, Dr. Sarel Oosthuizen, visited the IFCH at the suggestion of George Gale. Dr. Oosthuizen was sufficiently impressed with the Institute to recommend

[147] UKP H6/1/1, Interview with Professor S. Kark and Professor Gordon on the Facts and Aspects of our Medical School which are not Recorded, by. S. Cameron-Dow. December 1980, p 21-22. See also Noble (1999) for the mixed reactions of students.

that the CSIR sponsor a new initiative at the IFCH, and in 1949 the Family Health Research Unit was established under the direction of Sidney Kark. CSIR assigned two of its professional staff to work full-time with the unit, assisting IFCH doctors and health educators. Among the unit's research projects were a comparative study designed by Eva Salber assessing the birth weights of babies from different "race" groups of babies; Emily Kark's investigation of growth and nutritional status of black and Indian girls; and research by anthropologist Hilda Kuper on infant rearing in the Indian settlements of Merebank, Springfield and Newlands.[148]

By 1958, the accelerated pace of apartheid legislation encompassing all social arenas including education, placed both the IFCH and the Department of Social, Preventive and Family Medicine in greater jeopardy.[149] As a black institution, the Durban Medical School itself was under threat of being cut loose from the University of Natal and relegated to the status of a "Bantu college". The administration of such establishments was in the grip of the Minister of Education, who could throttle matters of academic freedom such as faculty appointments. The situation for the IFCH and its affiliated Department considerably worsened with the expiration in 1960 of both the provincial funding and the Rockefeller monies, despite Gale's efforts from Uganda, where he resided after leaving South Africa, to resuscitate these financial sources. Rockefeller was reluctant to renew support when the winds of political repression were

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[148] For more on the CSIR Unit and the involvement of the IFCH HEs, see Chapter Six, Section 3.1.

[149] The Bantu Education Act, passed in 1953 and implemented 2 years later, was part of the state's attempts to create a new hegemonic social order in which Africans were assigned an immutable position as "hewers of wood and drawers of water", in Prime Minister H.F. Verwoerd's biblical phrase. The Act separated and restructured the education system for Africans, emphasising primary school and technical instruction to produce a semi-skilled workforce. It removed African education from the general revenue and placed it almost entirely on the taxation burden of Africans themselves, save for a negligible contribution from the central government (Hyslop, 1999).

blowing harder, tragically epitomised in the 1960 Sharpeville massacre. As Gale explained, the government's harsh crackdown following the Sharpeville massacre fulfilled the Foundation's "fear[s] that South Africa...was now set on a course towards totalitarianism..."[150] Gale's replacement as Dean of the Medical School, I. Gordon, also tried valiantly but unsuccessfully to save the IFCH and the Department of Social, Family and Preventive Medicine. Both closed in 1960, with a single staff member from the IFCH, Dr. Zelda Jacobsen, retained for a couple of years by the Medical School to conduct courses in health education. The Karks, like other key senior IFCH staff, had already come to the realisation that "there was no professional future" for them in South Africa, and left in 1958, emigrating the following year to Israel, where their ideas found more receptive ground (Kark and Kark, 1999:198).[151] Their model of health care, known since the 1970s as COPC, achieved international recognition. As Mervyn Susser observed, "Not only Israel, but the world at large gained from their relocation outside the perimetre of apartheid" (ibid:viii).

4.4 Health Educators[152]

This section draws from archival and published material to explore how the engineers of the IFCH—the Karks and George Gale—interpreted the roles of health

[150] UKP H6/1/1, The Story of the Durban Medical School, told by George W. Gale, p.16

[151] The Karks preceded their emigration to Israel with a year at University of North Carolina (UNC) at Chapel Hill. The dispersal of IFCH staff began in 1948 with the departure of Gershon and Miriam Gitlin for Israel; Helen Cohn in 1952 for the U.S. (Harvard University) ; John Cassel in 1953 for UNC at Chapel Hill; Eva Salber and Harry Phillips in 1953 for University of Cape Town, followed by Boston (Harvard),then UNC for Phillips and Duke University for Salber. George Gale left South Africa in 1955 for Uganda; to be joined by John and Grace Bennett and Langford Letlhaku. Joe Abrahmson, who replaced Sidney Kark as IFCH director in 1958, left for Israel in 1960, as did Zelda Jacobsen in 1962.

[152] The documentary portrait of HEs in this section is intended to complement the interview data in Chapter Six.

educators. It situates "health assistants" (the official designation) in relation to South African and international examples, and traces the ways in which the NHSC's definition of "health assistants" evolved into the pathbreaking "health educators" of the Karkian model.

In archival sources, the term "health assistant" may be misapplied to a bewildering range of auxiliary personnel including medical aides, health inspectors, nurse aides and health visitors.[153] However, such paraprofessionals were distinct from the "health assistants" in the NHSC plan and the Karkian model, in which the terminology was eventually (by the early 1950s) changed to "health educators" to more accurately reflect their function. George Gale clarified the health educator position by defining what an HE was not: "[She] is not a health inspector, not a health visitor, not a social worker, not a medical social worker".[154] IFCH HEs generally did not deliver medical care, though during the Pholela health centre's early period—a time when the clinic was

[153] A summary of the four positions: 1) "medical aides" were African men who had undergone extensive medical and clinical training but performed limited duties "in no way commensurate with their training", according to George Gale, a former trainer and subsequent critic of the medical aid programme: "Instead of being virtually assistant district surgeons, as their training had led them to suppose would be the case, they found themselves merely medical orderlies, lower than nurses and lower than health inspectors." (GES 2957 PN2/5 Letter from George Gale to Sec. for Health le Roux, 19 May 1952. For more on medical aides, see Chapter 4.2); 2) "health inspectors" monitored adherence to sanitary regulations for municipal authorities; 3) "nurse aides" worked in clinical settings as assistants to nurses and district surgeons; 4) "health visitors" were public health nurses who had undergone a six-month postgraduate training; they were employed by municipal authorities to perform house visits to follow up registered (usually white) newborns, conduct antenatal and postnatal clinics, trace contacts for notifiable diseases such as T.B. and VD, and inspect midwives. Medical aids and health inspectors were male, while nurse aides and health visitors were female. For an example of the term "health assistants" being used to describe "medical aides", see *Report of the Committee Appointed into the Training of Natives in Medicine and Public Health* (Pretoria, Government Printer, 1928, U.G. 35-1928).

[154] NGR 4 The Training of Health Assistants as Health Educators, Memo by Dr. George Gale. p. 1.

charged with containing several typhoid, enteric fever and smallpox epidemics—they administered vaccinations and first aid (Kark, 1943).[155]

In South Africa, HEs most resembled "home welfare officers" as well as health assistants for specific programmes aimed at malaria, VD, and sanitation. George Gale regarded malaria assistants as a prototype for general health assistants but acknowledged that their "distant relationship" with health care personnel was a disadvantage, especially in comparison to HEs' "direct liaison with medical officers and nurses" (Gale 1936:324).[156] In the early 1930s, while malaria epidemics ravaged Natal and Zululand and killed tens of thousands of people on sugar estates and African reserves, the Department of Public Health employed African men to help combat malaria (Jeeves 1997).[157] By 1936 there were seventy malaria assistants working in rural areas. They received ten days' training before going into the field to monitor environmental measures required to control the disease. On their daily rounds, they met with local assemblies in the African reserves, disseminating information on malaria prevention which emphasised better sanitation and drainage as well as the importance of screens and nets in sleeping quarters. Like the HEs (but in a much more limited way), malaria assistants sought to induce changes in people's attitudes and practices, inculcating "malaria mindedness" (the

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[155] Vaccinations and first aid appear as subjects in a 1943 Syllabus for Health Assistants at Pholela, shown by HE Benjamin Zaca to M.W. Kanis (Kanis, 1979). I have not been able to locate the original. By the late 1940s, these duties had been minimised. Interview with Audrey Bennie, 23 June 2003 23 June 2003, HE at Pholela 1943-58.

[156] See also UKP H6/2/3, Letter from Gale to Sec. for Health le Roux, 28 Oct. 1954, p.5

[157] The exact number of African deaths is unknown, but conservative estimates of the toll for the 1928-32 epidemics hovers around 14 900 Africans. Magistrates' estimates were twice this number. Indian workers on Natal sugar estates also died, perhaps as many as 850 in the 1931-32 epidemic, as did 134 whites. I am indebted to Alan Jeeves' extensive discussion of the DPH's anti-malaria programmes in the 1920s and 1930s, in particular the central role played by Dr. Park Ross, the Senior Assistant Medical Officer in Durban.

phrase is from Dr. Park Ross, the pragmatic mastermind of the programme) as a crucial means of disease prevention.

Park Ross was subsequently brought in as an advisor to the training of male health assistants in peri-urban Natal townships, notably Edendale and Clermont. Between 1938 and 1941, health assistants under the tutelage of the Local Health Commission's Dr. David Landau, organised rudimentary sanitary services (pit latrines and the bucket system) for township residents and instructed them in other health-related matters.[158] Sidney Kark regarded the Edendale health assistants as an important precedent.[159]

In the late 1930s, the Johannesburg City Health Department launched an analogous development, deploying black male health assistants at public health clinics in Orlando, Sophiatown and Alexandra. Henry Gluckman was "one of the chief movers" of this programme (Burns, 1998:713). From 1938 until 1946 when he assumed the post of Minister of Health, Gluckman was instrumental in training these health assistants and then placing them in a network of "VD Clinics" complete with systems of diagnosis, tracking, and treatment of male and female patients. Eventually such health assistants joined public health campaigns ranging from tuberculosis treatment to occupational therapy and ambulatory emergency aid (Burns, 1998).

A concurrent programme for "home welfare officers" operated at the Mears School in the Transkei. Unlike the above-mentioned interventions aimed at specific

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[158] PAR (Natal Archives) 2PMB 3/1/1/2/5 Native Commissioner, Pietermaritzburg. Peri-Urban Areas. Establishment of Local Health Commission 1938-1941. The programme's effectiveness was hampered by the municipality's refusal to extend safe water supplies and full sanitation services to Edendale. Bala Govender, one of the first IFCH HEs, worked in Edendale for this Commission as the only Indian among six African health assistants.

[159] UKP H6/1/1, Interview with Professor. S.L. Kark and Professor Gordon on Some Facts and Aspects of our Medical School Which Are Not Recorded, p. 15

diseases or problems such as inadequate sanitation, the Transkei project envisioned its trainees as agents in a broader endeavour to "assist the community in every possible way in the direction of the social, economical and moral development of the home and family life of the people and the improvement of their health conditions".[160] The training covered an array of concerns: health, hygiene and sanitation; first-aid and home-made remedies; protection of water supply; improvement of diet through the consumption of vegetables and fruit; elimination of vermin and care of the aged. The subject of children's health and attendant topics such as prenatal care, "mothercraft" and infant feeding were essential. Home welfare officers also encouraged cultivation of vegetables, improving agricultural and poultry-rearing techniques as well as domestic science focusing on "general housewifery", sewing and cooking. Finally, "social improvement organisation", particularly through community centres and women's associations known as Zenzele Clubs, became a cornerstone of the Mears effort to enhance local development.

The Transkei training scheme produced only fifteen graduates, and it is uncertain whether any member of this group was actually employed. Mears resembled the IFCH in its general areas of interest and its anti-didactic approach—"the exercise of tact in all dealings with the people cannot be too greatly emphasised...a tutorial or condescending attitude should at all costs be avoided". Yet Mears differed fundamentally in one key respect. Like the all-male malaria, sanitation and VD programmes, and like the (white) "lady health visitor" venture which it evoked as a model, the Transkei project was rigidly

[160] GES 2727 1/70, Memorandum to the Secretary for Public Health Concerning Training and Employment of Home Welfare Officer in the Transkeian Territories, 23 Aug 1946. p. 4.

gendered.[161] The programme's goal of "impressing upon the Native women...the importance of the home unit in the national life" also aimed to enlist African women as assiduous promoters of modernity: "Are women as wives and mothers not the most important factor in African education?" Underlying the Mears approach was an assumption that family and child welfare were the naturally exclusive purview of women. The contrast between this essentialised link between women and "the health of the nation", and the IFCH's comprehensive mandate to mobilise all members of the community in improving their own health, will be discussed further in Chapter Seven.

Closer to the IFCH's holistic view of health education was the work of sociologist Helen Navid at Entokozweni Community Centre in the late 1940s to mid-1950s.[162] Like the Mears organisers and the Karks, Helen Navid believed that health and social development were part of the same continuum; practical projects such as vegetable clubs, social support networks, and educational opportunities could help ameliorate people's poverty and illness, but unlike the Mears School's belief that only women could effect such quotidian progress, Navid and the Karks entrusted their mission to both male and female HEs, and by extension to men and women in their care. Another parallel with the IFCH lay in Navid's interest in the intersections between culture and health, which inspired her anthropological inquiries into health beliefs and their correlation with morbidity, and studies of culturally-inflected infant feeding practices (Susser, 1993:1041).

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[161] The Transkei training programme was further restricted to married African women between the ages of 35 and 45.

[162] I am grateful to Prof. Mervyn Susser and Dr. Zena Stein for pointing out the similarities between Helen Navid's work in health education and that of the Karks'. At the Alexandra Health Centre under the direction of Stein and Susser in the 1950s, health assistants were part of a team including doctors, nurses, and midwives, but they had a much more limited role than at the IFCH (email communication with Stein and Susser, 10/03).

At Entokozweni Centre, as at the IFCH, health educators were envisaged as potential catalysts of broader social transformations, though still within largely apolitical parametres. This greatly expanded the NHSC conception of health assistants, which primarily saw them as a low-cost means of extending preventive or curative services. While emphasising that "health education, as an important promotive service, will receive high priority", the NHSC report relegated health assistants to modest, supportive roles, laconically stating that they "appear to be of considerable value in the matter of health propaganda and the recognition of certain simple diseases"; the report also recommended "their extensive use under the supervision of medical aids in preventive work".[163] The NHSC brief for health assistants required them to dispense first aid, as the Pholela HEs did in their first few years before this element was phased out. In contrast, the Karks desired to create "a health worker...who did not have the urgent demands for the care of the sick" (Kark and Kark, 1999:120). Instead of performing clinical or paramedical duties, HEs concentrated on "social health, personal relationships within family and primary groups, and community organisation" (ibid.). Despite these distinctions, it must be emphasised that the difference between NHSC health assistants and IFCH HEs was a matter of degree, not of kind: the former represented a more rudimentary, limited, but still-recognisable version of their later incarnation as HEs.

The NHSC's definition of health assistants drew upon international sources, in particular a programme instigated by the Dutch colonial government in Java (Indonesia) in the 1930s, featuring health educators known as "mantri".[164] E.H. Cluver and H.S.

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[163] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944): 91.

[164] GES 2957 PN5 Native Affairs Fact Paper VIII, Social Medicine in South Africa, March 1951.

Gear, the two health department officials who mustered enough government support to launch the Pholela Health Unit in 1940, referred admiringly to the mantri model, as well as similar personnel used in India and the U.S.[165] The primary means of engaging the populace in discussions of health was through home visits in which health educators "[went] out among the people…like an old-fashioned family doctor…who [knew] the family intimately…as their advisor and confidant".[166] George Gale, who worked closely but not always harmoniously with Cluver and Gear, appealed for this kind of intimate professional pursuit: "There must be an intermediary between the doctors practising social medicine and the homes of his patients; and that intermediary must be a general-purpose auxiliary speaking the vernacular and trained wholly for that particular job…[emphasis original]".[167]

Having "seen [health assistants] in action at Polela [sic]" in 1942, the NHSC suggested that they be the model for all future health assistants in health centres across the country.[168] Yet the Pholela project in the early 1940s was embryonic; the HEs' role had not yet fully coalesced into the configuration that it later took in Pholela and Durban, when there was a more conscious formulation of HE functions such as facilitation of

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[165] UKP H6/2/3 Letter from George Gale to Secretary for Health le Roux, 28 Oct. 1954, p. 5

[166] GES 2727 1/70. Circular No. 1/70 of 1946 to All Magistrates in the Cape, Transvaal, Orange Free State and Natal re: Health Centres.

[167] GES 2958 PN6/2 Dr. George Gale, Confidential. Annexure to Dr. Gear's Comments Upon the Training Scheme for Health Personnel: Durban. 2 Feb 1949. In this particular source, the redoubtable Gale defends health assistants against criticisms levelled against them by John Ryle and subsequently echoed by Gale's superior Harry Gear.

[168] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944): 137.

primary groups.[169] Referring to the fledgling HE training, Sidney Kark admitted: "although I say we began training it was a question of learning together..."[170] The original HEs were J. Mngoma, A. Ngobo, S. Shembe, E. Dzandibe, who had been malaria assistants in Natal and another, J. Sibanyoni, who worked alongside Sidney Kark in 1938 conducting a nutritional survey of African schoolchildren (Noble, 1999:86) The Karks soon discovered that these men, though helpful, were in some ways more of a liability than an asset. As young single men, their visits to homesteads where the male head of household was absent due to labour migrancy, aroused great suspicion.[171] In the tightly-knit Pholela community, they were "outsiders", visitors without local kinship ties. Decades later Sidney Kark reflected on this problem: "Though they were Zulu-speaking they weren't Pholela people. It was a mistake..." but was soon rectified by replacing them with residents: "once we were appointing local people there was a difference about the attitude of the people to the Centre".[172] Thereafter the Karks placed greater emphasis on securing local HEs, which was "not only a useful thing to do, but it's an absolutely essential thing that the community feels and know that this place belongs to them".[173] Another key decision was to select both men and women. The first Pholela HE was

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[169] However, all of the essential features of HEs' roles and duties in Pholela were carried over to Durban; therefore, unless otherwise specified, this section refers to both IFCH and Pholela HEs.

[170] UKP. H6/1/1 Interview with Professor S.L. Kark and Professor Gordon on Some Facts and Aspects of out Medical School Which Are Not Recorded, p. 11.

[171] Even Sidney Kark intimated that there may have been a basis to these suspicions: "...they were...young men so what they got up to I don't know, but I can imagine." Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992. p. 6.

[172] ibid.

[173] UKP H6/1/1, Interview with Prof. S. Kark and Prof. Gordon, p. 14. The policy of selecting local HEs was more difficult to maintain at the IFCH in the fast-growing city of Durban, where HEs came from the same "racial group" as the people they served but not always from the same neighbourhood.

Margaret Nzimande, principal of Inkumba School and relative of an influential—and initially hostile—local pastor, Joseph Nzimande, who Margaret eventually converted into a supporter of the health centre. Within two years, locally-recruited staff included, besides Margaret Nzimande (Shembe), her husband Benjamin Nzimande, Audrey Bennie and her husband Edward Bennie, Fred Madhlala and Raphael Zaca.[174]

But enlisting community members did not automatically guarantee success. Of equal or even greater importance to the efficacy of the Pholela and IFCH approach was its method of inviting rather than compelling alteration. The Karks "were...dissatisfied with the term 'Health Education', with its connotations of didactic instruction by a teacher who 'knows' to a class that learns by rote"(Kark and Kark, 1999:123). They relied, rather, on the art of gentle persuasion, to "get the people to a position where they wanted to change towards a better state of health".[175] George Gale explained why such overtures were more effective (albeit in language steeped in the era's condescension towards Africans): "The health education of backward peoples will never be successful if it consists merely of commands and prohibitions issued by authority. One must change their fundamental concepts".[176] Gale's ideas about health education were forged during his years at Tugela Ferry mission hospital in a rural and impoverished part of Zululand, where he found that "it is better not to attempt regular formal lectures or even 'talks', which tend to arouse antagonism by making clear their aim in minds naturally

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[174] GES, Vol. 2704, Ref. 1/62 and 2/62. Native Health and Medical Services Polela Unit. General Matters. Social Medicine in South Africa, Mar 1951.

[175] UKP H6/1/1, Interview with Professor S.L. Kark and Professor Gordon on Some Facts and Aspects of out Medical School Which Are Not Recorded, p. 11.

[176] UKP H6/2/3, Confidential Letter from G.W. Gale to Dr. J.J. du Pre le Roux, 5.11.52. p.6. Note: the term "backward' as a synonym for "African" was common even among liberals at the time. See for example the writing of R.F.A. Hoernlé, co-founder of the South African Institute of Race Relations.

conservative. Conversational teaching occasioned by the mood or problem of the moment is more readily absorbed than prearranged discourses" (Gale, 1936:322). Notwithstanding the disdain of an "enlightened" white man of science who declares Africans "backward" and "naturally conservative", Gale's attitude toward his Zulu-speaking audiences evinced a desire for dialogue that mirrored the Karks' notions about interactive health education and medical treatment. Guy Steuart, director of health education at the IFCH, attested: "There was far more talking with, than talking at people, thus avoiding a common fault in many health education projects. Lectures and 'mass' techniques played a very small part. There was no element of compulsion whatsoever and the results represent entirely voluntary action by the people themselves" (Steuart, 1957:98).

The most conducive setting for this kind of rapport was people's homes, where HEs conducted family and group discussions about topics relating to health and disease, particularly communicable disease prevention, nutrition, and the necessity for periodic health examinations at the clinic.[177] In the first instance, HEs explained the nature and spread of communicable diseases, discussed sanitary disposal of refuse and protection of food and water sources, and demonstrated compost and pit latrine construction. Regarding nutrition, HEs aimed to enhance local knowledge of the links between diet and health, stressing the crucial importance of maternal and child nutrition. As a practical correlative of their emphasis on increased vegetable intake and improved land-use patterns for Pholela's eroded mountainous slopes, HEs introduced new agricultural techniques such as trench-farming or terraced gardens, and distributed seeds to encourage

[177] The frequency of home visits to a given family was approximately once a month, and would generally last several hours (see Chapter 6.2).

people to grow a greater variety of vegetables.[178] When promoting the value of the periodic health examination (PHE), HEs spoke about the need for preventive action and early detection of disease. In a district where chronic ill-health was so common as to be virtually taken for granted, HEs attempted to help people realise that they did not have to live with such "normal" but debilitating conditions as malnutrition and tuberculosis.[179] Other disorders such as syphilis could also be diagnosed during PHEs, and in the follow-up discussions with families at their homes, HEs addressed "the spread of the disease,

> its effects upon the child, and its natural history...This education has always to take into consideration prevailing concepts of people in regard to the disease and the relationship of this concepts to culturally accepted theories and etiology and methods of spread of illness. Where such thought processes are in direct conflict with the ideas of modern scientific medicine, great patience and tact has to be exercised by the educator in an effort to bring such concepts more in line with modern ideas (Kark and Cassel, 1952:103).

Home visits were also an occasion for data collection by HEs, part of the Pholela clinic's research directive launched in 1942 as the "household health census" of a defined area.[180] Accordingly, HEs systemically collected and updated information about the family's general state of health, their economic and environmental conditions as well as "[their] changing attitudes...as expressed in the conversation and actions."[181]

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[178] Gardening remained an important focus of the IFCH programme in Durban, though HEs did not collect ongoing statistics about garden composition and prevalence as they did in Pholela. When Pholela HEs conducted a baseline survey in 1941, they found that in most households, only pumpkins and potatoes were grown, with almost no green vegetables; over a quarter of homes had no gardens at all. By 1950, the majority of homesteads had gardens and more than 25 varieties of vegetables were being grown, reflecting the success of the health centre's seed-distribution and related gardening programmes (Kark and Cassel, 1952:132).

[179] The Pholela clinic's early nutrition studies (1942 to 1945) found that over 80% of the local population "exhibit[ed[obvious and often gross stigmata of malnutrition" (Kark and Cassel, 1952:442).

[180] For more on the epidemiological component of the Pholela clinic's research, monitoring, and evaluation programmes, see Chapter Five.

[181] Excerpt from NGR 4 The Training of Health Assistants as Health Educators, by Dr. G.W. Gale. p6.

The on-the-job training that Pholela HEs received, for example in interview and survey methods as well as data analysis, was systematised into the first IFCH HE training course, begun in Durban in 1946. The training built upon the foundation laid down in Pholela. Home visits were a daily part of the curriculum, which balanced theoretical and practical instruction. A 1946 syllabus cites topics such as "Comparative study of the development of various social groups in relation to South Africa's historical development...the study of the way in which various modes of living influence health, e.g. economic organisation, belief patterns, behaviour codes, clothing, food habits" and most importantly, "the study of the family complex, including social psychology...[and] diagnosis of social factors in health and disease".[182]

These subjects were retained when the training period increased to three years, beginning in 1949. George Gale justified the longer training in a passage revealing that the expansion had at first been opposed by Minister of Health Gluckman, whose views changed after seeing HEs in action and hearing Sidney Kark's persuasive zeal:

> [Gluckman] was completely converted by what he saw in the field as well as by verbal arguments....Now the reason why Gluckman...and myself came to the view that the non-European health assistant—if he/she was to be an effective contribution to the preventive side of organised health service—required a very considerable amount of training, was that we came to understand that he would be working in a very difficult field. If he was to be effective, he must himself first properly understand the factors which are productive of health or of ill-health and he must then understand the best methods in the very difficult task of persuading his fellows away from their erroneous concepts to an acceptance of correct concepts in these matters.[emphasis original][183]

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[182] GES 2958 PN6/1 Letter from Secretary of Public Health Peter Allan to the Registrar, South African Medical Council. 15 April 1946.

[183] UKP H6/2/3, Letter from George Gale to Secretary for Health, 5 Nov. 1952, p.3

The health educator training at the IFCH provided a solid grounding in both biological and behavioural studies, with fieldwork for both components. The courses aimed to confer a basic knowledge of physiology, nutrition, parasitology (required for understanding the spread of infectious diseases), environmental hygiene, psychology, sociology, demography and epidemiology.[184] Each subject had its practical classes, e.g. refuse disposal in housing and sanitation, vegetable gardening, laboratory work and preparation of visual aid materials. In keeping with HEs' task as agents of social change, much attention was focused on how to use community organisation and primary groups as vehicles for health improvements (Kark and Kark, 1999:125). The field work that complemented lectures and seminars was organised into planned and supervised projects that trainees carried out in at least two different IFCH locales, with additional emphasis on a particular group such as mothers and children, adolescents, or workers.[185] After completing their initial training, HEs continued to do regular weekly in-service training in conjunction with the health team (Letlhaku, 1961:918; Steuart, 1962:89). Some HEs were given additional, specialised training in health recording and health statistics; others moved into laboratory duties, but the majority continued to work in the community. (See Appendix 3 for the final exam of HEs who received additional training in "clinical sideroom" i.e. lab procedures).

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[184] ibid. p. 6. See also GES 2727 1/70 Health Centre News Letter No. 1, Oct. 1947. Syllabus for Health Assistants.

[185] Block periods of 21 weeks were set aside for projects during trainees' second and third years, with each project carried out in a different community, i.e. one rural, one urban. This feature was deemed "of particular importance for the Native Health Assistant", as many African health assistants would be assigned to rural health centres. NGR 4 The Training of Health Assistants As Health Educators, by George Gale, 1952. p. 3.

Given HEs' close relationships with families, solidified during home visits, health educators were the ideal intermediaries for medical students receiving community health training at the IFCH through the Durban Medical School's Department of Social, Family and Preventive Medicine. According to HE Langford Letlhaku, health educators were closely involved with medical students' on-site training because "the health educator was, on the whole, the key person in arranging field visits of students to families, informal groups and mass groups. He acted as field tutor to the student and was responsible for follow-ups" (Letlhaku, 1961:919).

Between 1940, when the Karks had begun training the first group of former malaria assistants in Pholela, and 1954 when the final class graduated, over 300 health educators were trained, with 30 retained as staff members.[186] However, none of these health educators ever received formal accreditation or professional recognition for their training and work experiences, a source of disappointment to many, including the Karks themselves, who later stated, "We feel deeply to this day for those former co-workers who suffered frustration and deep resentment at this lack of recognition" (Kark and Kark, 1999:195).[187]

This exclusion from the medical and academic establishment was all the more baffling to HEs whom the Karks had consistently and warmly acknowledged as indispensable members of the health team. Again and again in various sources, the Karks recognised the key role played by the HEs, whom they called "the significant

[186] Most of the other HEs were assigned to health centres across the country.

[187] For HEs' responses to the lack of professional recognition, see Chapter Six: Section 10.1.

contribution we made at that time to South African approaches to health care [emphasis added]".[188] Emily Kark extolled them:

> ...we found in one of our evaluations, it was really the health educator who contributed to the success of the programme, because they were the ones...going round home to home, helping people protect their springs, and digging the latrines and helping with the gardens and giving the health education.[189]

In the end, it was precisely HEs' ability to inspire changes in people's attitudes and actions through intimate engagement with their lives and through non-didactic discussion that proved so threatening to opponents of the IFCH. George Gale averred that the Karks and other figures in the health centre movement, including himself,

> offended [opponents] particularly in their reliance on health education as the principle method for bringing about changes which would promote good health and prevent ill health. The practice of health education implies a belief in the democratic process and the Socratic method. This gave way to the belief that the non-Europeans who constituted 90 per cent of the clientele of health centres, would just do what they are told, without any dialogue.[190]

The democratic process invoked by Gale emanated from the health team itself, where health educators were respected for their unique contributions and encouraged to see themselves as integral to the IFCH's mission. Yet nothing nettled critics such as John Ryle more than the inclusion of HEs into the hallowed sanctum of the case conference, where in Ryle's opinion, "the part allotted to the [HEs] was altogether too exalted".[191]

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[188] UKP H6/1/1 Interview with Prof. S. Kark and Prof. Gordon, p. 14. For examples of Sidney Kark's recognition of HEs as key actors in Pholela and Durban, see Kark (1943; 1951; 1952; 1962; 1981and 1999).

[189] Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992, p. 56.

[190] George Gale, "Health Centres in South Africa, An Obituary.": Gluckman papers, University of Witswatersrand, A 1207 B 2.2., cited Marks, 1997:458.

[191] GES 2858 PN6/2, A Report on the Health Centres Service of the Union Department of Health, John A. Ryle, p. 9.

Ryle "took exception on ethical grounds to the discussion of intimate personal, marital, or other details of named families...[which] struck me as a serious departure from Hippocratic and long-accepted tradition".[192] Ryle trumpeted: "In no situation is it more necessary to maintain high ethical standards than where a backward country is being introduced to ideas and methods of a more advanced one".[193] Grudgingly acknowledging that HEs were necessary "as long as medical officers do not know the language of the people with whom they work", Ryle admitted that HEs "familiar with the language and local customs can carry out useful enquiries", but, he insisted, "these need not be of an elaborate kind [emphasis original]". Instead, he suggested that HEs be trained "for a simpler, more objective and largely technical type of work...."Above all, Ryle maintained that HEs lacking the cardinal prerequisite—"a sound university training"—should not be entrusted with "humanistic work involving tact, skill and such high responsibility".[194] Ryle's views provided ready ammunition for ideological foes who were all too eager to put HEs in their place (Jeeves 2000).

4.5 A Brief History of Health Education

One might say that health education has existed as long as health care itself. Practitioners do not only treat bodies, but ideally address patients' minds as well,

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[192] ibid, p. 10.

[193] ibid. It is worth briefly noting here that Ryle was a fellow of the Eugenics Society in Britain (Porter 1992:150); the influence of eugenics on Ryle's thought in general and on his dismissive views of HEs, who were predominantly black, would be an interesting future line of inquiry.

[194] GES 2858 PN6/2, A Report on the Health Centres Service of the Union Department of Health, John A. Ryle, p. 13.

dispensing advice about health and disease along with treatment. From the Classical medicine of the Greeks and later Galen, which considered the balance of "natural" and "non-natural" elements (Risse, 1992), to the spiritual advice offered by traditional practitioners, models of health care incorporated received wisdom about salubrious actions and conditions. With rising literacy in eighteenth- and nineteenth-century Europe, attempts to inform people about their own health increased with the proliferation of published health-related directives in household manuals (Porter, 1997).

From the 1870 onwards sundry physicians, social workers, and charity organisations promoted an early form of health education, but as a distinct discipline, it emerged full-blown in Europe and North America in the twentieth century (roughly in the 1930s in conjunction with state efforts to grapple with the Great Depression). From the first World War until the early 1930s, the most visible practitioners of health education were "medical social workers" and "lady health visitors" in the U.S., Britain and France.[195] Lady health visitors descended on poor and working-class communities to teach principles of wholesome living but frequently blurred the didactic terms "healthy" and "moral". Many of these pioneers preached the new gospel of "mothercraft" which instructed women in hygiene and childcare.[196] Students in the 1920s and '30s were

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[195] In Europe and the U.S. "lady health visitors" were a prominent feature in the late 19th and early 20th century public health movement. Initially, they were volunteers, usually middle class women, who sought to ameliorate the "ignorance and superstition" that they believed tainted the mothering practices of working class women and contributed to high infant mortality rates (Davies, 1988). By the 1920s, working class women themselves were recruited for this unpaid labour (Ross, 1990). In the following decade the position gradually professionalised, with paid nurses undergoing post-graduate training in public health work (Klaus, 1990). Between 1934 and 1947, South Africa ran a (white) lady health visitor programme, mainly in the Johannesburg area. See TES 6814 Ref.F56/43/25 Department of Public Health staff. Lady Health Visitors. 1934-1947.

[196] The "mothercraft" discourse encompassed constructions of "good" womanhood and motherhood. Wendy Kaminer argued that mothercraft sought to imbue women with a sense of their moral responsibility to raise exemplary children and maintain a virtuous society (Kaminer 1984).

exposed to the "school health movement" programmes of "hygiene education", concentrating on topics covering personal and household cleanliness as well as exercise.[197] From the 1920s to the 1950s, this kind of "health propaganda", disseminated in pamphlets, press releases, and films to targeted audiences, increased dramatically.[198]

Not surprisingly, health educators found a welcome home in hospitals and public health departments, ensuring their status as technical agents in health care delivery and the prevailing biomedical model. Accordingly, health educators believed that they had a mandate to perform interventions that could correct an individual's physiological or social "maladaptation", though they seldom considered the underlying social and economic structure that contributed to illness (Brown and Margo, 1978:5). The biomedical model continued—and continues—to underlie health education approaches, with crucial contributions from the 1950s onwards made by researchers in psychology, sociology and, most importantly, social psychology.[199] The latter discipline especially shaped health education by introducing small-group dynamics and Lewin's field theory, which analysed the interaction of individuals in collective entities (Lewin, 1951). The practical application of these theories entailed using group processes to alter personal

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[197] A consumerist agenda underpinned many of the hygiene campaigns of the 1920s onwards. Some scholards have argued that the school health movement was the brainchild of soap companies, who managed to enlist school authorities in programmes designed to increase the sales potential of cleaning products (Vinikas, 1992). For an African example of the intersections between health education and commercial interests (i.e. soap), see Burke (1996).

[198] Examples of health propaganda for targeted audiences included anti-marijuana films for young people like the U.S. movie "Reefer Madness" and VD-awareness campaigns for Allied troops during World War II.

[199] Health educators drew from the discipline of psychology, for example "learning theory", which studied the formation and inculcation of knowledge, attitudes and behaviour. However, they also found that such methods were difficult to transfer from the laboratory to social situations, where people encountered conflicting "reinforcement patterns." The application of sociological concepts pertaining to community organisation were similarly problematic in real-life settings, where communities were often cleft by class and racial conflicts.

behaviour, with health educators "manipulating" collective dynamics to influence outcomes.[200] As the field of health education became entrenched by the 1960s and '70s, it continued to borrow explanatory frameworks from other disciplines.

The political climate of a country has a profound influence on the type of health education practised. For example, the formulation of Canadian health education in the 1970s was predicated on the state's responsibilities to citizens in a social welfare system (Epp, 1986). From the 1960s, many American health educators have focused on "consumers" and their "lifestyle choices". There, the overarching ethos of the market economy ensures that individualistic mores dominate and the professional position of health educators reflect the priorities of for-profit private hospitals and the insurance industry's investors (Minkler, 1989). Yet even in the United States there is sufficient commitment to a health promotion/disease prevention agenda to maintain a broad-based consortium such as the "Healthy People" campaign, first launched in 1979 by the Surgeon General and still growing.[201] In Europe, where in the 1980s the WHO initiated a sweeping campaign called "Healthy Cities", national governments generally determine the wider scope of health education, which complements greater access to free health services and tighter environmental controls (WHO, 1984). Finally, in developing countries, health education emerged in the 1960s as a feature of local programmes sponsored by churches, local councils and universities, often with funding from foreign agencies (Werner, 1981; Heggenhougen et al, 1987). In the 1970s governments with

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[200] The manipulation might involve identifying an "innovator" among an assembled group, soliciting the innovator's support for a particular behaviour change, and encouraging the innovator to win broader support from individuals within the group (Cartwright and Zander, 1968).

[201] See Healthy People 2010 website: Healthy People 2010 Home Page, Office of Disease Prevention and Health Promotion, U.S. Dept. of Health and Human Services, 23 June 2004 <http://www.healthypeople.gov/About/history.htm>

extremely limited resources sought to make modest allocations for primary health care; in this context, health education addressed immediate concerns such as the purification of drinking water and low-cost oral rehydration strategies.

When broad-based social movements sought to reform or challenge state control over medical care, particularly when public health needs were not being met during the Great Depression in Europe or the U.S. civil rights era, health educators tended to reflect the militant *zeitgeist* and adopted a rhetoric of transformation. Urgings for a more revolutionary mission for health education often came from academically-based health educators such as William Griffiths (1972). But such calls went largely unheeded as health educators became more firmly ensconced in their institutional roles. As a founder of the health education profession, Dorothy Nyswander, lamented at the end of her career,

> My efforts were expended in working on the symptoms of closed societies; the basic conditions giving rise to the symptom were untouched ....Have I not actually helped to maintain the status quo in these situations? Have I not taught people to accept those gifts approved by the establishment which would make life more bearable but which would not threaten the power of the establishment itself? (Nyswander, 1967:14).

CHAPTER FIVE: ELEMENTS OF THE IFCH APPROACH[202]

What is striking about the Karks' experiences in South Africa is how much they were molded by the conditions of the communities they served. This is most evident in the Karks' own accounts of their early work in Pholela.[203] Yet there was little ad hoc or provisional about their model, which applied the philosophy of social medicine to particular local circumstances. The IFCH approach knit together diverse strands: it merged social and medical science to gauge cultural and demographic factors contributing to health status; used locally-recruited educators to disseminate information and foster community development; and integrated preventive, promotive and curative medicine. Having broadly discussed dimensions of the IFCH model elsewhere, this chapter will focus more closely on two of its organizing principles: the marriage of anthropology and epidemiology; and the stimulation of community initiatives.

5.1 Merging Disciplines: Anthropology and Epidemiology

Scholars writing about the health centres in Pholela and Durban have consistently noted how innovative the Karks were in their understanding of how to incorporate epidemiology and anthropology into community health projects (Trostle, 1986; Marks, 1997; Tollman 2002; Susser, 1993; Jeeves, 2001*b*). Indeed, James Trostle was so impressed by their originality that he heralded Pholela and Durban as "the birthplace of

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[202] Throughout this thesis, the terms "IFCH model" or "IFCH approach" are used synonymously with "Karkian" or "COPC" model/approach. There was a direct continuum between the model applied by the Karks in Pholela and at the IFCH more generally, and what later became known as COPC. Arguably, semantic differences exist between the terms "model" and "approach", but these distinctions will not be explored here.

[203] See UKP H6/1/1 Interview with Professor S. Kark and Professor Gordon on Some Facts and Aspects of our Medical School which are not Recorded, by S. Cameron Dow, Dec. 1980, and Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992.

the most important collective research effort in social epidemiology to date" (Trostle, 1986:61). The Karks themselves were aware of the unprecedented nature of their work in Pholela, remarking that "this was the first step taken in South Africa to provide a comprehensive health service with basic demographic and epidemiologic foundations", yet they also acknowledged their intellectual and methodological forebears (Kark and Kark, 1999:40).[204] Sidney Kark elaborated on the antecedents of their research:

> It was not so much that [the Pholela health centre's epidemiological studies] had led to the discovery of the connection between social relationships and health. This was a well-established thesis...Nor was it that the centre had been able to establish such a correlation. Sociologists and epidemiologists have developed methods for such studies and many have been the reports during the past century indicating the importance of such correlations. The significant feature of [the Pholela health centre] was rather the fact that it had been possible to evolve a technique which included such concepts as an integral part of its daily practice. (Kark, 1951:677).

The standard medical education the Karks received at Wits failed to equip them for the brave new world of culturally-sensitive COPC that they eventually established—after several years of trial and error—in Pholela. Upon their arrival there in 1940, the Karks quickly realised that "the training we'd been given was quite unsuited to the needs of the people", they were at first uncertain of how to "...get the people to a position where they wanted to change towards a better state of health".[205] Thus they endeavored to "meet [residents] in various situations, not only in clinic, we had to visit homes, we had to meet them in the fields, we had to go to their school and we had to function with

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[204] The Karks' training in epidemiology began during their medical studies at Wits, where virologist James Gear (brother of Harry Gear) was their early mentor. They modelled their demographic methodology in Pholela on the work of the British epidemiologists Wade Hampton Frost and W.N. Pickles. They furthered their study of epidemiology in 1947 as Nuffield Fellows based at John Ryle's Institute of Social Medicine at Oxford University.

[205] UKP H6/1/1, Interview with Professor S. Kark and Professor Gordon on Some Facts and Aspects of our Medical School which are not Recorded, by S. Cameron Dow, Dec. 1980, p. 11.

them in a variety of ways so that at least we would become familiar, we had to go to their weddings, their funerals, their miseries, their happinesses".[206] So began the Karks' immersion in social anthropology, which they supplemented with formal training.[207]

The urgent need for an anthropological perspective became apparent to the Karks at a public meeting they called to introduce themselves to the Pholela community. The gathering coalesced at the local magistrate's office, where five local clans assembled to receive the young couple. Joseph Nzimande, an elder of the Enkumba Church and one of the most prominent members of a leading clan, had already preached against the Karks at church and now voiced his reason for distrusting the white newcomers. Recalled Sidney Kark, "the first question he [Joseph Nzimande] asked me was, 'Do you know anything about *ufufuyane?*'" [208] The doctor replied, 'No', which caused Nzimande to "raise his

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[206] ibid.

[207] The Karks' first exposure to anthropology occurred informally at Wits University, through Medical School Dean, Raymond Dart, described by Sidney Kark as "a world famous anthropologist...[who] encouraged both of us...an enormous amount" (ibid: 5). The Karks also had extensive contact with Wits anthropologist Winifred Hoernlé, who, they wrote, "guided [us] to an essentially sociological concept of anthropology" and had "a profound influence on our use of the method of participant observation" (Kark and Kark, 1999:7). During the Karks' sojourn in Pholela and later in Durban, they read the work of U.K.-based anthropologists such as E.E. Evans-Pritchard and Max Gluckman (then in Northern Rhodesia), and also sought advice from Durban-based anthropologists Eileen Jensen Krige and her husband J.D. Krige, Harriet Ngubane, and their sometime IFCH colleague, Hilda Kuper (ibid:65).

[208] Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992, p.6. *Ufufunyane* was defined by Zulu lexicographer B.W. Vilakazi as "Rapidly spreading disease which causes delirium and insanity; type of brain disease, mania, hysteria." (Vilakazi and Doke, cited Ngubane, 1977:144). Harriet Ngubane, a leading Zulu anthropologist, described it as a form of spirit possession, "due primarily to sorcery, though chance is not ruled out as a secondary cause. A sorcerer is said to add soil from graves and ants from the graveyard to his harmful concoction. In this way the spirits of the dead are said to be captured and controlled by sorcery. The harmful concoction may be placed on a path used by the victim, and through contact with it she becomes sick." (Ngubane, 1977:144). *Ufufunyane* almost exclusively affected women; its symptoms were mental derangement, uncontrollable weeping, tearing of clothes, aggressive violence, and suicidal tendencies. A woman with *ufufunyane* "[was] said to be possessed by a horde of spirits of different racial groups. Usually there may be thousands of Indians or Whites, some hundreds of Sotho or Zulu spirits." (ibid). Ngubane notes that the phenomenon of *ufufunyane* was relatively recent; it was usually associated with the 1920s and 1930s, and was said to have been introduced into South Africa by "people from the north". For more on *ufufunyane* and other forms of spirit possession such as *indiki*, see Parle, 2003. I thank Ben Carton for the Parle reference.

hands in horror –'So, the Government not only sends you here, a young doctor, but you know nothing about the main disease that's killing us...And you come here to learn from us instead of being able to treat it.'"[209]

Overcoming Pholela residents' suspicions required tact as well as knowledge of local beliefs. Here the Karks relied upon Edward Jali, their colleague, friend and mentor. Jali was the Chief Medical Aid of the Pholela health centre whose wife, Amelia Jali, was the centre's chief nurse.[210] Sidney Kark described Jali's role as their interlocutor: "[H]e became really, very knowledgeable in the local custom and beliefs about health and disease. And he specialised in this...he was really our traditional practice advisor/consultant..."[211] Jali's gifts as a teacher and translator enabled him to explain scientific principles about disease causation in terms that even the schoolchildren of Pholela understood. His illustrations of disease causality motivated a number of children

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[209] Ibid., p. 6. Joseph Nzimande's antagonism was eventually overcome, not by the Karks themselves but by their staunch supporter and friend, Margaret Nzimande, a relative of Joseph's and, as headmistress of the Enkumba School, a powerful person in her own right. "The arguments she had with Joseph were fantastic. I literally think that that young woman did more to change Joseph than anybody else. Because later on, a couple of years later, Joseph blessed us in his church." (ibid). Sidney Kark provided additional reasons for what he called "the terrible antagonism of the people to us at first": Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992. p. 6. Local chiefs, for example, were not consulted in the planning of the health centre and thus resented it as an "unwanted and unrequested institution in their midst", even going so far as asking the Native Commissioner to remove it (Kark and Kark, 1999:23). Finally, the survey questions that HEs asked residents regarding household income and numbers of cattle provoked people to suspect the Karks and HEs as "government spies": GES 2704, 2/62, Native Health and Medical Services Pholela Unit. General Matters, 1940-52. See also Kark's testimony to the NHSC in 1942: "At the beginning we were met with very solid antagonism...They did not understand these 'black spies' that the Government had sent out into their homes..." (NHSC 1944:8650 cited Butchart, 1998:141).

[210] Sidney Kark credited Amelia Jali as being "the manageress of the four of us really [the Karks and the Jalis.] She...we opened a clinic to start with, and she literally...organised it [and] us." Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992. p. 5. Amelia died in the late 1940s during childbirth.

[211] Interview of Emily and Sidney Kark by Professor C.C. Jinabhai and Dr. Nkosazana Zuma, Durban 1992. p. 5.

to persuade their parents to construct the pit latrines necessary to avoid fecally-transmitted illnesses like typhoid.

Jali's proven skills as a cultural mediator at Pholela drew upon his earlier experiences a few years earlier, when he worked as a Medical Aid at the Church of Scotland Tugela Ferry Hospital. There, deep in thorn country, he began using Zulu imagery and terminology to convey Western biomedical concepts to traditionalists. He detailed his methods in a 1937 letter to Dr. James McCord:

> Every day I visit the people in their kraals, I find out about their health. As a rule there is almost always someone sick in each kraal but still trying to work. Then my lessons commence. I may speak to a mother, or to a hutful of men and women gathered around a dying friend, or to people I catch drinking beer. I tell them about the spread of disease. My best example is how T.B. is spread.
>
> In explaining about this disease, I tell them there is no *Mtakati* [wizard; evil-doer]. In T.B. the *Mtakati* is the sputum. The *Zifenes* [baboons; witch's familiar] he employs are their hairy feet and in their stomachs. As they feed in other places, they brush off the bacilli from their feet in the same way as the *umtakati* is said to carry medicine under his long finger nail and drop it on the road or in beer unnoticed. The flies also regurgitate as they eat. In this way they deposit or spit out the bacilli as an *umtakati* is said to spit out the medicine concealed under its tongue.
>
> As I give such illustrations, my audience seems to believe. I tell them that a fly is the *umtakati*, not their neighbours. I give similar illustrations for almost all other diseases.[212]

The Karks' interest in traditional medicine prompted them to "befriend...the herbalists" (*izinyanga*) in Pholela. A "very astute" local chief urged them to take this innovation even further and appoint *izinyanga* as consultants because, he told the Karks, "'you are missing out so many diagnoses of importance unless you have these experts, who are our traditional practitioners who can help you work out what kinds of illnesses people have and separate out the Bantu disease from the so-called White man's

[212] Letter from Edward Jali to James McCord (McCord, 1951:277).

disease'".[213] Reluctantly, the Karks explained to him that "we were not allowed legally to function with them [*izinyanga*]...[for] we were having enough trouble surviving...and all we needed was an [nyanga] to be working with us to the powers that be to decide this was really mad...."[214]

Insights from psychological and sociological perspectives also seasoned the Karks' engagement with anthropology. Their interdisciplinary perspective is perhaps most evident in the Karks' view of male labour migrancy, a feature of industrialised South Africa since the 19th century. Of the multiple pathologies wrought by migrancy, Sidney Kark, in what became "a classic paper of social epidemiology", singled out its role in the spread of syphilis from urban to rural areas.[215] Yet the Karks were also keenly aware of the psychological toll of labour migrancy, as they witnessed "difficulties in the adjustment of husbands and wives to one another for the greatest part of their wedded lives" (Kark, 1951:669). Pholela women, lamented the Karks, suffered especially from "very low material and affectional social support, and low self esteem..."(Kark and Kark, 1999:62). With the lengthy absence of husbands and female-headed households

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[213] UKP H6/1/1. Interview with Professor S. Kark and Professor Gordon on Some Facts and Aspects of our Medical School which are not Recorded, by S. Cameron Dow, p. 13.

[214] ibid, p. 13.

[215] Re: "classic paper": Susser, 1993. Although Sidney Kark's 1949 article is novel in its overall approach, it also reflects contemporary white anxieties about the presumed social and moral breakdown among Africans as a result of labour migrancy. Kark focuses on structural factors in the social pathology of syphilis, but his analysis includes a moral dimension. Migrant labour and industrialisation, he explained, "led to the development of an urban life which has profoundly disturbed the family stability and sexual mores of several million African people...producing great changes in Bantu social customs, breaking down a system of rigid moral standards, destroying old concepts of right and wrong, cheapening relations between men and women and bringing with it syphilis" (Kark, 1949:83). Sidney Kark suggested ameliorating socio-economic conditions, writing that "successful therapy requires the establishment of African urban and rural communities based on a stable family life." He stopped short of advocating transformation in the structure of the political economy (i.e. in industrial capitalism), and sought instead an "ordered ubanization" of the African workforce (ibid).

becoming the norm, the fundamental paradigms of a highly patriarchal culture were subverted. While such a dramatic transformation arguably was liberating for some, it indubitably caused stress for others. Sidney Kark noted that "not only are women the main providers of food for their children, but

> because of the absence of so many men from their homes they have to make important decisions without the guidance or help of their menfolk...This responsibility of women is a new situation in tribal terms, and the difficulty is that they have not the social status which grants them a corresponding power and authority...Conflict and indecision are often the result, and the effect on their health is disastrous.(Kark, 1957:11-12).[216]

Emotional strain and economic distress exacerbated the difficulties women encountered in another traditional feminine sphere, domestic agriculture. Pholela's environmental deterioration was well advanced by the 1940s; soil erosion impinged on crop yields and created food shortages that resulted in "a great deal of ill-health among the women" (ibid.) In a comment that encapsulates the Karks' insistence on the symbiosis between mind and body, they found that "the prevalence of anxiety states and neurotic syndromes associated with poor nutrition and fatigue was striking"(ibid).

Despite the Karks' use of psychological concepts, their interpretations of women's "psychosocial disorders" veered away from colonial (and post-colonial) psychiatric explanations of African mental illness, for example the missionary and ethnographer A.T. Bryant's essentialist equation between African women and hysteria (cited Parle, 2003:126).[217] Although the Karks alluded to the "frustration in sex and love

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[216] In traditional Zulu culture, widows and senior married women with adult children had a respected status in the household and had significant decision-making capacity, but younger married women whose children were still minors were in a much more subordinate position (Carton, 2000).

[217] The association between women and hysteria is, of course, hardly limited to African women; it reflected deeply embedded assumptions about femininity in general that have been the subject of much feminist and revisionist scholarship (Porter, Gilman, Showalter et al., 1993). For an exploration of colonial psychiatry in

life" (Kark, 1957:12) that may have added to Pholela women's burdens, they believed a condition such as *ufufuyane* stemmed not from any "innate" African/female hysteria but from "social stress and the loss of social support" (Kark and Kark, 1999:62).

Certain conditions associated with spirit possession and bewitchment were less gender-specific than *ufufunyane* but were equally prone to manifest themselves in physical symptoms such as otitis media and lower abdominal pain. The Karks believed that these "witchcraft syndromes" masked emotional disturbances in people's social and emotional lives, particularly troubled personal relationships in the family and kinship groups that unleashed "feelings of jealousy, envy, anger or hostility" (Kark and Kark, 1999:61). In a 1951 description of "witchcraft syndromes" that bore traces of then-current psychological terminology, Sidney Kark referred to bewitchment as a "culture-determined...[and] overt expression of the neurotic personality" (Kark, 1951:670). Despite this clinical categorization, he and Emily Kark did not attempt to dismiss or diminish the "realness" of the mystical or supernatural explanations offered by their patients, who saw themselves as maligned by an ill-wisher or punished by their ancestors for some offence.[218] Using an anthropological lens, the Karks sought greater

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West Africa, specifically how African mental illness was coloured by racial power relations, see Sadowsky, 1999.

[218] For further examples of the Karks and their IFCH colleagues viewed "witchcraft syndromes", see Kark and Stueart (1962), including chapters by Chesler et al.; and Cassel. The chapter by Chesler is particularly illuminating as it presents a case conference in which three IFCH doctors discussed patients from different cultural groups (Zulu, Indian and white), reporting that during patient consultations they modified their terminology of cause and treatment to accord with their patients' health belief systems. The doctors agreed that "one of the therapeutic influences...[is] their understanding of the background of these cases" and pondered "whether we endorse or indicate our acceptance of those cultural beliefs which are different from our own". Specifically discussing Zulu beliefs in witchcraft and poisoning (*isidliso*), they concluded that while "we want to, or should, change those beliefs, we realize that they may represent methods of adjustment as adequate or even superior to those with which we propose to replace them." Ultimately, although "we do not necessarily accept his [the patient's] belief...we accept him as a believer." (Chesler, 1962:154).

"understanding of the witchcraft and the ancestor cult as vital forces in human relations" (Kark, 1951:670). On this journey into Zulu notions of etiology and a concomitant "widen[ing] of [their] diagnostic perceptions", Edward Jali remained the Karks' indispensable personal guide (Kark and Kark, 1999: 62). As well, the Karks continued to search out explanations from academic sources. They found the seminal work of E.E. Evans-Pritchard (1937) regarding witchcraft, particularly compelling, and adopted Evans-Pritchard's premise that a belief in witchcraft contained its own systematic logic about the social causality of misfortune (Kark and Kark, 1999:67).[219] Similarly, the Karks' emphasis on the role of social and cultural change as a defining feature of African life in the 20th century mirrored key tenets in anthropological theory during the late 1930s to the 1950s.[220] Like several of the influential anthropological figures of that era, the Karks eschewed an interpretation of "culture" that rested on the "timeless ethnographic present" of Africanists such as A.R. Radcliffe-Brown (Fabian, 1983).

Yet the Karks' anthropological interests did not crowd out more immediate concerns. In the clinic from 7 a.m. to nightfall, the Karks had unremitting exposure to the maladies afflicting Pholela. They devoted themselves to attending to people's ailments but soon came to realise that they wanted to go beyond the mere assuagement of illness,

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[219] Evans-Pritchard's fieldwork was among the Sudanese Azande tribe, but he generalised his hypothesis to apply to all indigenous groups whose religious systems incorporated witchcraft beliefs. Evans-Pritchard's contention that such notions formed a logical explanatory system within a specific cultural context refuted earlier ethnographic interpretations that witchcraft ideas were evidence of the "prelogical mentality" of "primitives", as opposed to the "logical mentality of moderns" (Moore, 1994 citing Lucien Lévy-Bruhl, 1910). The effect of Evans-Pritchard's theory, wrote one scholar, "on all subsequent discussions of witchcraft and religion in Africa was so great as to be incalculable" (Moore, 1994:31). The Evans-Pritchard imprint is very evident in the work of Hilda Kuper (1947), who presumably introduced the Karks to his work.

[220] The period of the 1930s to the 1950s produced an efflorescence in Africanism through the work of Radcliffe-Brown, Evans-Pritchard, Meyer Fortes, Isaac Schapera, Audrey Richards, Monica and Godfrey Wilson and Max Gluckman. All but the first two of these scholars had Southern Africa roots or connections (Moore, 1994; Hammond-Tooke 1997).

to get a clearer picture of its patterns and distribution. The dearth of statistics for Africans in the area—there was not even a registration system for births or deaths—meant the Karks had to compile their data largely from scratch.[221] In 1942 they initiated surveys in a defined area they called the "River Valley", to establish a health centre address system and conduct a detailed family health census. Health educators were the quiet heroes of this prodigious undertaking, as they walked or rode horses on Pholela's steep hills, bearing a compass and speedometre to gauge distances and plot homesteads on a map.[222] Wording their questions carefully, they collected information that would help create a finely-nuanced portrait of health in a rural African community. Sidney Kark outlined the multilayered procedure:

1. Census of the home: name age, sex, religion, occupation and family relationship of each individual
2. Educational survey (adults and children): standard of school attained, name of institution
3. Food production: quantitative assessment of the main foods produced and qualitative periodic surveys of vegetable gardens. Measurements of crop yields, as well as milk yield during various seasons.
4. Livestock census
5. Surveys of housing, sanitation and water supplies for each home
6. Personal data: registration of births, deaths, marriages, sickness and pregnancies. Movements of the population including migratory labourers' time of departure and return. Important events and ceremonies were described and a weekly record kept of the main activities – occupational and ceremonial—of the community. A family file was introduced and within it were kept various confidential reports regarding intra-familial

[221] Prior to their arrival in Pholela in 1940, the Karks had sought out health-related information for the district in magisterial and government office records, which reported on local epidemics and notifiable diseases like leprosy, syphilis and TB. They also consulted with various officials and individuals in the area, but their investigations merely confirmed that data was sparse and often unreliable (Kark, 1981:197) For example, a government census of Pholela had been done not long before, but its figures underestimated the local population by 30%, as the health centre's own census showed. Similarly, the notification system for leprosy, syphilis and TB was so rarely adhered to that its data was largely inaccurate.

[222] The "River Valley" referred to the mountainous slopes overlooking the Umkomaas River. The initial defined area comprised 139 families (900 people). By 1951, the health centre's services extended to 8500 people (1000 homes) within a 12-mile radius, and by 1957 the defined area serviced 10 500 people (1300 homes).

> personal relations and various problems of individuals within those families (Kark 1952:671).

Survey or "denominator data" was then collated with "numerator data", i.e. clinical findings of periodic health examination (PHEs) and of treatments for specific illnesses. The Karks later commented that "[we] were amazed how introducing an address and home census defined the people as individuals and not merely as patients attending the clinic"(Kark and Kark, 1999:40). The material gathered by HEs allowed the Karks to integrate several dimensions—among them economic production, culture and environment—into a multilevel analysis of the health-illness dynamic. its

Such an ambitious epidemiological project did not spring forth instantly, and as the methodology evolved, parties at both ends of the survey engaged in the learning process: "Not only did the staff have much to learn regarding methods of carrying out such comprehensive examinations and integrating the various findings into an inclusive diagnosis, but the families required most careful and tactful education regarding the aims and the possible benefits to be derived from such a service" (Kark, 1951:672). Yet people soon appreciated the advantages of belonging to the "defined area" as they experienced overall improvements in their health.[223] As a testimony to the COPC achievement, with each passing year the health centre extended its orbit, often at the request of neighbouring communities. By 1957, the defined area's population was 10 500 (1300 homes). This incremental expansion permitted comparative measurements between the newly

[223] For example, the general death rate for Pholela (per 1000 population) halved from 28/1000 in 1945 to 13/1000 in 1959, and the infant mortality rate fell by more than two-thirds. Rates of kwashiorkor in children 0 to 2 years declined from 15/1000 in 1948 to 3.3 per 1000 in 1953, with a similar 60% decline in children 3-5 years. Other diseases of malnutrition such as scabies and pellagra showed equally dramatic improvements in the 1940-1959 timeframe, after which the health centre (devolved to an understaffed outpatient clinic) no longer gathered statistics.

incorporated areas and the older defined area, for example revealing a dramatic decrease in the infant mortality rate (IMR).[224] Armed with accurate data, the health centre was able to define appropriate interventions, or "action programmes" in COPC terminology, which could be evaluated over the long term.

The epidemiological profile of Pholela revealed three main categories of illness: malnutrition, pyschosocial disorders and communicable diseases. The latter included infectious diseases such as pneumonia and acute gastro-enteritis; endemic ailments such as tuberculosis, syphilis, tapeworm, and leprosy; as well as epidemics of smallpox, enteric fevers (typhoid), typhus, whooping cough, measles, dysentery and conjunctivitis. The signs of widespread malnutrition included conditions such as pellagra in children and adults, kwashiorkor in younger children, stunted stature, and strikingly low weight gains of women during pregnancy—less than 10 lbs.[225] Some of this data was gathered in maternal and child health sessions that were a prominent feature of the clinic's services. Another source of evidence for the Karks' study of diet in Pholela came from the periodic

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[224] Change in Infant Mortality Rate (IMR) for Pholela 1945-1956 (Kark and Kark, 1999: 140)

1942	280/1000 live births or 28%
1945-1946 (larger area)	202/1000
1950-1951	106/1000
1955-1956	86/1000

For comparative purposes, below are IMRs for the different racial groups in the same time period (Cluver, 1951). The figures for Africans apply to Bloemfontein only, as that was the only area where statistics about African health status were gathered.

1942	Whites	48/1000	1948	Whites	38/1000
1942	Indians	90/1000	1948	Indians	83/1000
1942	Coloured	178/1000	1948	Coloured	132/1000
1942	African	210/1000	1948	African	210/1000

[225] The poor nutritional status of Pholela inhabitants was evident in the low average weights for men and women, measured by the health centre. Average height for men: 5'5, average weight: 132 lbs. (60.5 kg) dipping to 125 lbs. (57 kg) for men 70 and over. For women in Pholela, the average height was 5'1, average weight 120 lbs. (55 kg), dipping to 112 lbs. (52 kg) for women over 70 (Kark, S. "The Height and Weight of Men and Women in Relation to Age.", in Kark and Steuart 1962: 189, 191).

health examinations of schoolchildren which measured their height, weight, and general physical state. These observations gave clinic staff an opportunity to study growth trends and seasonal incidence of infections and nutritional deficiencies, and was joined with data collected during home visits about prevailing conditions in the families of the children. Throughout this initiative, Sidney Kark emphasised that the PHE of schoolchildren was voluntary and was not carried out unless the parents' consent was given—an adherence to medical ethics that was rare at the time (Kark, 1944:42).[226]

After the Karks moved to Durban in 1945, they transferred their expertise in epidemographic method to the IFCH's urban communities. With growing numbers of health educators to gather data and on-site advice from anthropologists such as Hilda Kuper, the IFCH's amalgam of epidemiology and anthropology flourished, exemplified by the CSIR unit. The aim of the CSIR's unit's research was to link physiological measurements of a study group (e.g. babies) taken by medical staff to contextual socio-economic and cultural information collected by HEs in Merebank, Clairwood, and Lamontville.[227] The anthropological influence on the researchers' epidemiological method may be seen in the cultural sensitivity of the data-gathering, with the use of linguistically-appropriate terms and concepts in interview questions. In addition, input

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[226] Kark's insistence on voluntary and parental consent for medical examinations presaged the first formal ratification of medical ethics, the Nuremburg Code (1948), and was well ahead of its time in terms of standard practice. There is little historical scholarship about informed consent in the South African context, particularly for minors, although Packard portrayed a complete lack of consent for medical examinations of mineworkers (Packard 1989). Perhaps further research will reveal that South Africa had its own versions of the infamous Tuskegee Study of Syphilis (1932-72). For an overview of medical ethics in South Africa during apartheid, specifically the medical establishment's collusion with the apartheid state, see de Gruchy, Baldwin-Ragaven, and London (eds) 1999.

[227] CSIR studies compared ethnic differences in birth weights, growth and rearing of babies, ante- and postnatal maternal care, the correlation between nutrition and maturation, and etiological concepts. For more on the CSIR unit, see Chapter Four; and Chapter Seven, Section 3.1 for HEs' descriptions. See also Salber, 1962:155-59; Salber, 1989; Kark, 1962:135-42 and Kuper, 1962:93-113).

from HEs working in their "own" ethnic and racial groups helped to inform the design of CSIR studies, infusing them with "insider perspectives" on the effects of variables such as social networks, class and health-related beliefs.

5.2 Community Participation

Consistent with social medicine's aim of inducing collective empowerment, the IFCH sought to create a pathway for group mobilisation, illustrating Rudolf Virchow's suggestion that medicine is politics by other means. The IFCH health education programme epitomised an "ecological intervention approach" which seeks change at multiple levels within the social system, not simply at the individual level (Schultz et al. 1997).

Looking back on their experiences in South Africa, the Karks believed that one of the most important outcomes of the IFCH's presence in Lamontville was the formation of a Joint Planning Council, consisting of key members of the Lamontville community and health centre staff. The council provided feedback on various aspects of the health centre's services and made suggestions for improving programmes. By directly involving Lamontville residents in their own health care, the IFCH gave them a sense of agency and ownership, which in the Karks' view "may well have been the most significant contribution to the community's health" (Kark and Kark, 1999:160).

The IFCH's strategy of creating partnerships with communities was not limited to Lamontville. In every IFCH locality, health centre staff strove to enlist what Sidney Kark hailed as the "active co-operation" of participants in the health education programme, by "carefully explaining the object of each procedure, be it a discussion group on the rearing

of children or a planned survey directed towards elucidating a specific health problem..." (Kark, 1951:694). A related goal was to ascertain "those aspects about which the people can do much themselves", according to George Gale, who advised, "it is little use aiming to get the people to do things which are beyond their capacity, but if their interests and motivation are taken into account much can be achieved".[228] Sidney Kark shared Gale's outlook, and envisaged health educators' mission as "motivating the people to action in their own interest...

> By assisting them [community members] to meet their own felt needs in the first instance and gradually making them aware of the hitherto unfelt needs in respect of their health, the health centre becomes an intrinsic part of their neighbourhood. An authoritarian approach associated with dogmatic assertions as to *the* right way of life has little place in such a programme. Advice and guidance there must be, but these are usually more acceptable when sought for and it is to this end that situations like the informal interview and the discussion group are directed. They create the necessary situation for the development of self-help towards better health (Kark, 1951:694).

In order to conscientise communities and encourage them to act on their own behalf, HEs' first step was to create a space—group discussions, home visits, and surveys—in which people could articulate their problems ("felt needs") and identify possible solutions. George Gale gave an illustration of how this worked:

> A staff health assistant had organised a health education discussion in which a small group of women participated regularly. Gradually this particular group came to discuss the diet of their families, the rising cost of various foods and how they could improve their position. Two main resolutions were adopted by the group. The first was that they would improve their small home gardens by buying sufficient manure to mix with their household refuse in the making of compost. The second was to form a co-operative vegetable buying group. The leader of the discussions (Health Assistant) suggested ways and means of achieving this and referred to other workers who might know more of the 'how'....[Subsequently] the group decided to buy the manure as a joint venture, sharing the cost of transport, and to form their co-operative buying group. Of interest is the fact that

[228] NGR 4, 269/9/72, George Gale, The Training of Health Assistants as Health Educators, 1952, p. 2.

> others wished to join the group after they had seen what could be achieved, but the group decided that they could only come in if they joined in the group's discussions – as they felt that it was these discussions that were the basis of successful action.[229]

Galvanising self-help projects had long been a feature of the Kark's model, from their earliest days at Pholela, where Margaret Shembe (Nzimande), the first Pholela health educator, nudged the Karks to "move towards community participation in a very big way" when she instigated a nursery school for local children. Sidney Kark recounted how "voluntary women had to be recruited for this and encouraged to take a part in it, so they had to learn about nutrition of children, the requirements of the health of these children..." As the nursery school blossomed, so too did a sense of shared investment and interdependence: "They had to learn to trust one another because no one mother could do this full-time, it had to be a number of mothers...who would agree to rotate and supervise the children and their activities...." The nursery school had a ripple effect: "older women became interested as the young women became active", burgeoning into new forms of female solidarity and empowerment, culminating in the "chief of that area at a fifteenth year celebration" of the health centre in Pholela standing up and declaring: "'I think you should appoint a women's committee to advise this health centre and I will use that same women's committee to advise me and my tribal council.'" Sidney Kark pointed to the profound political and cultural implications of this inclusion of women as decision-makers in a highly patriarchal arena: "Now, anybody who knows that particular tribe and that particular culture will know what a radical transformation that was to have

[229] NGR 4, 269/9/72, George Gale, The Training of Health Assistants as Health Educators, 1952, p. 7.

a women's advisory committee to a tribal council and to a health centre."[230] In the context of rural communities in KwaZulu-Natal, such a move would be considered, even today, remarkably progressive.

It was also at Pholela that another aspect of the Karks' emphasis on community participation originated, namely, liaisons with the widest possible array of groups in the district, from the above-mentioned tribal council and women's association to missionaries, school teachers and parents of schoolchildren.[231] These networks garnered support for the clinic's programmes and activities. The health centre also drew local people in by organising events such as gardening contests featuring new types of vegetables that HEs introduced as a means of diversifying agricultural and nutritional habits, as well as a seed co-operative and a weekly market at which produce and crafts were sold.[232] Such events were enthusiastically attended and generated much-needed income for Pholela residents (Cassel, 1955).

Nurturing ties with community groups presented a greater challenge in the rapidly-growing city of Durban, where Sidney Kark discovered that "the absence of a neighbourhood sense of community has been a striking feature in several of the areas where [IFCH] centres were established" (Kark, 1951:694).[233] The Karks' belief that "the

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[230] UKP H6/1/1, Interview with Prof. Kark by Prof. Gordon, p. 12, 13.

[231] The Karks hastened to introduce themselves to these and other assemblies as soon as they arrived in Pholela in 1940, and thereafter HEs regularly met with such groups to conduct discussions on health topics and get feedback about programmes.

[232] Another group forum that the Karks instigated at Pholela was a club "which has catered for several of the varied interests of the community...It has organised concerts, tribal dancing, debating and literary societies, sporting activities, a women's society and a bursary fund for school children with money raised in the community itself" (Kark, 1951:696).

[233] There was considerable variation in the pre-existing degree of community organisation in IFCH areas. For example, the Indian community of Merebank, where cohesive families had settled for three generations, "boasted about forty local clubs and other organisations of a voluntary nature. It seemed that

development of a feeling of community interest is an essential pre-requisite to the growth of a neighbourhood self-help project for better health" led them to set up community centres in these areas, which Sidney Kark in 1951 lauded as "one of the outstanding developments in the short history of the Institute's health centre service" (ibid:695). One such establishment, the David Landau Community Centre in Springfield, has been particularly successful since its inception in 1948 until the present day.[234] The community centres were, like the IFCH itself, under the aegis of the Union Department of Health and as such did not have "executive authority to carry out a programme of social services which fall within the scope of other state departments or voluntary agencies" (Kark, 1951:695). However, community centres coordinated with the IFCH to act as a bridge between people who needed welfare services—the elderly, the disabled, and children—and the official "non-white" welfare agencies of Durban, limited though these were.

Other "extracurricular" activities helped to connect widely disparate communities. Eva Salber, co-director of the health centre in Lamontville with her husband Harry Phillips, recalled that "The Institute acted as a magnet, attracting compassionate

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no sooner was a need felt than a small voluntary agency would spring up and have an ample supply of experienced people to draw on. There was an almost obtrusive feeling of community responsibility." (Steuart, 1962:79). In contrast, the African community of Lamontville had a more fluctuating population, with many families newly-arrived from rural areas. Consequently, there was less integration and cohesion, and few community groups prior to the health centre's arrival. A part of Lamontville dated back to the 1930s, when it had been engineered by municipal authorities as a "model Native village" for teachers, clerks and labourers (IFCH statistics showed that income and educational levels were "above-average"), but the area directly served by the health centre was still under construction in the 1940s and '50s (Gampel, 1962:167). The inchoate aspect of the community was demonstrated in the initially tepid reception of the Lamontville Community Centre, donated by the National War Memorial Health Foundation: "Only considerable effort of the part of the Institute's community health workers [HEs] over a long period of time brought this community centre to some form of life" (Kark and Kark, 1999:124).

[234] The David Landau Community Centre continues to attract large numbers of participants in its programmes as well as a host of volunteers, including former IFCH HE Dr. Pramda Ramasar, who celebrates more than fifty years of involvement with the centre.

Durbanites—mostly women—who volunteered their services" (Salber, 1989:98). The Union of Jewish Women of Durban gave the health centre a food donation for malnourished babies, which Union members distributed in person to the babies' mothers at weekly sessions in the Lamontville centre. A Durban Women's College Guide ran a preschool for one hundred Lamontville children, and at the Lamontville Community Centre, volunteers provided adult literacy classes, a library, a debating society, physical training and sporting facilities for Lamontville youth.

The Karks' rationale for stimulating these community projects was couched in the language of "self-help" and individual/collective responsibility. Current terminology might frame the developmental benefit of this endeavour as an increase in "social capital".[235] Through community-directed initiatives like tribal dancing, sports, food co-operatives, planning councils and debating societies, residents created forums for physical, intellectual, cultural and civic expression. According to the holistic philosophy of the IFCH, these ventures represented "an important contribution to the health of the community" because they helped participants realise "their own potentiality for a happier and more wholesome way of life" (Kark 1951:697). Recent literature suggests that participation in shared activities can strengthen communal bonds and deepen individuals' sense of belonging to a particular neighbourhood, which could have health-promotive effects (Geiger, 1969, 1984; Israel et al. 1994; Glanz et al. 2002). However, a critical reading of "community organisation" would suggest that communities are often split by class, racial, and economic differences; community centres and clubs could merely consolidate rather than heal such divisions (Cox, 1974). While grassroots action is a

[235] See for example, the work of Robert Putnam, a social capitol theorist who empirically studies the benefits of civil society through civic participation, the strength of social bonds, and trust (Putnam 2000).

prerequisite for broad social change, it does not guarantee such change, and may even delay it by acting as a diversionary tactic, allowing the state to abrogate its responsibility to meet citizens' basic needs. Conservative concerns of political co-optation and social regulation characterised the historical model of community organisation in nineteenth-century Europe and the U.S., where it was implemented by charity organisations, settlement houses, urban leagues and local councils (Galper 1975). Any analysis of the IFCH must balance these contrasting interpretations.

CHAPTER SIX: RESULTS

This chapter presents data from interviews with HEs to convey a sense of their training and working conditions; the race, gender, and cultural contexts in which they operated; and how they describe the broader goals that animated their work. The material has been organised into ten thematic sections, divided into sub-sections.

The selection of material seeks to encompass both the range and the particularities of HEs' experiences, from their introduction to trench farming and composting under the charismatic sway of Robert Mazibuko, to their realisation of the sensitivity required to ensure a co-operative reception during home visits, to their opinions on the broader "political" nature of the IFCH's interventions. This chapter explores how the multi-racial character of the IFCH influenced day-to-day operations, and how HEs from different cultural backgrounds translated the anthropological interests of the IFCH into practice. This chapter is divided as follows:

Section One: Training

1.1 Structure of training department

Between 1946 and 1952, the IFCH trained 300 health educators; 30 were employed at the various IFCH health centres (excluding Pholela), while the remainder were assigned to health centres across South Africa. The early groups of HEs trained for

six months to one year, but by 1949 the course expanded to three years. Although Dr. Guy Steuart coordinated the health education programme, Dr. Sidney Kark oversaw the training course, with Nancy Ward (neé Cauverel) as the primary hands-on trainer, assisted by medical aides and later, health educators functioning as tutors.[236] It is indicative of the Karks' non-hierarchical inclusiveness that they later referred to Nancy Ward and her colleague J. Moshal, as "the first community health workers…joined by a number of black, Indian, coloured and white community health workers"(Kark and Kark, 1999:92), despite Ward's and Moshal's position as HE (CHW) trainers.[237] The white HEs, all of whom were social work or psychology graduates, aided in the instruction of African, Indian and Coloured HEs.

Neela Govender, a member of the first group of HEs who trained for three years recounted: "You know how many we had? The whole lecture room was as big as—it's a big hall—it was filled with people from Cape Town, Pretoria, packed to capacity".[238] Not all trainees made it through the course. Violet Padayachi Cherry described the attrition rate, "We started out with 350 people…There would be exams, and if you didn't do well, you would be let go, which happened. Each time after exams, people dropped".[239]

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[236] See Chapter Two re: medical aids

[237] Similarly, the Karks referred to Guy Steuart as a "health educator" despite his position as head of the Health Education programme (Kark and Kark, 1999:92).

[238] Interview with Neela Govender, 18 Mar 2003

[239] Interview with Violet Padayachi Cherry, 14 June 2002

1.2 Curriculum

Bala Govender, a member of the original 1946 group of 6-month trainees, listed the subjects he studied: "environmental hygiene, personal hygiene, nutrition, child care".[240] Neela Govender's three-year curriculum encompassed "Social Health, including Pyschology and Physiology – Dr. Bruckhardt was our instructor – Community Health, including nutrition, environmental health, communicable disease and gardening".[241] Throughout their training, HEs did laboratory and field work in conjunction with all subjects. As Daya Pillay stated, "After the theory part of the training, everything we did was practical – gardening, composting, housing".[242] A critical aspect of instruction dealt with "training the health educators to know what the signs of malnutrition were".[243] In their home visits to families, they would identify these signs and refer families to the clinic.

The HEs' descriptions of the training course adhere closely to the curriculum records in the archives.[244] However, both the interview subjects and the historical documents portray a training programme that was more ad hoc than fixed. In a

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[240] Interview with Bala Govender, 19 May 2000.

[241] Interview with Neela Govender, 23 May 2000. Her colleague Sally Chetty mentioned "Hygiene, childcare, housing, survey methods, biology, psychology, zoology." Interview with Sally Chetty, 21 July 2000.

[242] Interview with Daya Pillay, 4 July 2000.

[243] Interview with Maureen Michau, 14 Mar 2003.

[244] Syllabus for Health Assistants (from GES 2727 1/70 Health Centre News Letter No. 1, Oct. 1947).
First Year: Elementary science (Physics, chemistry, and Psycho-biology, Social Health 1, Statistics 1
Second Year: Physiology, Psychology, Social Health 2, Bacteriology, Parasitology, Entomology, First Aid
Third Year: Social Health 3, Nutrition and Food Hygiene, Environmental Hygiene, Diseases (Communicable and General).
Topics not specifically listed by the HEs as part of their training, but implied in their later descriptions of their work include occupational health, mental disorders, reproduction, mapping of homes, schools and water supplies and methods of community organisation and participation (Kark and Kark 1999:126).

confidential 1954 memo to the Durban Medical School, George Gale defended the IFCH's training format: "It [the training] is not static, but dynamic, in the sense that techniques both of Health Centre practice and of training of Health Centre personnel are constantly under review and, whenever it is considered necessary, are modified in the light of experience".[245]

1.3 HEs' assessments of training

Maureen Michau, who trained African HEs at Lamontville, recalled: "Trainers were told what areas to cover, but we were given complete and utter freedom to convey what we thought was necessary".[246] While emphasising the benefits of this flexibility, she noted a drawback where the "training was broad....[and] without much depth".[247] Violet Padayachi Cherry presented a different view. She called the courses "comprehensive and demanding", adding that "We had to do a lot of reading and preparing, and in the afternoons did practical work: environmental health, housing, sanitation, anything about latrines, water, you name it". She believed the training had "quite a lot of depth":

> For example, the gardening course was intensive. You didn't only learn about the four food groups, you learned how to get your own garden going and produce them, and how to teach it to people, to improve their skills...Also the communicable disease piece [and] environmental health piece, garbage and sewage.[248]

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[245] UKP H6/2/3, Memo by George Gale, 15 Jan 1954, p.2, 3.

[246] Interview with Maureen Michau, 18 July 2000.

[247] ibid.

[248] Interview with Violet Padayachi Cherry, 23 May 2001.

1.4 Memorable Subjects

For Violet Padayachi Cherry, as for other HEs from urban backgrounds, the practical instruction in methods of gardening literally broke new ground: "All I knew of gardening was [growing] shallots on a windowsill in an apartment in Durban". She continued,

> Each one of us was given a plot of garden: the grass was higher than us! And I remember looking at it and saying, 'Oh, who's going to cut the grass?' And they said, "You!" I said, "I'd never cut grass in my life, I can't do that", and they said, 'Oh yes you can.' And I had to go cut the grass. I mean I was so horrified!

The HEs' immersion in gardening techniques reflected the IFCH's aim to "get people to understand that they can be part of creating their own food supply".[249] A subsidiary goal emphasized that "health workers [should] go talk to people about stuff that they [have] experienced...when you had to go cut the grass and make the compost and do contour furrowing and crop rotation, it suddenly became a real thing and you were proud of your efforts".[250]

The agricultural lectures and demonstrations were given by Mr. Frank Bayer, head of the IFCH's Environmental Health and Communicable Diseases programme, and Robert Mazibuko, a renowned pioneer of trench farming later associated with the Valley Trust at Botha's Hill.[251] This duo seem to have made a lasting impression on the HEs; almost all vividly recalled gardening classes. Pat McLeod said that Frank Bayer's "passion was compost. He'd give such intense lectures on compost. There turned out to

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[249] Interview with Violet Padayachi Cherry, 23 May 2000.

[250] ibid

[251] Maureen Michau stated that Dr. Halley Stott of the Valley Trust was a frequent visitor to the IFCH: "He spend nearly a year at Clairwood, observing." Interview with Maureen Michau, 14 Mar 2003.

be a problem: the first-year students started stealing the jars of urine [the medical urine sample] from the toilets, to use in composting. They had to put up a sign: 'Please do not steal the urine samples'".[252] Violet Padayachi Cherry recounted more direct methods of adding nitrogen to the compost: "We had to go ask the guys to pee in the compost pile, which had everybody in hysterics".[253] Other testimony revealed that initially reluctant HEs were won over by the charisma of the famous trench farmer: "They were not very happy about [this work]: they saw it as slightly infra dig [beneath their dignity], but Mr. Mazibuko was an absolutely wonderful man who convinced everybody. He enthused them, it was very interesting to see".[254]

Another unfamiliar subject for the urban recruits was "sanitation, that was totally new... You lived in the city where you had a flush system".[255] In fact, while Durban proper and a few outlying areas such as Lamontville had a flush system, most "black" neighbourhoods had either no services or rudimentary sanitation—"the bucket system. It was picked up three or four times a week...[whereas] the centre of Durban had sewage"[256]. HEs were acutely aware of the effects of municipal neglect: "a lot of people who just used the yard. That's where they went. When you walked through areas that were not developed, you had to watch where you were walking."[257] While the bucket system was an improvement over no sanitary provisions at all, the infrequency with

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[252] Interview with Pat PcLeod, 5 July 2000.

[253] Interview with Violet Padayachi Cherry, 23 May 2003.

[254] Interview with Maureen Michau, 18 July 2000.

[255] Interview with Violet Padayachi Cherry, 14 June 2002.

[256] Interview with Violet Padayachi Cherry, 14 June 2002.

[257] Interview with Violet Padayachi Cherry, 14 June 2002.

which buckets were picked up created conditions for disease.[258] One HE spoke of the IFCH's attempt to overcome the lack of services: "The health educators would promote the use of pit latrines".[259] The sanitation section of their training focused on environmental hygiene as a means of preventing illness. Maureen Michau elaborated: "They did have a course in sanitation and water cleanliness and so on. And in fact a lot of what they did then was what we do now, when we have a cholera epidemic or something...there's all sorts of education about how to purify the water and things like that. How to build latrines...that was part of it".[260]

Sanitation and gardening were not the only topics challenging the HEs. Violet Padayachi Cherry recalls her (and her fellow Indian female HEs') shocked reaction to lectures in phsyiology and reproduction:

> We [her fellow Indian HEs] knew so little. And what we knew about sexuality we learnt in this course. I remember we were so horrified when they were discussing anatomy and physiology and sending around pictures of penises...we were hiding under our desks! The men were making such fools of us...were just so mortified that they would publicly talk about all this. ...there was a course about embryology and they would talk about what went into the fetus...we studied it, and we answered questions about it, but we weren't comfortable with it.[261]

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[258] Despite municipal authorities' obsession with the disease threat purportedly posed by African, Indian, and Coloured populations and the consignment of these populations to outlying areas, there was little provision of public health measures such as water or sanitary services. For one example, see the 1951 Local Health Commission documentation of Pietermaritzburg Muncipality's refusal to supply water to Edendale: NAD 3/PMB 4/4/2/209. In the absence of government-supplied refuse and sewage disposal, municipal bodies such as the Durban City Corporation tried to force landlords (often Indian) in slum areas such as Cato Mano to supply such services to their African tenants, to no avail (Scott 1994: 112). Where the "bucket system" was used as the sole means of sewage disposal, the potential for disease was still high. As Sidney Kark and Julia Chesler noted in their chapter in Kark and Stueart, eds. (1962) pp. 114-134, "pail latrines depend for their cleanliness on the replacement and removal service. A careful study carried out by a health inspector in the Indian slum are [Merebank] indicated inadequate replacement services and an overuse of the latrines by the population. The result is a pollution of the lavatory and its immediate environs as well as a not uncommon practice of indiscriminate defaecation" (p. 119).

[259] Interview with Sally Chetty, 21 July 2000

[260] Interview with Maureen Michau, 14 Mar 2003.

[261] Interview with Violet Padayachi Cherry, 23 May 2001.

For this "unexposed young student" facing such "completely new things", successfully completing the training course conferred a great sense of accomplishment: "...the fact that I persevered through the three years, and graduated with this diploma at the end, to me was an achievement, like you can do it".[262]

Section Two: Aims and Methodology

2.1 Flexibility

Just as the training programme was "constantly under review and...modified in the light of experience", as George Gale put it, the HEs' methodology adapted to situational demands and goals. As Violet Padayachi Cherry stated, "They [the Karks and other IFCH administrators] were constantly looking for new things, and different strategies and different options. You know, the way they looked at research too. It was research for a purpose, to see programmes and services emerge".[263]

2.2 "Preventive, Promotive, Curative"

Despite its policy of experimenting with "different strategies and options", HEs had a strong sense of the IFCH's core principles and practices, reflected in the relative uniformity of their descriptions of their aims and methodology, with virtually all evoking the mantra: "preventive, promotive, curative". Underlying this uniformity was the HEs'

[262] Interview with Violet Padayachi Cherry, 14 Jun 2002.

[263] ibid.

awareness that their approach was distinct from the standard health-care paradigm, with its focus on individual curative care. As Gertrude Sibisi noted: "In clinics, they used to just treat patients and let them go. But Dr. Kark wanted to prevent disease."[264] Violet Padayachi Cherry agreed:

> To me, the words Institute of Family and Community Health resonated because my sense of it was it was not your picture of going to the doctor for a health problem, where you went when you were sick, and you got shots and medicine and you name it. This was another concept, this is what appealed to me. I did think that part of what we would be doing would be a kind of social work thing.[265]

The links between the triad of "preventive, promotive, curative" are presented below in the HEs' narratives. Yet the key to these links lay in an even more complex array of factors influencing health and disease. Sidney Kark, in a 1951 chapter about the Pholela health centre, elaborated on these concentric rings of influence:

> The whole process of the health centre's development was one which reflected an increasing understanding of the individual in terms of his family situation, of the family in its life situation within the local community and finally the way of life of the community itself in relation to the social structure of South Africa. By this detailed study the centre had moved from the plane of vague generalization about the importance of various social forces to an increasing understanding of those forces in relation to health and disease as manifested in individuals. (Kark, 1951:677)

An illustration of how well this message was relayed to the HEs is contained in Violet Padaychee Cherry's analysis of the IFCH's approach, which, more than 50 years after Kark's description, eerily echoes it:

> ...the focus was on looking at the individual within the framework of family and community, that was the concept of the IFCH. You no longer are looking at ten children with diarrhea, or *x* number of people with tuberculosis or typhoid or

[264] Interview with Gertrude Sibisi, 22 July 2000

[265] Interview with Violet Padayachi Cherry, 23 May 2001.

> whatever, you are looking at that problem in the framework of the social and other kinds of background of the individuals and you were factoring in all these different things that went into giving them the problem.[266]

The IFCH's "holistic" (a term favoured by several of the HEs) approach entailed moderate rather than radical interventions. Better health could be attained "through nutrition, relating to agriculture, and through immunization, household hygiene. The nutrition programme stressed that healthy foods and cooking habits were within reach: "what was good and possible."[267] For example, in Lamontville, HEs "emphasised the need to go back to traditional dishes: green foods, wild herbs. They were still used at that time. We suggested using ground mealie meal instead of white mealie meal."[268] HEs also suggested slight modifications of cooking methods: "You must not overcook vegetables; cook only for 5-10 minutes"[269] and consumption of "the simple foods that are available...not expensive foods. You don't have to have money to have a balanced [meal]..."[270]

While the HEs saw the preventive and promotive aspects of their work as critical, they also believed that referring individuals and families to the clinic was an intrinsic part of their duties, with the clinical functions complementing the health education and vice versa. Gertrude Sibisi gave examples of all three aspects of the IFCH services:

> Promotive: the importance of good food...Preventive: [clinic staff] would immunize for whooping cough, diptheria, chicken pox. Curative: [clinic staff]

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[266] Interview with Violet Padayachi Cherry, 23 May 2001.

[267] ibid.

[268] Interview with Maureen Michau, 18 July 2000.

[269] Interview with Gertrude Sibisi, 22 July 2000

[270] Interview with Neela Govender, 21 June 2000.

> would do a blood test. If someone had a venereal disease, they must get their husband to come in for treatment...TB was very common. We tried to get them to come to the clinic for treatment.[271]

2.3 Community Participation

Neela Govender believed the preventive and promotive elements of health education offered something to the community that the clinical services could not necessarily provide: a sense of self-efficacy:

> Because I'm trying to prevent. I'm educating people and bringing knowledge to the people, not just giving medical care. I'm here to help people think differently, to take charge of their health themselves, and to use what is available rather than say, they can't afford to be healthy. I thought that was more satisfying. Primary health care.[272]

Violet Padayachi Cherry also stressed the participatory nature of the IFCH's approach, as exemplified by the issue of immunization:

> You raise their [parents'] awareness, and make them become partners with you, and say, "Now, you need to understand why your child needs to get this [immunization]...You [parents] could do something about it. Parents could be active participants in keeping their children healthy.[273]

In all of the forums in which the HEs worked—homes, schools, and community centres—they engaged not so much in didactic instruction as in *eduction* (from "educe", to bring out from latent or potential existence) health-promotive attitudes and practices. To accomplish this, HEs and medical staff required not just awareness of local beliefs

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[271] Interview with Gertrude Sibisi, 22 July 2000.

[272] Interview with Neela Govender, 18 Mar 2003.

[273] Interview with Violet Padayachi Cherry, 14 June 2002.

and behavior, but an empathic ability to understand the intricate ways that these were embedded in cultural and individual patterns. Violet Padayachi Cherry observed:

> Nothing is just thrown at people. You discreetly talk to people and engage and involve them, and get their opinions and cultural belief systems. You don't go charging in where angels fear to tread. You also respect even if you don't buy what they believe in. You've got to work your message around their beliefs, finding ways to modify behavior and you let them buy into something, let them think that it belongs to them, it came from them.[274]

All of the HEs interviewed emphasised that the IFCH approach entailed dealing with families sensitively, fostering maximum participation. HEs went in not as experts with information to authoritatively impart but rather as patient listeners who would draw families into discussions during home visits. As Bala Govender explained: "The strategy was to spend quite a bit of time with the family, learning about them, and trying to get them to think about how to solve their own problems". He stressed that if health educator "went in like an official, without tact or friendliness, that approach was not effective".[275]

HEs would modify the pace and topics of health education sessions according to the audience's perception of their most pressing needs:

> If I learned anything, it was that you don't go there with your own agenda and say, today we're going to talk about smallpox. It just doesn't work that way. Sometimes you start where they're after. I remember Kark saying to us once, when we said, 'how much time do we have to do this?' and he said, 'Well, sometimes you have to go with a pace that the community gives you. They may not be ready for this. You may go in wanting to talk about gardening, and they want to talk about increased rates and taxes...or they may be worried about the kids getting into school, and there aren't enough schools, so you will let them talk and tell you about it, even if there's nothing you can do to help them. And who knows, maybe you'll have an idea or two'.[276]

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[274] Interview with Violet Padayachi Cherry, 14 June 2002.

[275] Interview with Bala Govender, 19 May 2000.

[276] Interview with Violet Padayachi Cherry, 14 June 2002.

2.4 Caseload

HEs' mandate to "develop a close connection to the family"[277] meant adjusting the duration and frequency of family visits as needed. "The purpose of the visit was to talk to families, to find out what their problems were. We might visit a particular family 3 or 4 times if the family needed a lot of help. We would sometimes stay all day if needed....but usually each visit was about 3 hours".[278] Generally families would be visited "at least once or twice a month. Each field worker had about 25 families in his/her case load".[279] According to the HEs, the number of families visited in a day varied from 3-6 homes/day, or more if area was conducive in terms of geographic proximity of houses.[280] In densely-packed areas, a rough sampling method was sometimes used: "We would go to every 5th house".[281] The HEs tended to work singly or in same-gender pairs and were usually on foot, though occasionally for surveys used a driver. During the home visits, the HEs would also collect socio-economic data such as the number of family members in the home, the standard of education, "the family's budget—how many people in the household were working, what food they were buying"[282] and

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[277] Interview with Charmaine Philcock, 14 June 2000.

[278] Interview with Daya Pillay, 9 June 2000.

[279] Interview with Sally Chetty, 21 July 2000.

[280] (See Section Six, Working Conditions, for more information on the geographical aspect of the IFCH areas).

[281] Interview with Sally Chetty, 21 July 2000

[282] Interview with Gertrude Sibisi, 22 July 2000

environmental conditions, i.e. waste disposal method, safety of food and water supplies. This data was later correlated by the statistics department with clinical and survey data.[283]

2.5 Felt and Unfelt Needs

Dr. Guy Stueart, whose vision of health education permeated the IFCH HE programme, formulated a distinction between "felt" and "unfelt" needs. In general, "felt" health needs were those expressed by the people themselves in the course of group discussions. For example, people might lament how many young children died in their community, or how their still-living children were often ill; they would voice a desire for healthy children. "Unfelt" needs included the root causes of such ill-health such as inadequate diet, the poor state of environmental hygience, the lack of immunization, and the desirability of changing certain child-rearing or –feeding practices (Stueart, 1962:65; also Cassel, 1955). A successful HE programme must transform "unfelt" needs into "felt", and then inspire community members to act to meet those needs.

2.6 Periodic Health Exams

A key component of the IFCH's methodology was the periodic health exam (PHE). The PHEs were conducted by medical personnel in the IFCH clinics. Several of the HEs mentioned their importance, not simply as a means of filling in the biophysical

[283] See Appendix 4 for a sample "checklist" used by the HEs in home visits

details in the portrait of a family's health status, but also because the PHEs linked the promotive work of the HEs with the curative/preventive work of the clinic.[284] In their home visits, HEs would encourage people to attend the clinic for a PHE and stress that the clinic's services should be used not just reactively, in the case of a health crisis (though the health centre did provide outpatient care), but preventively. According to Violet Padayachi Cherry: "you conveyed the concept that you didn't wait until you were sick, you did things on a regular basis".[285] For example, in the case of tuberculosis, which was "always a big problem...in those days...you taught them about the importance of x-rays".[286]

2.7 Health Teams

The IFCH's integration of promotive, preventive, and curative care was accomplished through the mechanism of the health team, i.e. HEs conferring with doctors, nurses, demographers in regular meetings. Gertrude Sibisi described the structure of health team meetings:

> We used to come and give our report. We had our families...the [nursing] sisters had their [patients], mothers and children, especially pregnant women...we would discuss a family, what kinds of health problems they had. We all contributed, then the doctor would conclude. We worked together as a family—doctors, nurses, health educators.[287]

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[284] Interviews with Pat McLeod, 5 July 2000; Sally Chetty, 21 July 2000; Gertrude Sibisi, 22 July 2000; Violet Padaychee Cherry, 14 June 2002.

[285] Interview with Violet Padayachi Cherry, 23 May 2001.

[286] ibid.

[287] Interview with Gertrude Sibisi, 22 July 2000

One HE, who later trained in psychiatry, equated the health team meetings with "treatment and diagnostic meetings where everyone contributed their bit. I think the IFCH health team meetings did that: sharing impressions, suggesting changes. It was also very important in the racial and cultural sense".[288] Pat MacLeod corroborated this function of the health teams: "Everyone enjoyed sharing cultural experiences".[289] She emphasized, "The wonderful thing about this Institute was that you worked as a team. Dr. Lapping [the doctor in charge of the health centre at Mobeni] would discover medical problems, and would pass this information onto the health assistants, who would try to change habits relating to the medical problem".[290] Several of the HEs pointed to the health teams as central to what they lauded as the "multidisciplinary" nature of the IFCH.[291] Sylvia Shearer stressed the congenial atmosphere that prevailed: "You felt a freedom, in being able to express your opinion, ask questions".[292] Pat McLeod agreed: "It [the health team] was easy, outgoing, democratic I suppose".[293]

However, freedom and democracy had limits, as Maureen Michau expressed: "[HEs] were quite comfortable providing input, but we were a bit reticent about contradicting a particular approach....we felt we couldn't question the doctors' research aims or methods...."[294] Violet Padayachi Cherry also felt that HEs' feedback was

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[288] Interview with Violet Padayachi Cherry, 23 May 2001.

[289] Interview with Pat McLeod, 15 June 2000.

[290] ibid.

[291] Interviews with Sylvia Shearer, 23 July 2000; Pat McLeod, 15 June 2000; Maureen Michau, 18 June 2000; Violet Padayachi Cherry, 23 May 2001.

[292] Interview with Sylvia Shearer, 23 July 2000.

[293] Interview with Pat McLeod, 23 May 2003.

[294] Interview with Maureen Michau, 18 July 2000.

confined to certain parametres: "if you were talking about things that you knew about, your own cultural group, I don't know that you would have felt uncomfortable about speaking out".[295]

2.8 Primary Groups

One of the most significant elements of the HEs' approach was "primary group" theory.[296] This theory was based on the belief, according to Guy Steuart, that "the health of a community is not dependent only on the quality and extent of the technically expert services or disease preventive facilities that are provided; but that it depends also on the extent to which the community's everyday life, its knowledge, feelings and behavior, is itself promotive of health"(Stueart 1959:7). The best way to access these facets of the community's everyday life was through "the more informal social groups and situations of daily living that...play such a vital role in making us who we are...." (Stueart 1959:10). Such groups may include family or kinship groups, but also consisted of private friends and neighbours with whom one shared a degree of intimacy and influence.[297]

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[295] Interview with Violet Padayachi Cherry, 23 May 2001.

[296] Dr. Guy Steuart, the head of the Health Education programme, was a pioneer in primary group theory, and titled his 1959 Ph.D. thesis (UNP) *The Importance of Primary Groups to Health Education.*

[297] The IFCH used a card index system to keep track of the primary groups in various areas. The IFCH estimated that about 60% of the people living in these areas were included in this community group index. When conducting a particular intervention, such as the infant feeding survey in Lamontville and Merebank (see below), these primary group index cards were consulted to help HEs target particular groups of mothers for the study (Kark and Kark, 1999; 156).

A feature of primary group theory was identification of an "opinion leader" whom the HE would ask to convene a group meeting, where the HE would act as a facilitator, guiding the discussion on health-related issues such as nutrition. Neela Govender explained:

> We would find a key person, like the dominant mother in a group of mothers, and ask them to call a meeting, so that we could have a group discussion about some aspect of health...Ask her, would you mind getting your friends together, 2 or 3 or 4, it doesn't matter, it's your pick. Because they get on with each other, naturally...there's so much interaction, exchange of ideas, so we want to use that channel...transmission of knowledge is far greater with that kind of group...Interchange of ideas to bring about behavioural change is easier with these informal primary groups.[298]

Related to primary group theory was another methodological concept, described by Violet Padayachi Cherry: "Kark had this thing he developed about intensive families and non-intensive, meaning those who had more leadership influence with others, and where he'd concentrate a certain amount of education and hope that it would soak through".[299]

2.9 Maternal and Child Health

Using primary groups as the medium, HEs often addressed topics such as "immunizations, children's immunizations. Also, working on the importance of mothers

[298] Interview with Neela Govender, 18 Mar 2003.

[299] Interview with Violet Padayachi Cherry, 23 May 2001.

getting prenatal care, letting them know that it wasn't enough to have the prenatal care, that mothers had to have postpartum care".[300]

The importance of maternal and child health to the IFCH programme was articulated by several of the HEs: "We did a lot...about antenatal care, not waiting until the bitter end, especially the things she [the mother] needed to keep the fetus healthy".[301] Violet Padayachi Cherry referred to the HEs' aim of "letting people know what was available for their use...at no cost to themselves, and that it would be beneficial to their children...Making a thing about early childhood services, and making them feel that this was a building block for the future".[302]

The maternal and child health programme also served as a vehicle for community organisation through initiatives such as milk clubs and preschools as well as food- and seed-buying co-operatives. Preschools provided advice to parents about child-rearing practices while "developing social interaction as a whole, the result being greatly increased opportunities for self-expression, discussion of problems and experience in social relationships as well as organized group action"(Ward 1962:334). Preschools also functioned as a means of addressing nutritional deficiencies in resource-poor communities. Daya Pillay described setting up what she called "the first preschool in that area [Newlands]. No one told me to. I just did it. I also organised a milk club for the pre-school. I arranged for a free donation of milk to be delivered every day. It was the most

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[300] ibid.

[301] Interview with Violet Padayachi Cherry, 23 May 2001. See also interviews with Maureen Michau, 18 July 2000; Sally Chetty, 21 July 2000; and Neela Govender, 18 Mar 2003.

[302] Interview with Violet Padayachi Cherry, 14 June 2002.

practical thing I ever did".[303] Although the IFCH was instrumental in the initial stages of the milk clubs and preschools, it encouraged communities to "take over the reins", resulting in milk clubs being held in people's homes rather than at the health centre (Abramson 1962:349). Neela Govender alluded to the response: "People were thrilled because we had milk-clubs for the little children, who were benefiting".[304] Even in the white community of Woodlands, where nutritional needs were not as dire and milk clubs were unnecessary, preschools fulfilled a dual purpose of creating a sense of community and providing a forum for health education (Ward, 1962: 334). Sylvia Shearer, a psychology graduate who worked at the Woodlands preschool, noted, "The lower socio-economic group that we serviced needed nutritional advice...we also encouraged breast-feeding."[305] Maureen Michau recalled, "the nursing sisters were very good at instructing mothers how to do it [breastfeed] and maintain it".[306]

In areas like Lamontville, where many mothers worked, Gertrude Sibisi described how the IFCH adapted its messages: "Mothers who were working would breast-feed in the morning but give a bottle of [milk made from] dried skim milk powder during the day. We said to use boiled bottles".[307] If mothers were unable or chose not to breastfeed, the health education focus shifted to improving hygenic standards in food and water storage, and in food preparation and feeding. Maureen Michau noted that, particularly in

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[303] Interview with Daya Pillay, 9 June 2000.

[304] Interview with Neela Govender, 18 Mar 2003.

[305] Interview with Sylvia Shearer, 23 July 2000.

[306] Interview with Maureen Michau, 18 July 2000.

[307] Interview with Gertrude Sibisi, 22 July 2000. According to IFCH research, the comparative rates for non-exclusive breasfeeding were: Pholela, 96%; Lamontville, 72%; Merebank, 83% (Kark and Kark, 1999:154; Abramson 1962:351).

Lamontville, "[Working] women were going off breastfeeding, but they didn't have the hygenic facilities to do formula feeding".[308] She later elaborated: "...[T]there was a lot of GI infection and that. It was one of the major causes of death among children. One of the things [we] did was tell mothers about hygiene, about how to boil the water first of all, to clean the bottles".[309] When the breastfeeding mother was clearly malnourished, as were many women in Merebank, for example, the IFCH provided milk powder and in some areas, vegetables from model gardens, and urged earlier and more varied infant feeding. The programme also tried to discourage the use of reed enemas as a "traditional" treatment for infant diarrhoea and a major contributing factor to high IMRs in Pholela and Lamontville, but found that the practice was "not easily forsaken" (Kark and Kark, 1999:152. See also Stueart 1962:69, 86).[310]

Section Three: Research

3.1 CSIR Unit

Several of the HEs interviewed had worked with the CSIR unit, conducting door-to-door surveys on selected topics. Such "survey visits" typically lasted 60- 90 minutes,

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[308] Interview with Maureen Michau, 18 July 2000.

[309] Interview with Maureen Michau, 14 Mar 2003.

[310] Another goal of the infant feeding programme was to persuade mothers to initiate breastfeeding immediately, contradicting Zulu and Indian beliefs about the "harmfulness" of colostrum and the desirability of waiting a few days until the "real milk" came in. In Zulu practice, neonatal infants were fed *incumbe* (watered down maize or sorghum meal); in Indian tradition, newborns were given honey. The programme further aimed to introduce a greater variety of weaning and early-feeding foods, such as fruit juice, banana, potato, egg, and a variety of cereals as opposed to just maize (Kark and Kark, 1999:158).

though in the case of a maternal nutrition survey, involved an intensive, day-long observation and quantitative analysis of maternal food consumption: "We had to sit there the whole day, weighing everything the pregnant woman ate, analyzing for caloric content, observing preparation methods".[311]

The Indian HEs collected survey data in Indian areas (Merebank, Springfield, Clairwood and Newlands) while African HEs worked in Lamontville and Pholela, although HEs had frequent meetings with their counterparts working in other areas to discuss their respective projects. Neela Govender, who worked for the research unit in Merebank and Clairwood, recalled: "We worked together, we had meetings every morning, where we came to present what we came across in our interview contact with the family. Every morning. We used to have [Mrs.] Nala, and myself, and Professor Kark, and Sister Mobane. And so we related very well".[312]

3.2 Menarche Survey – Objectives and Outcomes

The menarche survey was a longitudinal study designed for the research unit by Emily Kark to measure the growth and maturation status of African and Indian girls, with particular reference to their maturation through their pre-puberty, puberty and adolescent stages. This data was compared with socio-economic status to determine whether there was any correlation.[313] However, the survey gathered not just physiological and socio-

[311] Interview with Neela Govender, 22 July 2000.

[312] Interview with Neela Govender, 18 Mar 2003.

[313] The girls' levels of physical maturation were correlated to their socio-economic status (measured through their father's occupational group, i.e. professional, white-collar, self-employed, and manual labour, further sub-divided by education and income level) to determine whether there was any significant relationship between social class and onset of sexual maturation; the study's findings confirmed a positive correlation, particularly among the Indian girls (Kark, E. 1962; also Kark and Kark , 1999).

economic data, but also anthropological data about cultural attitudes towards sexual maturation. Pramda Ramasar, a social work graduate who collected data for the menarche survey, saw the survey's purpose as "getting to know more about the beliefs, customs, practices of the community, to form a profile".[314] Neela Govender characterized the research objectives as, "how does environment and way of affect one, why are Indian girls slow in their physical development, reaching puberty, menarche age. Was it cultural?"[315]

Female HEs canvassed homes, ascertaining if the household included girls at puberty level. If it did, they explained that "the centre was trying to get a picture of the whole community", including information about maturation rates. This delicate topic had to be broached carefully:

> At first, the mothers were suspicious, and the girls shy. Our initial way of breaking the ice was to educate them about the IFCH, what its goals were. At the time, there was a lot of TB in the area; we drew their attention to the fact that this was the kind of place they could go to...We gave them examples [of how the centre functioned] to make them feel more secure, such as the school health programs.[316]

Not only the girls and their mothers were a bit taken back by the survey's topic, but so were the female HEs themselves: "Initially, we were a bit shocked...it was not easy at first".[317] Pramda Ramasar used a powerful rationale for girls and their mothers to participate in the survey: "We emphasized the need for sex education, of how to prevent

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[314] Interview with Pramda Ramasar, 23 May 2000.

[315] Interview with Neela Govender, 18 Mar 2003.

[316] Interview with Pramda Ramasar, 23 May 2000.

[317] Interview with Pramda Ramasar, 30 June 2000.

pregnancy. There was such a stigma of unmarried pregnancy".[318] For her, the most important outcome of this survey was that "we may have opened the door for mothers to talk more to their daughters about sexuality and their bodies".[319] Some of the female HEs went further, by organizing meetings in which young girls could discuss body issues and other topics: "We actually set up a group for young girls, to talk about things, about their lives and interests, maybe about sexuality."[320]

Related to the Menarche Survey was another survey geared to married Indian women, which aimed to provide data about culturally-influenced sexual attitudes: "finding out what did married women think of sex, for example we would ask them to describe their honeymoon night of an arranged marriage".[321] (For reception of this survey, see section 3 below). Such topics could be used as a means of introducing related issues such as spacing births and contraception, which were "taught at the IFCH, quite actively...It was very hard for unmarried girls to teach that, because it meant that you knew about it, and you perhaps...so you had to be very careful about how you handled that...With older women, you didn't just launch into talking about their sex lives and whether they were using [contraception]. You had to really observe those parametres".[322]

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[318] Interview with Pramda Ramasar, 30 June 2000

[319] ibid.

[320] Interview with Violet Padayachi Cherry,

[321] Interview with Neela Govender, 22 July 2000.

[322] Interview with Violet Padayachi Cherry, 14 June 2002. According to Ms. Cherry, the main contraceptive method promoted at the IFCH was IUDs. In contrast to VP Cherry's statement about contraception being promoted "actively" at the IFCH, the Karks in 1999 wrote, "We realised early on that family spacing advice would be quite inappropriate in these communities [Lamontville and Merebank] as it might be construed as a demand of the white government." (Kark and Kark, 1999:131).

3.3 Infant Nutrition Survey

The CSIR unit conducted an infant nutrition and growth study in Pholela, Lamontville and Merebank, comparing how ethnic differences in infant feeding patterns, postpartum care of mothers and babies, and concepts of the causes of disease in infants, impacted on maternal and child health, particularly on the infant mortality rate (IMR).

Maureen Michau, who worked with African HEs carrying out the survey in Lamontville, portrayed the disease conditions that the research aimed to mitigate:

> [The survey] included all babies born in Lamontville in 1949. The babies were examined monthly. We recorded all information about their health status...There was a great drive for a reduction in the infant mortality rate, which at that time was something like 50%. If babies couldn't be brought to the clinic we went out to them.[323]

(In fact, the IMR in Lamontville for the period 1948-51 was 75/1000 live births, or 7.5%. See Chapter Seven for a discussion of the disparity between the perceived and actual IMR.) Maureen alluded to the "practice of giving enemas to the children...their rectums would be excoriated, they would be open to infections. It was a very, very serious problem". Paraphrasing African nurses who instructed HEs to address the issue cautiously, Maureen reported: "You must never say to them [mothers] directly, 'Did you give this child an enema?' You must say [Maureen's voice softened], 'And tell me the symptoms, and I suppose that you did try the enema?' and they would say, yes, yes, yes...But one of the techniques was never to confront them."[324]

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[323] Interview with Maureen Michau, 18 July 2000.

[324] Interview with Maureen Michau, 14 Mar 2003.

Section Four: Reception by Community

4.1 Pholela and Lamontville Experiences: Written Sources

This section summarizes how health centre directors such as Sidney Kark, John Cassel and Eva Salber wrote about reception of IFCH interventions and following sub-sections present the HE's observations of community reactions.[325]

In various publications and interviews about the Pholela health centre, Sidney Kark and John Cassel discuss local residents' initial opposition to the health centre's attempted interventions. Resistance occurred on many fronts. Staff struggled to enhance consumption of eggs and dairy products; improve environmental sanitation through pit latrines and food/water protection; treat migrancy-related conditions such as tuberculosis and syphilis, and implement new agricultural techniques to combat soil erosion (Kark, 1944:41; Cassel, 1955:35). The Karks and their Pholela colleagues addressed these forms of resistance through a multifaceted effort that included identifying potential "change-agents" in the community and enlisting their support; exploring cultural patterns and beliefs affecting health, and determining which of these would be easiest to modify.

Kark and Cassel point to discernible changes that the health centre was able to effect, particularly improved diets through vegetable gardens and consumption of milk powder[326] and greater willingness to seek treatment for tuberculosis.[327] However,

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[325] Dr. John Cassel was director of the Pholela health centre from 1948 to1953 when he emigration to the U.S. (University of North Carolina, Chapel Hill). Dr. Eva Salber and her husband, Dr. Harry Philips, had joined the IFCH in 1946. Following their training at Springfield and a year at the "coloured health centre" in Clairwood-Jacobs, they directed the Lamontville IFCH from its inception in 1948 to 1954, when they left for Cape Town and subsequently emigrated to the U.S. See Salber 1989: 82-106.

[326] Milk, as a cattle product and thus a culturally central feature of Zulu identity, is surrounded by powerful prescriptive and proscriptive connotations. For example, women, especially wives, were believed to have a "polluting" influence on cattle and cattle products, and thus could seldom consume milk. The health centre managed to sidestep this taboo by introducing milk powder, which was not considered real milk (Cassel 1952:29)

intractable features such as labor migrancy and its continuous reintroduction of diseases such as syphilis and tuberculosis, were part of broader structural systems that the health centre could not address (Kark, 1952). Kark and Cassel also believed that the health centre had limited success in its efforts to combat soil erosion through the introduction of new agricultural techniques, given customary land use patterns and the lack of sustained multisectoral co-operation (Kark and Cassel, 1952:136; Kark, 1944:41).

Eva Salber delineates similarly halting progress for the IFCH clinic in Lamontville, and deftly captures some of the reasons for residents' initial distrust. As government employees, IFCH staff were seen to have dubious motives, particularly when HEs asked probing questions about household composition and income in their census surveys. For the many township dwellers who earned extra money by the sale of illegally brewed beer, such questions were bound to be unwelcome. Even the medical personnel's diagnostic method involved asking "too many" questions, in contrast to traditional practitioners like *izangoma* (diviners), whose skill lay in knowing without asking. An additional obstacle for the Lamontville clinic occurred just before it opened in 1948, when a mobile TB-testing van had screened the local populace; those with x-rays

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[327] Resistance to tuberculosis treatment stemmed from a number of factors: 1) local people believed that tuberculosis had "always existed" in their community. Therefore, Pholela residents maintained, traditional practitioners had more reliable experience treating it than white doctors ever could; 2) local concepts of disease viewed tuberculosis as spread by an ill-wisher who put *idliso* (poison) in one's food. The poison eventually caused the sufferer to vomit blood and lose weight and could only be "purged" through an emetic given by an *nyanga* (herbalist); 3) since people were rarely diagnosed or treated i.e. hospitalised for tuberculosis until virtually moribund, diagnosis and treatment were viewed as tantamount to a death sentence, with the added indignity that death would occur alone in a hospital, far from the succour of one's family and ancestors. The main factor in overcoming resistance to tuberculosis treatment was medical: by the late 1940s more effective antibiotics were available, whose demonstrable efficacy gave people more confidence in the ability of the health centre staff. By the early 1950s, demand for x-ray services exceeded the clinic's ability to provide them, and tubercular patients were more willing to undergo treatment at the centre (Cassel, 1955:35).

showing TB were shipped off to dreaded TB hospitals. IFCH staff were therefore assumed to be TB officers-in-disguise, whose duplicity was "confirmed" by their eye-testing chart, in which the second line read "T B". The health centre was eventually able to overcome many of these misgivings, aided by the fact that most of the IFCH staff (aside from doctors) were Africans, and that even the non-Zulu speaking doctors such as Salber and Phillips took the trouble to learn Zulu terminology for the various ailments they treated. Like Cassel, Salber credits the efficacy of post-war antibiotics for helping to win people's confidence (Salber, 1989:88, 89).

4.2 Positive and Negative Responses

Like the written sources, HEs narratives of community reception show that responses spanned a continuum from indifference and skepticism to enthusiasm, gratitude and cooperation.

The gathering of data about family income in areas of high unemployment and informal economic activity, an intervention that might be expected to provoke hostility or deception, apparently created little consternation. Neela Govender observed,

> When they knew that we were from the health centre, and this is what the health centre stands for, I don't think anybody had any problems. I didn't have. When you say, no we want to know, because we want to render certain services to the people, so we want to know how many people are working or unemployed, how many children there are, whether there is enough facilities, I don't think they minded.[328]

[328] Interview with Neela Govender, 18 Mar 2003.

Gertrude Sibisi also perceived "the families [as] very cooperative...they would tell us their problems".[329] Charmaine Philcock echoed these sentiments. She visited white and Coloured families and was "always well-received; we never encountered hostility. Families were glad to have someone come to visit".[330] Pat McLeod, who accompanied African HEs in Lamontville and Pholela, felt a sense of welcome, "even in Pholela. But on the other hand, one doesn't know how much ground work is done before you get there".[331] Pat felt that the positive reception resulted from the community's high regard for the Pholela clinic, well established by the time she visited in the early 1950s.

In addition to sensitive financial issues, HEs broached even more potentially sensitive areas such as venereal disease. Sometimes persistence was necessary: "If husbands didn't want to come in for treatment, the male health educators would go to visit them several times", Gertrude Sibisi noted. She recalled instances where she herself was openly thanked for her perseverance: "One family that I was dealing with, every child miscarried. The man came in for treatment [for syphilis], the wife came. They had six babies after that. They were very grateful. Even today, if they meet me they are happy".[332]

But such intimate topics were not always well-received. Sally Chetty and Pramda Ramasar, who both worked on the menarche survey in Merebank, found that "at first, people were suspicious".[333] Aware of this potential reaction, Neela Govender recalled her

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[329] Interview with Gertrude Sibisi, 22 July 2000

[330] Interview with Charmaine Philcock, 14 June 2000

[331] Interview with Pat McLeod, 23 May 2003.

[332] Interview with Gertrude Sibisi, 22 July 2000

[333] Interviews with Sally Chetty, 21 July 2000; Pramda Ramasar, 23 May 2000.

anxiety when collecting data about "what did married [Indian] women think of sex. For example, we would ask them to describe the honeymoon night of an arranged marriage...At first I was worried about what the reception would be".[334] Her fears were unrealised: "even though I was an unmarried woman, the married women took me seriously". She found that "people were very open. They treated [the subject] with humour".[335] As she questioned them about their "knowledge of the physiology of pregnancy", she revealed, "I was surprised at how they opened up to me, because I was not married. I only knew about pregnancy because of training at school and at the health centre. And when I asked them about pregnancy, I was surprised about how little they knew".[336]

HEs were aware that communities could react with suspicion to certain unfamiliar measures, for example children's immunization, particularly since it was being dispensed by the apartheid state. Violet Padaychi Cherry said, "They didn't know, I mean here were people coming and offering all this. And let's face it, there was no cost to it, and sometimes people are suspicious of anything you get for nothing....And also, it was government related". However, such reluctance soon abated: "People were so eager to get help for their children and families that it wasn't an overly resistant community...Even in the African community, they were not going to say, 'No, this comes from the government and I'm not going to take it.' They needed it".[337]

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[334] Interview with Neela Govender, 22 July 2000.

[335] ibid.

[336] Interview with Neela Govender, 18 Mar 2003.

[337] Interview with Violet Padayachi Cherry, 14 June 2002

Positive reception mitigated certain features of HEs' work, such as physical discomfort that they endured as they walked long distances in the Durban sun. Violet Padayachi Cherry waxed nostalgic:

> People were very hospitable. Someone was always calling you to come and have a cup of tea, come and get some water. People were very poor, they couldn't afford to give you anything. [Yet] they always offered you lunch if you were there. They'd come and put whatever they had on the table, which was remarkable.[338]

However, this depiction of "typical" hospitality should not necessarily be taken at face value (see Chapter Seven for further discussion). At times, hostility awaited visiting IFCH staff. Violet Padayachi Cherry described her sense of peril when working "near Merebank,

> towards an area they called Happy Valley...squatters lived there. African squatters, and they brewed beer, and you didn't know when you were going to fall into one of these brewing areas. That happened all the time too. It was very, very scary. Very, very scary. Because people were hostile; they didn't want you poking in there.[339]

White HEs who trained African HEs in Lamontville maintained that IFCH efforts were sometimes rebuffed. Pat McLeod explained how her African colleagues "were up against a lot of cultural negatives, against growing vegetables, or composting. They were aware of their limited success...They would express their frustration".[340] Pat also believed that the health centre in Pholela, which she visited in the late 1940s, was ineffectual in changing agricultural patterns like "cultivation of crops, prevention of soil

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[338] Interview with Violet Padayachi Cherry, 14 June 2002

[339] ibid.

[340] Interview with Pat McLeod, 5 July 2000.

erosion, general use of the land". She attributed this lack of success to "very culturally entrenched bad habits. Okay, they go one about under the apartheid regime they [Africans] were given the worst land and they were all confined to an area, and it didn't go along with their cultural nomadism, but at the same time, they resisted, and they're still resisting".[341]

Maureen Michau described rejection of some of the IFCH's nutritional measures in Lamontville:

> They [the IFCH staff] were trying to introduce dried skim milk to the people as a supplement. Not only skim milk but also dried milk for the babies. People would come to the clinic, they would be given this, they would be told by the nursing sister how to mix it and so on, told what hygiene was, but many of them were reluctant to use it. Some would give it to animals, some would just throw it down the hillside. Often the sisters would come back and say, 'Oh, we found a big heap of milk powder lying on the hillside, people had just thrown it away.' The next thing was, they did not have the facilities to use it in a hygienic fashion. And they didn't see how significant it was to have to boil the water first of all, to clean the bottles and things like that. Bottle feeding was hazardous. And then of course there was always the competition from the wonderful adverts for infant formula, which in many cases had too much sugar and were not as good as this ordinary milk, which they were getting for nothing. And yet they paid the excessive amounts for this formula rather than getting this ordinary milk, because that was something to which they were used....[342]

Local scepticism also extended to the IFCH's attempt to introduce soya beans. In part, taste preferences doomed this effort—"the taste is so different" [343] —as well as their novelty: "[they] were not a thing that anybody knew, and it didn't taste very nice".[344] Maureen Michau believed that another factor was the additional fuel required for

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[341] Interview with Pat McLeod, 23 May 2003.

[342] Interview with Maureen Michau, 14 Mar 2003.

[343] Ibid..

[344] Interview with Violet Padayachi Cherry, 23 May 2001.

soybeans' long cooking time. Paraphrasing African nursing sisters' explanation of this rejection, she recalled, "They'd say, 'How can you expect soya beans to be used? Where do you get the fuel [to cook them]?' "[345] Lack of resources undermined "alternative approaches to cooking such as the 'hot boxes'. [These are] cartons, insulated with newspaper and tinfoil. You start cooking food in the stove, then transfer to the hot box. But where do you get the newspaper and the tinfoil?"[346]

Financial constraints meant that people were wary of adopting innovations such as hot boxes and soya beans. But familiar practices such as gardening were also problematic in such resource-poor areas as Lamontville. Maureen Michau elaborated on "the biggest problem of all, the fact that they [gardens] were not fenced off...People would come and say, people's chickens are running into our garden and we don't know what to do, and the cattle are roaming into our gardens and it's all very well for you to say this [i.e. grow gardens]".[347]

4.3 Was the IFCH a "success"?

An overall impression of HEs' assessments of the IFCH may be gleaned from this chapter as a whole, but this section presents some responses to a specific inquiry about whether HEs regarded the IFCH as successful. Maureen Michau offered a conditional opinion:

> I think it would have taken time to be successful. I saw that the principles were absolutely wonderful but very often the implementation did not take into account

[345] Interview with Maureen Michau, 18 July 2000.

[346] ibid.

[347] Interview with Maureen Michau, 14 Mar 2003.

> the fact that they were dealing with many people who were not familiar with all the new ideas and so on. I mean, the educational aspect, they were constantly trying to introduce new types of health education...but very often they found that it wasn't received in exactly the way that they hoped that people would receive it.[348]

Asked whether IFCH staff were ever discouraged by the disparity between intended and actual effect, she replied,

> I think that they actually found that they [the Karks and the IFCH staff] were making a difference....and although it was a slight difference it was encouraging. I don't think that people who worked there were discouraged, people who worked there were pioneering folk, sort of sturdy in their resolve to improve conditions. And people who were very realistic, who knew that they wouldn't be able to change things in a year or two, but who knew that what they were doing was the right thing.[349]

In another interview Michau characterised IFCH staff's response to community resistance as an acceptance that "anything new is not easily taken on. We were aware of problems, but we persisted. We had convictions about these things". The notion of novelty gave her some solace: "You can't refine things in about 4 or 5 years. It takes a bit of time. And so many new ideas were coming in, and we were reading about this and that and the other thing". She ventured, "I think that maybe people [IFCH staff] abandoned things a bit too soon, and started something new. You know how people do this at the beginning of a venture...." Her remarks contained an implied criticism: "I often felt that more time could have been spent on action research, and less on academic research", alluding to the fact that she spent hours filling out family charts: "They were terribly time-consuming".[350] She wanted to alert IFCH leaders but "so much was being done that

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[348] Interview with Maureen Michau, 14 Mar 2003.

[349] ibid.

[350] Interview with Maureen Michau, 18 July 2000.

was new, that there wasn't time for contradictions. If things had developed further, then there would have been time for streamlining. But everyone was exploring".[351]

The challenges of "new beginnings", along with woefully inadequate funding, dogged IFCH staff. But perhaps their greatest challenge lay in the socio-economic conditions that they felt powerless to change. Maureen Michau reflected on the enormous challenge of mitigating destitution and unemployment:

> How can you help people who are so poverty-stricken, who cannot find jobs, who haven't got the education to really understand the new ideas that were coming in and so on...I think that what they [the Karks and other IFCH staff] were trying to do was adapt to local situation. Trying to do the best they could under adverse circumstances. And that, I think, is very important. You don't just give up and say, well because we haven't got this and we haven't got that we're not going to do anything. You just adapt to the situation and do what you can.[352]

Despite her mixed assessment of the IFCH, Maureen Michau pointed to the success of some of the more specific HE initiatives regarding nutrition and self-help: "That is one of the lasting things," she reported. "The whole idea of home gardens. The idea that people's nutrition should be improved, that they were not powerless, they were empowered—because they all had little plots of land—they were empowered to provide for themselves if they wanted to".[353] In a similar vein, Neela Govender saw positive responses to the HEs' tact: "people opened up, they felt they could confide in you, to tell you their problems". She saw long-term effects for health education efforts, particularly in community organisation. She catalogued the successes:

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[351] Interview with Maureen Michau, 18 July 2000.

[352] Interview with Maureen Michau, 14 Mar 2003.

[353] ibid.

> For example, we started a seed club. Vegetable gardens. So many other things people can do to make them aware of health problems, and how much they themselves could be responsible for their own health. Right? And social...people getting together to help themselves. That's lasting, isn't it?...If you've taught them the importance of breakfast for a child, and the importance of breastfeeding, if you've given them knowledge about the physiology of pregnancy, that's not something they can forget. They will pass it on to another generation, or influence each other...we sow the seed, and it must grow, and spread.[354]

Sharing Neela Govender's optimism, Sally Chetty stated that "the most important lesson that I learned from Dr. Kark was the fact the you are doing something to educate the people, to serve the community. The message was, "we tell you, you pass it on".[355] For Violet Padayachi Cherry, the IFCH succeeded in "broadening [people's] understanding of what was out there".[356] For disadvantaged communities, this knowledge could in itself be empowering, as it sent them the message that they were not being ignored: "Looking at where we started, with the most needy, the poorest families, that had nothing, [you had] the feeling that you were in some small way able to improve their lot. Even if all you did was to make them knowledgeable about what health services were available. And I think that that's what it's all about, in any setting".[357]

Section Five: Culture and Gender

This section will illustrate how culture and gender intersected with the HEs' work, either helping or hindering their efforts. It will also explore how these factors affected them as individuals.

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[354] Interview with Neela Govender, 18 March 2003.

[355] Interview with Sally Chetty, 21 July 2000

[356] Interview with Violet Padayachi Cherry, 14 June 2002.

[357] Interview with Violet Padayachi Cherry, 14 June 2002.

A significant portion of the material depicts how such factors played out in the IFCH areas that were primarily Indian (Merebank, Clairwood and Springfield). The preponderance of data from female Indian HEs' is partly due to the composition of the HE study sample (see Chapter Three); it also may reflect a stronger sense of ethnic identity among the Indian HEs interviewed, hence a greater willingness to discuss culturally- related matters. Their testimony exposes an element of the IFCH's service that has often been overshadowed by attention to African cultural and gender contexts in Pholela and Lamontville.

5.1 Education

One topic that appears to be a touchstone was education. Several of the Indian female HEs spoke of cultural restrictions they had to overcome in their pursuit of schooling. Sally Chetty referred to the exceptionality of the Indian female HEs within their community: "At that time, it was very rare for Indian girls to be allowed to leave the home; they [the parents] didn't think it was necessary for Indian girls to get an education. I was the only one of four sisters to have a job like that".[358] Violet Padayachi Cherry elaborated on the assumptions behind this prohibition: "I think right through to the early '40s, the priority was more for education for men, because they were going to look after the family, and look after parents in their old age, and girls would get married and go away and look after their own families".[359] Although Neela Govender initially denied that

[358] Interview with Sally Chetty, 21 July 2000. After Sally Chetty left the Institute in 1953 in order to get married, she encountered further resistance to her attempts to continue her education: "At that time I was married - it was an arranged marriage. I was not interested in getting married. My husband's family did not believe that women should leave the home. My mother-in-law did not allow me to write the exams at the Technikon which I was supposed to write."

[359] Interview with Violet Padayachi Cherry, 14 June 2002.

she had difficulty accessing education—"No, because girls were already getting education, they were becoming doctors and teachers and all that"—she also admitted,

> But I did have a problem. It all depends on your older generation. Now I must tell you a little of my story...Now, when you reach puberty, the older people say, you can't go to school now, because girls are not supposed to do so they become, so they might...fall foul of, you know what I mean. So they are very protective. We are taught the ethical codes, how to protect yourself. Being a female it's more serious. So, they didn't want me to go to school. But we had a headmistress, Mrs. Morrell,[360] and Mrs. Morrell used to tell us – they were all out to encourage women – by that time Dr. Goonarantham was already a qualified doctor. And we had quite a lot of educated females. So it's not every home that had this restriction. But then others were influenced, to this extent. Fatima Meer was with us in Girls High. And so, at that time, Mrs. Morrell used to say, if any of your parents try and stop you, just be stubborn, like you know, all non-violent. A small satyagraha[361]...my dad was very liberal. My mom was torn between the husband and my grandma. My grandma said, I want to see them get married. She was old-school. Well, I had my small satyagraha. So then I went to Girls' High. Okay. Well, I had to promise my dad, that I'm going to uphold his trust in me, you see.[362]

5.2 HEs' Views of Gender Roles

More than anything, cultural and gender dynamics necessitated that HEs adapt to the prevailing social conditions in the communities in which they worked. Programmes carried out in the Indian community, through the vehicles of home visits and primary group gatherings, were tailored to the domestic availability of Indian women, whereas

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[360] Pauline (Pondy) Morrell (1903-2002) was mentioned by several of the Indian female HEs as a pivotal figure for her unstinting advocacy of girls' education. One HE remembered, "She actually went door-to-door to persuade parents to allow girls to go to school. You know, begging them in fact. The Hindu and Christian families were the first. Moslems later, and Gujarati. They were much more resistant to sending their girls to school" (Violet Padaychi Cherry). Pauline Morrell was the sister of Helen Cohn, the IFCH's first nursing director, and was interviewed by the author (Durban, 2000) regarding background information about the Karks and the IFCH.

[361] "Satyagraha" was the Gandhian term for an act of non-violent resistance.

[362] Interview with Neela Govender, 18 Mar 2003.

health education targeting African women in Lamontville often occurred in the community centre to accommodate their work schedules and greater participation in public life (Stueart 1962:79). HEs learned to adjust their approach to the circumstances, as Violet Padayachi Cherry demonstrated:

> ... women had such specific roles – [they] were cooking, or washing, or ironing, or doing some specific task that sometimes you felt as though you were intruding. I would often say, 'Let me come and sit in the kitchen with you. Can I shell the peas, or what have you.' They were very formal in the beginning but once you got to know them they would make you sit down at the kitchen table.[363]

Women's spaces could be both circumscribed and spread out, as Neela Govender discovered when conducting the maternal nutrition survey in Merebank:

> One incident was, this woman was advanced in pregnancy. There were communal taps in the area, ...and there was an area where there was red sand. You had to get the sand to smear the floor...The son was off duty that day, he was at home. Then she [the pregnant woman] had to bring wood from the surrounding area, and chop the wood. It was open fire. This lady had also to fetch water. I was surprised that this husband of hers didn't make a move to fetch the water. She had this big jug, and she filled the jug from the communal tap, she took the water onto her knee and onto her head...Then she came home with the red sand to smear the floor, then she chopped the wood, then she was sitting near the fire, preparing supper. I was very, very upset, because I'm a woman's lib lady, you see. So anyway, she did everything. You can't tell her not to. I mean, you just observe. After, I told Professor Kark that I felt like kicking the man...So that's the thing, that's the wife's duty. And she was at time a very frustrated woman, with little kids running around, she had other children, and she just went hell for leather with them.

Despite her anger at this situation, Neela felt hamstrung: "You can't interfere too much...you can't tell the man, you should have helped her. I don't think anyone would do that...You can't suggest it. I wouldn't be allowed in the home anymore. And you feel, as time goes on, that it will change, or by culture contact, with other groups".[364]

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[363] Interview with Violet Padayachi Cherry, 23 may 2001.

[364] Interview with Neela Govender, 18 Mar 2003.

Violet Padayachi Cherry stressed that sexual prohibitions further narrowed the channels of knowledge available to women: "many times when they [Indian women] are married, they are virgins. They know so little about their bodies. They don't understand their bodies. And yet the pressure is so great on them to get pregnant. And if you're not pregnant within the first three or four months, it's like, what's wrong with you?"[365] By providing young women with forums such as the menarche survey and the girls' discussion groups, HEs aimed to combat restrictive gender roles: "I think women were very oppressed and were really subjected to no free expression at all unless they were alone in a group and they could talk amongst themselves. They certainly didn't dare talk, or take a position, or have an opinion, in front of their husbands".[366] The atmosphere in HE-convened forums was deliberately non-didactic. Neela Govender described how she would "talk about the men's way and the women's way, with jokes, you know, not very official, but informal. It's more effective...that's how you get them to talk".[367] HEs would also recruit "intensive families" to help them address gender restrictions. Violet Padayachi Cherry gave an example: "If we were talking about, maybe allowing more freedom for women, young women, and talking about the arranged marriages piece, we then would target influential families and focus a lot of education on them".[368]

Not all HEs advanced a liberating agenda for women. Audrey Bennie, one of the first African female HEs to be recruited in Pholela, enlisted local cultural practices of

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[365] Interview with Violet Padayachi Cherry, 14 June 2002.

[366] Interview with Violet Padayachi Cherry, 23 May 2001.

[367] Interview with Neela Govender, 18 Mar 2003.

[368] Interview with Violet Padayachi Cherry, 14 June 2002

ukuhlonipa (customary codes of respect and deference), reinforced with a Christian ethos of wifely deference, in her attempts to instil health-promotive household mores: "I would tell wives, 'Ukuhlonipa is the Lord God's law'...Clean your body, clean your house. Obey your husband".[369]

5.3 Modification of Health Education Materials and Methods

The cultural sensitivity of the IFCH approach is reflected in its adaptation of health education materials and terminology to accord with local norms. Violet Padayachi Cherry remembered,

> ...when Kark was talking to us about our field projects, and we were going to do something in Merebank about smallpox and vaccinations, I remember doing this elaborate poster and showing it to Kark, and he said, 'Do you think that's going to work, out there?' I said, 'Why not? I've got all this stuff in about getting your vaccinations..' He said, 'Take that home and show it to your mother, and come and tell me what she has to say about it.' (she laughs) So I did. My mother looked at it and said, ' That's not going to give anybody any information. Don't you know what causes smallpox?' And I said, " It's a germ." She said, "Then you really don't know much about how Indians, your own people. Look at it. This is the visit of a goddess, the goddess Mariammen.' You're privileged when she visited. Automatically, the house must be cleansed, and people from outside can't come in, it's like imposing restrictions on people coming in and out. You've got to be bathed...you keep your body cool and you're given light things to drink. It looked to me like in the early days, the gurus in the temple had worked out a way to convey to people certain principles of taking care of people with this disease. They said, since you're privileged that the goddess is visiting you, your house has got to be immaculately clean. So my mother said to me, "That poster is not going to do anything to convey to Indian people who you're going to talk to about getting vaccinations.' I went back and told Mr. Kark, and he smiled his Buddha smile and said, 'Well, it looks like you're going to have to re-do that.'[370]

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[369] Interview with Audrey Bennie, 23 June 2003
[370] Interview with Violet Padayachi Cherry, 23 May 2001.

Maureen Michau also found that at the health centre in Lamontville "a lot of emphasis was placed on the need for the most appropriate approach in terms of cultural beliefs". She noted that HEs "were provided with techniques to be able to relate effectively with local people, for example, ideas about communication, innovation".[371] Medical staff, aware that many of their patients "would think nothing of going to the clinic and also, when they felt it necessary, going to the witchdoctors" (or traditional Indian healer), sought to harmonise their explanations of etiology and treatment with the cultural beliefs of their patients (Chesler, 1962).[372] Maureen Michau cited the chairside manner of the dentist at the clinic, "He taught people how eating coarse food was important. The idea of dental hygiene was different. People used reed and bark, rather than toothbrushes. The dentist didn't try to discourage it, because he knew that people didn't have the money to invest in toothbrushes".[373]

Visual aids used by the health educators were pre-tested by focus groups to increase their clarity and appropriateness.[374] Even so, certain educational devices failed to be effective, as Maureen Michau illustrated:

> The health educators and nurses used audio-visual aids, like flip charts, stylized drawings, scale models. [It was] a minefield, an absolute nightmare. They needed to adapt to the cultural perceptions, because people didn't understand the materials. For example, they used a three-dimensional model of a uterus with a baby inside [to illustrate gestation], but the mothers didn't relate to it at all.

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[371] Interview with Maureen Michau, 18 July 2000.

[372] ibid.

[373] Ibid.

[374] For further discussion of adaptation of materials, for example posters warning of the dangers of obesity that were tested and changed to be more acceptable for their audience (Africans in Lamontville), see chapter by Bert Gampel in Kark and Steuart, eds. (1962), pp. 292-308.

> ...Pictures of [enlarged] flies didn't work, because people would say, 'No, we don't have any flies like that. Our flies are small'.[375]

As in Pholela, where medical aide Edward Jali had responded to people's bewildered incomprehension of enlarged pictures of flies by using a simple magnifying glass to show them how a fly's anatomy made it an ideal disease carrier, HEs "took an actual fly, and they said, "this is the creature that we've got drawn here".[376]

5.4 Disparities and Difficulties

For IFCH medical staff, a key component of cultural sensitivity was "the need for the physician to be aware of social distance and to make efforts to bridge the difference between himself and many of his patients" (Chesler, 1962:150). This "social distance" sometimes occurred even between HEs and their clients; HEs' education, class status and religious affiliation might set them apart from members of "their" community. Formulators of IFCH policy such as the Karks and George Gale saw the HEs as ideally positioned to bridge the gap between a biomedical framework and traditional African or Indian health beliefs and practices, but the HEs themselves, exposed to conflicting scientific or religious paradigms, sometimes regarded customary beliefs with suspicion. Neela Govender, who conducted a survey on sex education among married Indian women, particularly relating to pregnancy, remarked upon "the [women's] ignorance. And some of the beliefs. You begin to correlate why certain practices are there in the

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[375] Interview with Maureen Michau, 18 July 2000.

[376] Ibid.

community, and how it comes about".[377] Some African HEs with strong Christian identities (*amakholwa*) applied more perjorative terms than "ignorance" to the spiritually-based health beliefs their non-Christian clients. Audrey Bennie dismissed the notion that *amadlozi* (ancestral spirits) could have protective or healing powers, a central tenet of Zulu cosmology (Ngubane, 1977), with a horrified assertion that "*amadlozi* are devils".[378] Despite evidence that the Karks and African HEs made contact with traditional medical practicioners, *izangoma* (diviners) and *izinyanga* (herbalists), Gertrude Sibisi flatly declared, "We didn't talk about *sangomas* then during Kark's time".[379] Audrey Bennie went further in her negation: "...people were discouraged from going to *izinyanga*. We said, 'You are wasting your time, these things do not work. Go to the doctor, he will give you an injection or pills. The doctor will examine you and see what's inside'".[380]

Intra-group language barriers could also complicate relations between the HEs and their clients, as Sally Chetty recalled: "At that time in the Indian community, English was not as commonly spoken. I am a Tamil speaker. If the family was Hindi speaking, I could understand, but not speak it. Often, the fathers would be able to speak Tamil, so they would be brought into the discussion". In an incident described by Neela Govender, a father's presence as a translator in the menarche survey nearly had disastrous consequences:

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[377] Interview with Neela Govender, 18 May 2003.

[378] Interview with Audrey Bennie, 23 June 2003

[379] Interview with Gertrude Sibisi, 22 July 2000. For contrasting evidence, see Interview with Sidney and Emily Kark by Dr. C.C. Jinabhai and Dr. Nkosazana Zuma 1992, p. 12; also author's interview with Dr. H. Jack Geiger (Sept 2000). Violet Padayachi Cherry confirmed that "Kark [met] with witch doctors, and ...some of the health assistants were encouraged to go talk to witch doctors and find out some of the things that they were doing, and tell them about what we were doing". Interview with Violet Padayachi Cherry, 14 June 2002.

[380] Interview with Audrey Bennie, 23 June 2003

> I went to a Hindi family [she is a Tamil speaker]. This mother didn't understand English very well. So I was trying to convey the information about why I was there [to ascertain if there was a girl of menstruating age in the household]. She was finding it difficult to understand...Then I saw the husband coming towards me. He asked, 'Can I help?' Now I didn't realise that the girl who we were talking about was inside, listening. So I told the gentlemen, that this is the actual issue that I came here for. Then he explained to the wife and went away. So she gave me all the necessary information that I wanted. Two days later, while I was passing, the mom and the aunt called me over. They used to refer to us as sisters. They said, sister, come here. I asked, what had happened? They said...she [the girl] wanted commit suicide. She wanted to burn herself with paraffin. I said, what for? 'Because she was ashamed to face her father, because now the father knew about her menstruation – a woman's thing.' But the elders knew this was a stupid way of thinking, so they told her, don't be stupid. They saved the girl from burning herself. I was shocked. So there was one of the incidents, when you don't know the difficulties.[381]

Despite such occurrences, certain cultural- and gender-related practices could also facilitate a sensitive topic like menarche. Pramda Ramasar remarked of the menarche survey: "The only thing that helped up, was that the Tamil-speaking group observe the first menarche. They treat her [the menstruating girl] like a bride, so that helped".[382]

Section Six: Race Relations at the IFCH

A cursory overview of the health educators' descriptions of race relations at the IFCH suggests that the multiracial staff experienced considerable solidarity. Neela Govender stated simply: "Getting on with each other was fantastic. We had no problems about that".[383] Even HEs from communities devastated by the 1949 Durban Riots, which pitted Zulu-speaking Africans against Indians, claimed that "relations between Africans

[381] Interview with Neela Govender, 18 Mar 2003.

[382] Interview with Pramda Ramasar, 30 June 2003. Although Pramda is Hindi-speaking, she was informed by Tamil-speakers of the Tamil practice of "secluding a girl behind a screen during her first period, giving her only eggs and vegetables to eat, dressing her in festive clothes."

[383] Interview with Neela Govender, 18 Mar 2003.

and Indian co-workers at the centre were not really affected"[384] in the aftermath of the violence.[385] Sylvia Shearer felt positively upbeat about the health team's multi-racial dynamic: "We crashed through those barriers".[386] Maureen Michau agreed, "It was a much closer relationship [between races]".

Yet because the racial divisions in South Africa were entrenched by law, racial integration at the IFCH remained elusive. Indeed, HEs frequently contradicted or qualified their initial assertions about race relations in the workplace. For example, Maureen Michau, who first portrayed friendly mixing between white, Indian, African and Coloured staff at the health centre, added, "it depended on the people. Some of the black people didn't want to mix with us, you know. They felt so strongly about the situation".[387] Even nominal symbols of solidarity, such as a uniform worn by HEs to denote their position, came with a "some are more equal than others" discretionary clause, as Maureen revealed: "There was one thing that we all had in common. A cream uniform. And whether you were white or black or whatever…you wore the same cream uniform. But the whites were not compelled to wear the uniform. I always did, I thought they were lovely".[388]

Segregation and later apartheid dictated a racial and socio-economic hierarchy, although HEs alluded to this fact hesitantly or elliptically, if at all. Maureen Michau hinted at the difference in status between the races:

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[384] Interview with Bala Govender, 4 July 2000. See also interview with Neela Govender, 22 July 2000.

[385] For more on 1949 Durban Riots, see Freund, 1995 and Webster, 1979.

[386] Interview with Sheila Shearer, 21 July 2000.

[387] Interview with Maureen Michau, 14 Mar 2003.

[388] Interview with Maureen Michau, 14 Mar 2003.

> They were seen as, in fact, the thing is, it was a different educational level too. All of the white women, all the white HEs, had at least one university degree. All the black HEs had...I'm not so certain some of them had actually got their full matriculation. And one was aware that they were paid less, and the work that were being equipped for, was at a, not a lesser level, but at a less complex level.[389]

Violet Padayachi Cherry described the hierarchy from another perspective, characterising the white HEs as "not strictly health educators...

> They were either research or on a teaching level, and many of them had social work and psychology backgrounds, and so academically they were virtually in a class by themselves. We saw them more in a supervisory capacity; they were not like peers, though I must say they were all fairly nice people.[390]

HEs were able to have sustained inter-racial contact through training, health team meetings, and co-ordination of surveys, but opportunities for more social interaction (in the work setting) were circumscribed. Maureen Michau stated, "They [African and Indian staff] didn't often come to our tea room, because they were either out doing field work or at the clinic".[391] What this statement does not reveal is that there were two separate spaces in which to relax and talk. Neela Govender remembered: "they had different tea-rooms and all that...when we were there, we didn't have white health educators training, there were only Coloured, African and Indians. There was no problem, we had the same common room...but the whites had their own common room".[392]

Sidney Kark, as director of a government-funded institution, could not avoid restrictions such as separate facilities, but he expressed consternation at more self-

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[389] ibid.

[390] Interview with Violet Padayachi Cherry, 14 June 2002.

[391] Interview with Maureen Michau, 18 July 2000. In a subsequent edit of the transcript, Maureen wrote, "[The limited mixing] may also have been because, in accordance with government policy, separate facilities were provided".

[392] Interview with Neela Govender, 18 Mar 2003.

imposed forms of segregation. Bala Govender, among the first trainees in 1946, remembered: "It was a mixed group, yet people tended to congregate in their racial groups. Kark came in, look at us, and said, 'Africans here, Indians here, Coloureds here, whites here. Why don't you all mix together?' So we tried to mix our seating after that".[393] However, after the 1948 Nationalist party victory made segregation du jure, the effect was visceral: "it was like there was a death in the family".[394] Bala recounted,

> .... Kark said to me, 'Doomsday.' He called an assembly. He was emotional, and recalled the day he had told us to mix up. He said, 'It is very painful for me to tell you now to go into your different groups. Be very careful about mixing. If you don't stay in your groups, this place will close down.[395]

Still, the shadow cast by discriminatory laws could not enshroud all spaces. HEs did interact openly with their fellow HEs of other races. For many of them, the degree and nature of interaction, particularly during their training, was utterly unfamiliar, as Sally Chetty attested: "I was surprised, when I came to the Institute, to see this multi-racial mixing...At first, I was nervous".[396] Violet Padayachi Cherry confirmed that "we all had to make an adjustment. It was realising for the first time that we were not within our families and that we were being exposed to people with totally different backgrounds. I didn't know any more Africans at a social level and any of my fellow [Indian] health educators, because again, things had been limited".[397] It was a novelty to experience inter-racial relationships on a basis of parity:

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[393] Interview with Bala Govender, 21 Jun 2000.

[394] ibid.

[395] Interview with Bala Govender, 4 July 2000.

[396] Interview with Sally Chetty, 21 July 2000

[397] Interview with Violet Padayachi Cherry, 14 June 2002.

> It was the first time you had a peer relationship [with other races]. In the past, the only Africans you knew were people who worked, and I think the only opportunities they had to know Indians were Indian storekeepers in the African locations. And so, they knew nothing about us.[398]

The gulf between HEs of different races may have been somewhat breached by closer contact, but stereotyped expectations could persist. Pat McLeod repeatedly expressed her astonishment upon encountering conditions in Lamontville that contradicted the squalor she had expected: "I was quite surprised at how affluent some of the households appeared to be…It was actually very interesting how well some of [them] were doing…several households where I was very impressed with the cleanliness, the consciousness of nutrition".[399] Pat recounts an occasion in Lamontville, when conducting an infant nutrition survey in the company of another white HE: "[We were] looking around at food in the household…I was horrified when I saw a tin of sardines. I said, how can they afford sardines?" Her companion gently rebuked her by saying, 'They like sardines, that's why they have them, are you going to stop them from having sardines just because they cost so much?"[400]

Generational perspectives were another factor that highlighted differences between racial groups. Violet Padayachi Cherry alluded to advanced age of some African HEs, who were "coming back after second and third jobs. They were teachers or nurses or what have you…and they were taking a third shot at something and they seemed to

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[398] Ibid.

[399] Interview with Pat McLeod, 23 May 2003.

[400] Interview with Pat McLeod, 23 May 2003.

know more than all of us [Indian female HEs]".[401] However, while the older African and Coloured trainees may have had more life experience, the Indian girls had an advantage in the training course itself, resulting in all of them successfully completing the training: "I think that the only reason that we [Indian HEs] survived was that we were fresh out of school, disciplined to study...and parents made you", whereas "many of them [African and Coloured HEs] had been teaching or nursing...and perhaps they had been away from studying for a while and they struggled a little". She depicted the older Africans' reaction to the youth and inexperience of the Indian girls:

> They [the African male and female HEs] were so amused that we knew so little about life. I mean I'm sure that all of us [the Indian female HEs] were straight out of school, we came from very restrictive families where you didn't have a lot of exposure. I'm sure none of us had had a sexual relationship with anybody. All this talk in class about the anatomy, we were just traumatised. It was just too much. And if anybody so much as made an overture, teased you, you absolutely ran, because it was just something you had never experienced before.[402]

Daya Pillay also referred to the "teasing" between different groups, which she illustrated with an anecdote about a loaded joke she told to her African colleagues: "When God was handing out brains to put in people's heads, you must have got yours last, because you have such curly hair." Asked about her colleagues' reaction, she claimed, "Oh, they all laughed".[403]

Another way in which apartheid regulations affected the IFCH was white staff's inability to go into black areas without a permit.[404] Maureen Michau noted, "Certain of

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[401] Interview with Violet Padayachi Cherry, 23 May 2001.

[402] Interview with Violet Padayachi Cherry, 14 June 2002.

[403] Interview with Daya Pillay, 4 July 2000.

[404] Regulations stipulated that whites going frequently into black areas had to apply to the Department of Native Affairs for a permit.

the people at the Institute did have permits", citing the medical staff as examples. Like many of her fellow white HEs, Maureen did not have a permit, "which was really rather ridiculous, I mean that's another weakness—that we did not have free access to the area where the clients were...And because of that, we [white HE trainers] were talking about situations that we were not actually going into".[405] Sylvia Shearer, despite her claim to have "crashed through those barriers" admitted that her coterie of psychologists "could only serve the white community, because we didn't have the tools. There was no psychological test material for non-whites. There were language barriers, a lack of understanding about cultural norms".[406]

Section Seven: Working Conditions

7.1 Wages

Remuneration of IFCH personnel reflected the institutionalised inequalities of South Africa, with significant gaps in the salaries of various racial groups.[407] Yet both

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[405] Interview with Maureen Michau, 14 Mar 2003.

[406] Interview with Sheila Shearer, 23 July 2000

[407] As of 1951, annual wages for white female HEs were £144; male non-Europeans £120; female non-European HEs £108. All groups were to receive a £12 raise per year (GES 2957 PN5, Social Medicine in South Africa, March 1951). Compare with per capita annual income for Durban according to the 1951 Union census: Indians: £40; Africans £40; Whites: £282 (cited in Kuper 1960). By 1954, salaries for some IFCH positions (e.g. white female HEs) had almost tripled, while others (African female HEs) had stagnated.
1954 annual wages for various IFCH personnel (in £) were as follows:

Doctors (all white):	£1020 to £1680
African medical aid:	216.
White nurses:	430 (staff nurse) to £510 (sister) to £710 (head sister)
Coloured nurses:	240 (staff nurse) to £280 (sister)
African nurses:	180 (staff nurses) to £240 (sister).
White female HEs:	360
Coloured male HEs:	165

white and Indian HEs interviewed emphasised the low wages (calling them "a pittance")[408] while the African HEs interviewed, despite being on the bottom the pay scale, regarded the pay as better than they could get in other jobs.[409] Violet Padayachi Cherry remarked, "by the time I'd finished paying for my train ticket to Merebank, there was very little left. You had to take your own lunch, otherwise you struggled".[410] The relatively low wages were a reflection of the HEs' paraprofessional status, further exacerbated by racialized and gendered pay scales, as well as the meagre funding allotted to the health centres in general (only 2% of the entire national health budget went to health centres across South Africa).

In contravention of the NHSC report, which, remarkably, had recommended the same wages for both sexes (though it suggested different racial pay scales),[411] female HEs were paid less, reflecting standard public and private sector practice: "certainly...the

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Coloured female HEs:	150
Indian male HEs:	165
Indian female HEs:	150
African male HEs	132
African female HEs	108

Source: UKP H6/2/3 S. 53/1/45 Circular from J.J. de Plessix le Roux, Secretary for Health, 4.11.54. The following year, the wages for white female HEs again increased disproportionately, to £430, whereas salaries for all other personnel remained the same: UKP H6/2/3 Ref. No. S.54/1/45 Circular from the Central Dept. of Health to the provincial Deputy Chief Health Officer, 4 Feb 1955.

[408] Interviews with Daya Pillay, 9 June 2000; Sally Chetty, 21 July 2000; Neela Govender, 18 Mar 2003; Violet Padayachi Cherry, 23 May 2001; Maureen Michau, 14 Mar 2003 and Pat McLeod, 23 May 2003.

[409] Interview with Gertrude Sibisi, 22 July 2000, who left teaching for better-paying work as an HE. Audrey Bennie in Pholela stated that as a rural woman, she had few wage-earning possibilities so was satisfied with her pay. Interview with Audrey Bennie, 23 June 2003.

[410] Interview with Violet Padayachi Cherry, 23 May 2001.

[411] The NHSC Report recommended that "in the NHS there should be equal opportunity and equal pay for men and women performing work of the same nature:, and that there "should be no bar to the employment of married women." While maintaining racialised pay scales, the Report did "state emphatically that we are opposed to any selection which discriminates between one race and another." *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944):78.

females were paid less. I think that it was just a given".[412] Another discriminatory norm adopted by the IFCH was the demotion of women to temporary employee status when they married, making them ineligible for pensions or other benefits accorded to permanent staff.[413]

However, other forms of compensation helped make up for the low wages: "you had health benefits...and you got a little increase at the end of each year".[414] Because of the lack of examining rooms for whites in most of the health centres, such health benefits were only extended to the African, Coloured, and Indian HEs.[415] Violet Padayachi Cherry, who had her first child while employed at the IFCH, said, "I don't remember paying anything for my entire ob-gyn care".[416] In contrast, Maureen Michau, who also went on (unpaid) 3-month maternity leave, pointed out that "as a white, I wasn't allowed to access the clinic services. This was apartheid, so they had to be strict about that. I had to go to a private doctor..."[417]

The lack of resources accorded to the health centres was evident in the spartan buildings of the IFCH. Maureen Michau stated,

> We were very aware of that [the lack of funding]. We were in an old military building out at Clairwood, and I can't recollect any sort of modern facilities there. For example, the dentist did not have an electric drill or anything of that kind. He actually worked the drill by foot...One did feel strapped for funds. At that time,

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[412] Interviews with Violet Padayachi Cherry, 14 June 2002; Maureen Michau, 14 June 2003; Pat McLeod, 23 May 2003.

[413] Interviews with Pat McLeod, 23 May, 2003; Maureen Michau, 14 June 2003.

[414] Interview with Violet Padayachi Cherry, 14 June 2002.

[415] The only health centre that treated significant numbers of white was Knysna in the Cape.

[416] Interview with Violet Padayachi Cherry, 14 June 2002.

[417] Interview with Maureen Michau, 14 Mar 2003.

> one actually thought, maybe they're doing this to show us what it is like in rural areas. That may have been an element.[418]

7.2 Motivations

Wages influenced how interview subjects perceived their motivation to become HEs. Maureen Michau asserted, "We didn't work for money. Our pay was absolutely rock bottom". She felt that the IFCH tended to attract people who were idealistic, "often people from homes that were privileged".[419] For Pat McLeod, the pay was "a bit less compared to what I could have gotten anywhere else, [but] I found the work so interesting...and that was more important to me than anything else".[420] Of the African and Indian HEs' motivations for joining the IFCH, Maureen Michau speculated, "I think that they saw this, for them, as a good job, and they were also very dedicated".[421]

Violet Padayachi Cherry indicated that it was in fact the stipend that HEs received during their training period that motivated her to pursue health education rather than her family's choice of teaching:

> ...when you went into teacher training, you didn't get paid. Some of us, who were poor and struggling...[were] thinking of some way to earn some money to contribute to the family...It wasn't a fortune, but you were earning some money in three years, and you got a little increase at the end of each year.[422]

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[418] ibid.

[419] ibid.

[420] Interview with Pat McLeod, 23 May 2003.

[421] Interview with Maureen Michau, 14 Mar 2003.

[422] Interview with Violet Padayachi Cherry, 23 May 2001.

The white HEs referred to the low wages as evidence that the job attracted idealistic people; the Indian and African HEs regarded the pay as having certain advantages despite its meagreness, such as health benefits and a training stipend. African and Indian HEs in particular, who suffered the brunt of legally depressed wages, may have found the pay better than in many other skilled fields. For Gertrude Sibisi, a former teacher, the higher pay at the IFCH was an incentive to leave her teaching profession, and the fact that many of her fellow African HEs were former teachers (according to other interview subjects) suggests that this motive—among others—may have attracted them.[423]

7.3 Post-1948 Atmosphere

Besides the direct consequences of the 1948 election (e.g. the nominal ban on mixing relayed by Sidney Kark), IFCH staff like Maureen Michau "were aware immediately the Nationalist government came into power…

> This [the IFCH] was a leftover from the previous government, and once they started functioning fully as a Nationalist government, they would start investigating this and changing it and…reducing it and so on, which they did do of course.[424]

The already-prevalent awareness of the health centre's volunerability increased, as Violet Padayachi Cherry recalled:

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[423] See Interview with Gertrude Sibisi, 22 July 2000. As Jonathan Hyslop demonstrated, the education system for Africans was in a state of flux during the 1940s, with increasing unrest among students and teachers in many mission schools. Tightening of controls by the Nationalist government presaged the Bantu Education Act (1953), where a decrease in professional autonomy and status may have added to pre-existing factors such as poor pay and working conditions, prompting an exodus of African teachers from schools (Hyslop 1999).

[424] Interview with Maureen Michau, 14 Mar 2003.

> Funds were limited, and you had a resistant, antagonistic government. Remember, Gale and Gluckman and so on, they were replaced by all these other horrors that came with the Nationalist Party, and they did see social and preventive medicine as having communist overtones.[425]

The sense of political threat deepened in the early-to-mid 1950s, and often translated into harassment from the government:

> There was so much insecurity...we were constantly threatened with visits from the...government from Pretoria, and when they came there was all this questioning and probing and there were rumours that they were going to close down the health centre and all of us were looked at with great suspicion, the Karks were looked at with great suspicion, and so you felt as if nothing was going to be there for too long, and people were leaving in droves.[426]

7.4 Urban Nature

Physical working conditions in the peri-urban IFCH areas were quite distinct from the Pholela (or Tongaat) practice, where the remote setting played such a large role in the lives of health centre staff and local people.[427] Some of the IFCH areas such as Lamontville, Clairwood and Springfield, were still works in progress, with ongoing construction of houses and streets. As Violet Padayachi Cherry noted: "We had to go out and chart streets. There were no streets. There was something on a map, but we'd have to go find it".[428] Physically, the work could be very demanding: "It was pretty tough...working in the garden and you walked miles and miles because they [a driver]

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[425] Interview with Violet Padayachi Cherry, 14 June 2002.

[426] Interview with Violet Padayachi Cherry, 23 May 2001.

[427] IFCH areas such as Clairwood and Springfield were "urbanized", yet were classified as peri-urban by municipal authorities, with consequent neglect of infrastructure and services (Scott, 1994).

[428] Interview with Violet Padayachi Cherry, 14 June 2002.

dropped you at a point, and everything else was walking on foot. And it was hot, in the summer it was very hot".[429]

Urban conditions could sometimes be daunting given the inadequacies of infrastructure and services, but as the Karks' descriptions of Pholela demonstrate, the deficiencies were even more apparent in the rural areas. Maureen Michau spoke of African HEs' willingness to be assigned to a rural health centre after their training as evidence of their dedication, given the challenges of rural conditions:

> ...at that stage, moving into a rural area was considered to be like going into hell, but many of them [African HEs], I would say the majority of them, understood that they would be able to do their best work in the rural areas...You know, that was a very big thing. It may sound little to someone who wasn't aware of how different the rural areas were. I mean, they were going into conditions where they had absolutely no modern facilities. And they were people who had grown up in townships, I know some of them didn't have much, but at least they probably had electricity, they had an infrastructure where they could catch a bus and go places and so on. They would be going into isolated areas, but they were prepared to do it.[430]

Section Eight: Political Implications

The model of health care implemented by the IFCH emphasised, in the words of Maureen Michau, a "broader sociological understanding of the underlying socio-economic causes of poor health, such as the land issues and migrant labour".[431] Yet HEs diverge in their opinions about whether this emphasis contained political implications, with the majority accenting the hazardous repercussions of overt anti-government

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[429] Ibid.

[430] Interview with Maureen Michau, 14 Mar 2003.

[431] Interview with Maureen Michau, 18 July 2000.

messages or activities during the apartheid era, and the consequent need to re-frame issues in less threatening terms.

8.1 Contradictory Views

At times, paradoxical views may converge in a single narrator. Maureen Michau maintained that the IFCH "training was done in a scientific, sociological way, rather than political". [432] When training African HEs, she framed the issues to encompass the "....basic underlying economic situation in the country at that time.

> ... how little land there was available to a very large segment of the population, and how poverty is an incipient thing that can undermine almost anything that you do. For example, you tell people to eat healthily, and to cook things properly, and often they didn't even have the means to buy the fuel to cook healthy foods. I tried to point out that underlying poverty would be very difficult to overcome.[433]

For her African audience, Maureen's candour signalled that they too could voice their resentment of the status quo:

> They got quite angry. They realised, some of them realised the sort of situation they were actually in. It was sort of a feeling of helplessness, but also a feeling of anger. It was a beginning, a realisation that you couldn't just accept this. Don't forget, the fifties were quite explosive years in this country, and people were becoming aware of their inferior situation, there's no other word to describe it.[434]

In an earlier interview, Maureen had insisted, "We were not a lot of political hotheads. Just dedicated people...who were trying to be honest. Bright young people who

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[432] ibid.

[433] Interview with Maureen Michau, 14 Mar 2003.

[434] Interview with Maureen Michau, 14 Mar 2003.

were conscious".[435] Yet honesty and consciousness demanded action: "I became very, very politicised....I took part in all sorts of rallies, I joined the Liberal Party, and I felt that I had to make my voice heard...I think that we were all in a politically charged atmosphere at the health centres. It was definitely so".[436] Maureen was not alone in her activism, but "funnily enough, it was many of the white HEs [who were political.] There were girls who came from very, very well-off homes, privileged homes, and who were quite appalled by conditions in this country, and in fact many of them actually left this country...There were quite a few of them, who were very aware of the situation".[437]

In contrast to Maureen's contention that "we were all in a politically charged atmosphere at the health centres", Pat MacLeod declared: "It wasn't political...The atmosphere was very congenial".[438] She is echoed by Violet Padayachi Cherry: "I don't think any of us went systematically after the political message", though citing one male Indian HE, Ampraghosh Meharchand, who "was very active. He was jailed at one time...we all knew about his activities, but we didn't come out openly and march with him or anything, but we were very supportive of him".[439] Referring to other politically active, or at least vocal, IFCH staff, she stipulated, "We knew that various people were [politically active], but it was not something you openly discussed...because you knew that there might be repercussions for people".[440] Despite such trepidation, she became

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[435] Interview with Maureen Michau, 18 July 2000.

[436] Interview with Maureen Michau, 14 Mar 2003.

[437] ibid.

[438] Interview with Pat McLeod, 5 July 2000.

[439] Interview with Violet Padayachi Cherry, 14 June 2002.

[440] ibid.

involved in "behind the scene" activity with the Progressive Party and the Liberal Party, along with many of her fellow Indian friends and colleagues: "We all knew Alan Paton. We went to things that he gave, any event that he organised, we were there." She even "helped with campaigns, although [she] couldn't vote".[441]

Bala Govender, who spoke of being politically active since his time as a HE in Edendale with the Local Health Commission, responded somewhat evasively to a question about whether he had ever discussed political issues with Sidney Kark, "He [Dr. Kark] was interested in a certain aspect of health; he had in mind to raise standard of health care for the under-privileged".[442] He added that, as civil servants, neither he nor Dr. Kark could be openly political. This opinion was shared by Pondy Morrell, who socialised with the Karks: "He was hesitant about making statements about politics."[443] Violet Padayachi Cherry outlined the possible repercussions of activism: "You know you had to tread a very careful line, because if it got out that you were there being paid by the Union government, before you knew it you would be locked up".[444] She felt that certain issues could be discussed more openly if cast apolitically:

> It was okay to say, 'You're right to want your children to be educated, their only hope is to get educated, so we have to work harder to get schools built, and that may mean making sacrifices and collecting money for school-building, which was happening...Don't put your aspirations on hold. Accept the fact that the government is not going to build them for you.[445]

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[441] ibid.

[442] Interview with Bala Govender, 4 July 2000.

[443] Interview with Pondy Morrell, 29 June 2000.

[444] Interview with Violet Padayachi Cherry, 14 June 2002.

[445] ibid.

Neela Govender also refuted the idea that the IFCH's work was political, preferring to see it as a catalyst for self-help and mutual aid:

> I didn't view it as political. I saw it as a way of helping people to help themselves. I don't know what you would call that. To make people responsible for their lives as much as possible, under whatever circumstances. Some of them do have the resources, but they don't know how to challenge them, you see. And then who has got the information and the knowledge and they means, can always help the other, to give them a helping hand, to bring them to their level....by exchanging ideas, they were giving them some means of self help....[446]

She characterised the IFCH in a broader philanthropic rather than political light: "it was a service for the good of the people, maybe for the people that deserved it. But overall I thought it was something that was wonderful for humanity as such. So I never gave it [the political implications] a thought...To me, it was just an overall humanitarian effort to improve the quality of life of the people".[447]

Despite the variance in opinion among the HEs regarding the political implications of the IFCH's work, they were in accord that after 1948 the sense of political threat increased: "Social, Socialist, that's the connection they [the Nationalist Party government] made. Several of the Kark people, colleagues who worked with them were labeled communist. I think at times, even Kark and his work, his concepts, were labeled communist".[448]

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[446] Interview with Neela Govender, 18 Mar 2003.

[447] ibid.

[448] Interview with Violet Padayachi Cherry, 14 June 2002.

Section Nine: Memories of the Karks

Violet Padayachi Cherry described her first meeting with Sidney Kark, characterizing him as playfully testing her mettle, "testing me out too, because I was sassy…I would argue back":

> I'd heard about it [the opening at the health center], and called around, and was told me that the person to go and visit was Sidney Kark, in Springfield. So I took a bus and went to see him. He looked at me – I weighed about 80 pounds, I was a skinny little Indian girl – and he said to me, 'How old are you?' I said, 'I turned 15 in November.' This was just after the riots in Durban in 1949. He said, 'You don't look old enough to be out on your own.' And I said, 'I am indeed' – very indignant. He said, 'There's no point in you taking this course because your family will marry you off and it will just be wasted. I was horrified! I said, 'How can you say that? I just fought with my family, and got their permission [to come here].' This was just after the riots, I think it was April or so. He said, 'This is the kind of work that you are not equipped to do.' I said, 'Well, how would you know that?' He said, 'Go take up something safe like teaching or nursing, and then you won't have any trouble with your family.' So I said, 'But I want to do this.' He said, 'Well, what do you know about it?' And I said, 'Well, I don't know about it, but I'm hoping you will tell me.'[449]

Kark did tell her what the training and work would entail, but as the training course was not due to begin for another four months, her gave her an interim assignment: assisting Pondy Morrell, the principal of Dartnell Cresent girls' school, in her efforts to care for Indians who had taken refuge in the school after the 1949 Durban Riots (see section Five on race). Kark stipulated, "If you survive [working with the refugees] and come back, then I'll let you take the course".

Daya Pillay also depicts a "testing" exchange with Sidney Kark:

> One day at the clinic, we were discussing why people have flies in the house. Karks had said, 'If you see a fly in the house, you are filthy.' I contradicted him, thinking of my mother. She was very clean, yet there were still flies in the house.

[449] Interview with Violet Padayachi Cherry, 23 May 2001.

> Kark said, 'I don't care what you have to say...if you have flies in the house it means you are filthy.'[450]

She suggested to Kark, as a preventive measure against flies, that people could paint around their windows with sealant, and claimed that Kark replied, "I didn't ask for prevention. I asked for the cause". She paused, then added, "Still, he was a lovely person. Like a Buddha".[451]

Pramda Ramasar saw Emily Kark "was very easy to get along with".[452] Daya Pillay concurs, "Emily was more approachable", whereas with Sidney, "everybody was in awe".[453] Pat McLeod contrasted the couple: "Emily...had her feet more firmly on the ground. Sidney was not all that practical really...He was inclined to have his head up in the clouds, more theoretical. Emily was more nitty gritty".[454] Sally Chetty asserts, "They [the Karks] were very understanding, down-to-earth, humble, good listeners. They were very close to us, showed love and affection for us".[455] She remembers social occasions that the Karks would host for the IFCH staff: "At the end of the year, the Karks would have a big party, with food, wine...sandwiches and cake". As a cultural aside, she mentions, "Although we [her fellow Indian female HEs] would accept the wine, we wouldn't drink it".[456] Pondy Morrell, who mixed socially with the Karks contended, "It

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[450] Interview with Daya Pillay, 4 July 2000.

[451] ibid.

[452] Interview with Pramda Ramasar, 23 May 2000.

[453] Interview with Daya Pillay, 4 July 2000.

[454] Interview with Pat McLeod, 23 May 2003.

[455] Interview with Sally Chetty, 21 July 2000.

[456] ibid.

was a very serious household. Sidney was awe-inspiring. You could never talk to him casually".[457] Bala Govender contrasted Sidney Kark with David Landau, with whom he also worked as an HE in Edendale, "Kark was more human. Dr. Landau just gave you instructions. Kark would gaze at you and then ask, 'But did you ever think of it this way?'"[458]

Section Ten : Closure of the IFCH

By the mid-1950s, many IFCH staff sensed that the IFCH was becoming increasingly unsustainable in a hostile political environment. Recognising that the closure of the health centre was inevitable, in 1956 Violet Padayachi Cherry made plans to leave for another job. She was asked by two of the IFCH doctors (Bert Gampel and Judy Chessler), 'Are you sure you want to leave?' I remember saying to them, 'If you look at the handwriting on the wall, it's falling apart. People are leaving, some of you are leaving. Where will it all end?" She continued, in a statement that contains a piquant insight into her sense of status as an HE: "'We don't have the capabilities to defend this model. We're the health educators, perhaps at the lowest end of the spectrum'".[459]

10.1 Lack of Accreditation for HEs

Those health educators who were still employed at the IFCH at the time of its January 1961 downgrading to an outpatient clinic, at which time the HEs' positions were

[457] Interview with Pondy Morrell, 29 June 2000.

[458] Interview with Bala Govender, 4 July 2000.

[459] Interview with Violet Padayachi Cherry, 14 June 2002.

severed, apparently did not receive their last paycheck.[460] Neela Govender remembers, "But the funny thing, they couldn't pay us out, because we were so large a number".[461] An issue which appears to have aroused disappointment was the lack of accreditation to HEs when the HE programme closed down: "Now we were shunted [to hospitals and other places], as health educators...The nurses were okay—they were qualified people. But we health educators had to enter a new discipline".[462] Neela Govender viewed the IFCH's inability to secure official status for HEs with a degree of ambivalence:

> Guy Steuart was the one person that wanted...because we had spent three years in intensive training, both practical and theory, and he thought that we should get some sort of recognition. That was the sad part of it. But Professor Kark wouldn't, because I think Professor Kark was pressurized by the government, or whatever. I don't know, whether the universities were against it, I don't know. They wouldn't give it to us, they only gave us a testimonial, which was the sad part. They [they health educators] were worried, because that meant they didn't have the option to do what they wanted. There were pressures from the outside.[463]

She postulated extenuating circumstances for Kark's inability to secure recognition for the HEs:

> ...you have to know, in that era, how hard it was, because the government was against it. They didn't want to allow...under the United Party, I think Professor Kark would have had the opportunity to help us [get accreditation] but when the Nationalist party came in, they wouldn't allow it. So how can you fight? But one man that fought very hard for formal recognition [for health educators] was Guy Steuart. He signed our testimonial as well. So that was how we got them from the University of Natal.

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[460] I was not able to locate archival evidence to corroborate this.

[461] Interview with Neela Govender, 18 Mar 2003.

[462] ibid.

[463] ibid.

Asked whether any of the HEs were angry, she replied, "Well, there were quite professional people among the health assistants. They felt disappointed, they felt let down. Well, they were pushed into different hospital institutions". Questioned whether anyone blamed the Karks, she answered, "Oh maybe. They didn't [blame them] personally, but we all shared a great disappointment. At least we should have had monetary payment, never mind recognition of a degree. But at least it was something to get you into hospitals. In fact they made sure that none were without employment".[464] However, hospital employment turned out to be less than ideal: "I was assigned to the surgical out-patient unit as a ward assistant. I didn't do much health education. The nurses didn't understand what we were supposed to do, and their attitude was bad".[465]

10.2 Reasons and Responses

As is evident from previous sections, most HEs attributed the IFCH's demise to political repression. However, for Pat MacLeod, economic factors also played a part: "Dr. Kark's vision was highly expensive from a personnel point of view. The ratio of health team to clients was so large. The caseload was ideal. Even at that stage, I was aware that it was too good to be true".[466] Pat added, in a comment that accurately points to another factor in the extinguishing of the NHSC's vision of a unified health centre service, "Too

[464] Interview with Neela Govender, 18 March 2003.

[465] Interview with Neela Govender, 22 July 2000.

[466] Interview with Pat MacLeod, 5 July 2000. Although some HEs may have had fairly light caseloads, in general the IFCH staff-to-client ratio was low, particularly the doctor-to-population ratio of 1:3500. See Chapter 4.3 for further discussion.

much money is made out of medicine".[467] Despite her premonition that the IFCH's end was near, she "was devastated when government support was withdrawn. It shouldn't have been allowed. It could have had enormous benefit to the whole country".[468] Pramda Ramasar also felt a sense of betrayal: "We were cheated out of a very good project." However, she believes that a more equitable health care system is possible, "now [that] they [health policy-makers] are grappling again with the idea of primary health care".[469]

[467] ibid. Opposition from the organised medical profession became increasingly insistent from the late 1940s on. Although the South African Medical Association had nominally supported the NHSC, in fact SAMA covertly and consistently torpedoed the plan, fearing the competition to private practitioners.

[468] Interview with Pat MacLeod, 15 June 2000.

[469] Interview with Pramda Ramasar, 23 May 2000.

CHAPTER SEVEN: DISCUSSION AND CONCLUSION

This research does not puort to be a definitive analysis of the IFCH or the HEs who worked at the affiliated health centres in Durban. Rather, the thesis uncovers aspects of the IFCH's health education programme which have been previously overlooked; namely, how HEs perceived the programme's aims and outcomes, and how they translated the IFCH mandate into practice. Although this study presents granular evidence of the HEs' training, environment and duties, there are many facets of the HEs' work that need to be explored further. The limitations imposed by the sample size and composition (addressed in Chapter Three) leave fertile ground for future research on topics such as how African male HEs' viewed their experiences at the IFCH.[470]

The IFCH HEs' narratives reveal some of the potential dangers inherent in conducting oral history, such as the romanticising effects of nostalgia or lapses in memory. However, some oral historians have argued that these weaknesses are in fact strengths, as they expose a deeper form of truth than mere factual veracity. In other words, there are no "false" oral sources, only ones that create meaning through imagination, symbolism or psychological processes such as self-ratification (Portelli, 1991).

Of course, HEs are individuals with their own idiosyncratic perceptions and a very human desire to express their independent spirit. As one HE remarks, "No one told me to. I just did it".[471] Imbued with such personal assertions, HEs' narratives must be weighed with the same critical care that historians employ when combing through written

[470] However, collecting oral testimony from these elderly research subjects is a rapidly receding possibility.

[471] Interview with Daya Pillay, 9 June 2000.

sources. For example, Daya Pillay's memory of Sidney Kark issuing the uncharacteristic pronouncement, "if you have flies in the house it means you are filthy"[472], may indicate either an unreliable narrator or an instance where Kark's "testing" humour (corroborated by several informants) was misunderstood.[473] The HEs' presentation of events may have been influenced by their perception that my study intended to celebrate their contributions to the Karks' model of health care. Thus they may have consciously or unconsciously filtered out uncomplimentary memories. Similarly, the roseate glow that HEs cast on their experiences may also reflect their desire to reaffirm the value of their work.

Interpretation of oral history entails several levels of critical engagement, from connecting individuals' stories back to historical and cultural processes, to decoding how interview subjects articulate a coherent sense of themselves. The significance that a narrator assigns to events or experiences is also influenced by what Ronald Grele calls her "ideological worldview", which in turn informs her understanding of the past (1985). For instance, her historical awareness may rest on assumptions about the necessity of advancing towards the greater good. In contemporary South Africa, the notion of progress – the movement from oppression to freedom – is particularly evocative, and may inform the health educators' view of social change. The HEs' narratives resound with their belief that the IFCH and the Karks represented a brief shining moment in their country's health services. As Pramda Ramasar asserted, the legacies of the Karks' model

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[472] Interview with Daya Pillay, 4 July 2000.

[473] Pillay's comment may also spring from the defensiveness of a member of a group (Indian) often saddled with racist connotations of "dirtiness", and confined to areas such as Clairwood that were unsanitary, marshy, and fly-ridden.

of primary care "[are] only now beginning to be re-discovered".[474] Thus, the health educators saw themselves as participants in a rare multiracial challenge to apartheid (albeit one that was funded and supervised by the government), which anticipated South Africa's journey from darkness to light, or in this case, from whiteness to liberation.

While the HEs interviewed were forthcoming about many issues relating to the goals and operations of the IFCH, it is perhaps their silences about racial inequalities which proved even more telling; these silences might indicate what oral historian Luisa Passerini calls a "bad fit" or "gap" between "pre-existing story-lines" and individual constructions of the self through memory (Passerini, 1987; 1992). As Passerini demonstrated in her analysis of Italian workers' memories of fascism, when individuals reconstruct their past, they may leave traces of unresolved contradictions at precisely those points where they internalised or rationalised oppression, signalling these tensions through omissions or evasions (Passerini, 1987). This might explain why interview subjects downplayed details about separate staff tea-rooms and patients' examining rooms, different wage levels according to race and gender, even the "disappointing" lack accreditation for HEs. In many cases they spoke of these factors only when prompted by the interviewer.

Although the HEs described the IFCH as a brave bastion of liberalism, the health centres were nevertheless enmeshed in the apartheid system. Dominant cultural narratives fostered by white supremacists permeated people's inner and outer lives, influencing how they constructed community narratives and personal stories. At times, the HEs' narratives betrayed tensions inherent in the disjuncture between stereotype and reality. When Pat MacLeod attributes the lack of gardens in Lamontville to Africans'

[474] Interview with Pramda Ramasar, 23 May 2000.

unfamiliarity with vegetable growing and consumption, rather than to more salient explanations such as inarable land, the stereotype wins out. Her allusions to the "nomadism" of Pholela's Zulu-speaking forebears, whose "culturally-entrenched bad habits"[475] supposedly caused soil erosion, bear the imprint of apartheid-era myths about "roaming Bantu tribes".[476] Conversely, liberalism informed by "white guilt" could exaggerate existing evidence of inequality, as illustrated by Maureen Michau's reference to a 50% IMR in Lamontville, in contrast to the IFCH's actual finding of 8% (Kark and Kark, 1999:140).

Religion and cosmology, too, shape the oral narratives. When Gertrude Sibisi claims, "We didn't talk about sangomas then," she superimposes her own view as a non-traditional African upon the IFCH's actual practices.[477] Audrey Bennie's summary of her work in Pholela is another case in point. She stresses cleanliness, baking, clinical services and *amakholwa* (Christian) rejection of *izinyanga* and *izangoma,* revealing more about her mission training and status as the daughter of a minister than about the Pholela health centre's attempt to bridge the gap between "western" and indigenous models of care.[478] The ostensible distaste for traditional healers evinced by Gertrude Sibisi and Audrey Bennie shows how inadvisable it would be to assume that African HEs would automatically share or endorse the values of their pre-colonial ancestors or their

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[475] Interview with Pat McLeod, 23 May 2003.

[476] For example, early 20th century missionary/ethnographer A.T. Bryant disseminated a version of southern African "tribal" history in which "Bantu pastoralists" spread out and decamped when cattle herds exhausted local food sources. According to this interpretation, white settlement represented the first permanent habitation of southern Africa. Revisionist historical and archaeological evidence has long since challenged such claims (Thompson, 1990).

[477] Interview with Gertrude Sibisi, 22 July 2000.

[478] See Chapter Five and Chapter 6.5.4 re: the Karks' interest in traditional healing.

traditionalist brethren.[479] In addition to characteristics such as Christian identity which may have placed African HEs at odds with their communities, all the African, Indian and Coloured HEs had attained matriculation or Junior-Certificates and were thus were atypical of the overall educational levels of their respective racial groups in the 1940s.[480]

Among the various narrative strands in the HEs' interviews are manifestations of what Portelli terms a "communal" mode of story-telling. For some HEs, a sense of belonging to a particular ethnic group is a significant aspect of their identity. For example, Indian solidarity informs Neela Govender's statement about her arduous training: "They didn't think any of us [Indian girls] would last. By the end of that three-year training session, all the Indian girls who had taken it were still there." While Neela and other Indian female HEs spoke extensively of barriers they overcame to gain access education in a community that curtailed opportunities for girls, they also normalised the acceptance of educated Indian women by pointing to accomplished figures like Drs. Goonarantham and Fatima Meer. These professionals, like the female health educators themselves, were exceptions. As of 1948 there were only 261 Indian girls in secondary school in the whole of South Africa, compared to 7688 African and 1654 Coloured

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[479] For more on the self-identities of Christianised Africans, see Elphick and Davenport (1997). See also McCord (1995), where Katie Makhanye, James McCord's interpreter and assistant over the course of 40 years, expresses contempt for *izinyanga,* but nevertheless resolves to bring her schizophrenic son to an *inyanga* for treatment. Makhanye was rebuffed when she was recognised as a Christian (McCord, 1995:235). The ambivalence of Christianised Africans towards indigenous healers mirrors "civilisation-barbarism" dualities so often evoked in 19th and 20th century South Africa by a range of white ethnographers such as A.T. Bryant.

[480] According to a 1944 government report, "About two-thirds of Bantu children get no education, and of those who do perhaps 8 per 100 proceed beyond the second standard [4 years of schooling]. While 90 percent of the Coloured and Asiatic children go to school, only 10 per 100 attend the third standard." The situation for whites was not much better: "[H]alf the European children are out of school by the age of 16. Some 90 per cent of the total reach the Standard VI course but only 11 per 100 reach matriculation standard." Report No. 2 of the Social and Economic Planning Council, cited by the NHSC: *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944): 9.

girls.[481] In areas the IFCH served, data collected by IFCH health educators corroborates that education levels of Indian women in Merebank and Springfield were much lower than those of Lamontville and even rural Pholela.[482] Despite this evidence of restricted schooling for girls, Indian female HEs stressed the centrality of education to their identity.

It is axiomatic that a story-teller may simultaneously reveal and obscure. The aim of narrative analysis is to delve into *why* narrators present as they do. Behind every "distorted" representation are unconscious forces shaping that particular version. For example, Neela Govender's memory of the Menarche Survey reversed the actual findings. She believed the research probed "why are they [i.e.Indian girls] slow in their physical development, reaching puberty, menarche age? Is it cultural?"[483] In fact, the survey found that Indian girls reached menarche earlier than their urban and rural African counterparts. Socio-economic status had a greater influence on the age of menarche than did "cultural" or racial identity *per se*. Girls whose families were in the highest income and educational bracket (in this case, Indian, as whites were not surveyed) had the lowest age of menarche (13.45 years), more than six months earlier than the urban African girls (14.15 years) and fifteen months earlier than the rural African girls (14.88 years), suggesting that nutrition and overall state of health were strongly associated with rates of

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[481] SAIRR, AD 843 1.5 National War Memorial Health Foundation, "The Shortage of Nurses in South Africa", Part Two, Table II, cited in Marks, 1994: 264.

[482] As of 1951, 70% of Indian women in Merebank never attended school, and only 2% reached Standard Six or higher. Whereas in Lamontville, over 50% of African women reached Standard 6, and only 5% never attended school. In Pholela, only 6% of women achieved Standard 6 education, while 38% never attended school. See Kark, S.L. and Chesler, J. "A Comparative Study of Infant Mortality in Five Communities." in Kark and Stueart, 1962: 119.

[483] Interview with Neela Govender, 18 March 2003.

maturation.[484] Neela Govender's inverted rendition of the menarche research may be molded by her "insider" view of Indian girls' development, physical and otherwise. The implication here is that Indian girls should retain some of the innocence of childhood until well into adolescence, a point corroborated by Violet Padayachi Cherry's description of how "horrified" and "mortified" she and her fellow Indian trainees were during lectures on sexuality, anatomy and reproduction: "[W]e knew so little, and what we knew about sexuality we learnt in this course".[485]

The IFCH HEs form a community themselves. Among their different modes of history-telling is an institutional narrative that celebrates their workplace and their membership in a select group that participated in a momentous endeavour. Their interpretations of race relations at the IFCH, the Institute's wider impact as well as recollections of the Karks themselves have, at first glance, a surface consistency: "all races got along", "we did valuable work and people were healthier as a consequence", etc. Only rarely do their personal stories expose fissures in this rendition. For example, Daya Pillay undermines her claim that no friction existed between Indian and African health educators, even after the 1949 Durban riots, with her account of a racist joke that she told to her African colleagues (which supposedly elicited laughter). Violet Padayachi Cherry's anecdote recalling the hostility of African squatters towards her might be influenced by racial anxieties.[486] The HEs' reluctance to disturb the institutional narrative is apparent in the tentativeness of Maureen Michau's testimony describing the disparity

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[484] See Emily Kark's research: Kark, E. 1962:178-186; Kark and Kark 1999:168).

[485] Interview with Violet Padayachi Cherry, 23 May 2001.

[486] Interview with Violet Padayachi Cherry, 14 June 2002. Another possible explanation would point to the intimidating vigilance of illegal beer-brewers.

in status between HEs of different races: "They were seen as, in fact, the thing is, it was a different educational level too...."[487] A similar hesitancy, replete with double negatives, muffles Violet Padayachi Cherry's admission of HEs' inhibitions on the health teams: "I don't know that you would have felt uncomfortable providing input..."[488]

Given the patent inequalities of apartheid-era South Africa, which for instance precluded the widespread training and deployment of black doctors, the IFCH was forced to perpetuate a multi-tiered system, with white doctors and even white HEs at the top of the racial and class pyramid. Violet Padayachi Cherry's comment—"we're the health educators, perhaps at the lowest end of the spectrum"[489]—is a singular admission of the HEs' own awareness of this hierarchy. The racial identities of Violet Padayachi Cherry (Indian) and Pat McLeod and Sheila Shearer (both white) may be a factor in the latter's insistence that the IFCH was "democratic".[490] It must be noted, however, that the health care sector (past and present) in South Africa and elsewhere, is notoriously hierarchical. Even in single-race environments, the position of HEs or CHWs as paraprofessional extension workers is often "at the lowest end of the spectrum" (Werner, 1981; Walt, 1990; Jackson and Brady, 1999).

Gender is another crucial factor shaping the narratives of the HEs. All of the interview subjects except one, were women, though this is not indicative of the gender ratios of the IFCH HEs as a whole: in fact, more male than female HEs were trained and

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[487] Interview with Maureen Michau, 14 Mar 2003.

[488] Interview with Violet Padayachi Cherry, 23 May 2001.

[489] Interview with Violet Padayachi Cherry, 14 June 2002.

[490] Interview with Pat McLeod, 23 May 2003. Interview with Sheila Shearer, 23 July 2000.

employed, reflecting the DOH's preference for non-white male HEs.[491] It is interesting to note that the position of white male health educator did not exist. At first glance, this may suggest that the position was seen as incommensurate with the "dignity" or professional capacities of white men, unlike the more technical post of health inspector. That African and Indian males were considered appropriate for HE work evokes Catherine Burns' argument about constructions of masculinity which "neutered" African males and rendered them suitable for feminised work such as nursing (Burns, 1998). Unlike nurses, the concept of "health assistant" was, from its origins in colonial Java and India to its 1930s South African incarnation as malaria assistants in Zululand, associated with men. As C.C. Anning elaborated in 1937:

> These men, of good address and of sufficient age to carry weight with their fellows, have a background of intensive instruction in the working of the human body, the meaning of infection, the methods of the spread of infectious disease, and the prevention of that spread. They have been equipped to follow up cases of infectious diseases, and the contacts of such cases, to gain the interest and the confidence of the sufferer and their families in order to encourage them to attend at the clinics; to deliver lectures on health topics in beer halls, cinemas and schools; to prepare health pamphlets in Zulu; to inspect and report on defects of housing and sanitation. (Anning, 1937:7, cited in Butchart, 1998).

The introduction of female HEs to health centre practice—initially envisioned by the NHSC—was therefore a novelty, as was the NHSC's unheeded insistence that "there should be equal opportunity and equal pay for men and women performing work of the same nature".[492] Given that IFCH services entailed home visits during the day, the inclusion of female HEs made practical sense. The exclusion of white male HEs, while

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[491] See Jeeves (1997) re: male health assistants. Re: preponderance of male health educators on IFCH staff: UKP H6.2.3 S53/1/45 Letter from Department of Health to Deputy Chief Health Officer, 4 Feb. 1954.

[492] *Report of the National Health Services Commission 1942-44* (Pretoria, Government Printer, 1944, U.G.30-1944): 96.

arguably a manifestation of "de-masculinised" views of African and Indian male HEs, may also have resulted from the lack of an "appropriate" audience of white men at home during the day, given the greater likelihood that white males were employed. Similarly, high rates of African and Indian male unemployment in the IFCH areas provided a ready pool of clients for African and Indian male HEs.

Unlike the programmes for white "lady health visitors" and African "home welfare officers" at Mears School in the Transkei, the IFCH did not impose age, gender, or race restrictions on the HE position. It is worth noting in greater detail the rationale of the Transkei project for selecting only "African matrons" for its training course, as a point of comparison to the inclusive recruitment policies of the IFCH.[493] The director of the Transkei programme, F.R. Mears, deemed "young unmarried African women of the teacher class" unsuitable as trainees, for the following reasons: 1) their careers would be cut short when they married; 2) their audience of "Native matrons" would view them as "inexperienced in home and family duties" and would "consequently resent [their] advice"; 3) they might be "predisposed, as young people often are, to an attitude of condescension in imparting their knowledge to their elders"; 4) their isolation in rural areas would put them in a position "which would become morally dangerous"; and 5) they would expect, as teachers, too high a salary.[494] Such assumptions evidently did not inform the IFCH's hiring practices, despite Sidney Kark's teasing remark to Violet Padayachi Cherry, "There's no point in your taking this course because your family will

[493] This is not to say that the IFCH's employment practices were untainted by racial or gender discrimination. White HEs earned far more than did Africans, Indians or Coloureds, and male HEs were paid more than their female counterparts. Moreover, married women were designated "casual" employees and were therefore denied pension and holiday benefits.

[494] GES 2727 1/70. Memorandum to the Secretary for Public Health Concerning Training and Employment of Home Welfare Officer in the Transkeian Territories, 23 Aug 1946, p. 3.

marry you off and it will just be wasted".[495] Young, single female HEs were not deterred from imparting sensitive information about pregnancy and childcare, and discussions of domestic hygiene were not packaged as mothercraft. At least one female HE felt that her youth and unmarried status, in conjunction with her education, may have enhanced her "professional" position as it so clearly subverted conventional expectations.[496]

In contrast to the Mears project, the IFCH did not appear to inculcate a "colonizing" discourse of health education as inherently "feminine", i.e. for women by women, in the manner suggested by some critiques of contemporary CHW programmes (Ramirez-Valles, 1998; Symonds, 1991) or of the health field in general (Graham, 1985). Female HEs did not make any claims of being innately suited to their work by virtue of their gender. Rather, they emphasised external factors such as their education and training. When discussing their decision to join the IFCH, they accented economic or idealistic reasons rather than social pressures that cast health education as an "appropriate" professional choice of women. For example, both Bala and Neela Govender cited their original desire to become doctors, but financial constraints prompted them to pursue the HE option instead.[497] Neela explained why she did not mind substituting the medical profession for, as she put it, the "wider...more comprehensive" field of health care: "My wish was to be of service".[498] While there may be "feminising" implications to such a statement, it is significant that Neela and her husband conceptualised their motivations in similar terms.

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[495] Interview with Violet Padayachi Cherry, 23 May 2001.

[496] Interview with Neela Govender, 18 Mar 2003.

[497] Interview with Bala Govender, Neela Govender, 21 June 2000.

[498] Interview with Neela Govender, 18 Mar 2003.

The IFCH as a whole did not escape gender-based assumptions that naturalised the respective roles of female and male staff. The maternal and child research programmes were the province of Drs. Emily Kark and Eva Salber; nurses were exclusively female[499], and certain HE duties such as demonstrating the construction of pit latrines, were assigned only to males. Gendered perspectives are threaded through the HEs' interviews; from Violet Padayachi Cherry's remark about the wage disparity between male and female HEs to Neela Govender's self-described "women's lib" anger towards a husband who impassively watched his pregnant wife struggle with onerous chores. Yet where the issue of gender discrimination regarding salary does emerge, it is muted by resignation: "It was just a given".[500] None of the HEs spoke of the racialised wage scales which in a profoundly unequal society were even more of "a given". Their reticence about salary may extend to personal income in general. As Violet Padayachi Cherry observed, "You didn't stand around comparing payslips".[501]

The HEs spoke of the low wages with a kind of rueful amusement rather than bitterness. This might reflect the analgesic effect of time: for elderly people reminiscing about what was for many a first job, the low pay may be remembered fondly as a marker of their economic survival or progress. Only one HE mentioned the lack of a final payment, and even that statement was downplayed—"funnily enough, they couldn't pay us out…".[502]—which could be another manifestation of interview subjects' disinclination

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[499] For more on the feminisation of nursing, see Marks, 1996; Burns, 1998; and Graham, 1985).

[500] Interview with Violet Padayachi Cherry, 14 June 2002.

[501] ibid.

[502] Interview with Neela Govender, 07 Feb 2003.

to portray the IFCH in a negative light.[503] The lack of accreditation for HEs is presented in a jumbled mixture of blame—"They wouldn't give it to us"—and exculpation: "There were pressures from the outside."[504]

Ambivalence also swirled through HEs' contradictory perceptions of the IFCH's "reformist agenda". Though HEs unanimously believed they effected social improvements, they differ about whether their interventions carried a radical message. HEs who rejected the notion that the IFCH or its health education programme was political may have been manifesting their own apolitical inclinations. When Pat McLeod claimed the IFCH "was not political...the atmosphere was congenial"[505], she implied that these two adjectives are mutually exclusive. Similarly, Maureen Michau's avowal that "we were all in a politically charged atmosphere at the health centres" is imprinted with her "conscientised" outlook.[506] Dr. H. Jack Geiger, who gained exposure to IFCH practice during his 1957 internship at Lamontville and Pholela health centres, noted:

> There was a profound limitation....As some senior staff at Pholela and Lamontville bitterly complained, the whole program was cautiously and carefully apolitical. Community organisation never meant community control and never aimed at fundamental social change. The community health centres at Pholela and Lamontville never addressed the roots of disease and poverty in South Africa's oppression and apartheid, and probably could not have and still survived. Health, not liberation, was Kark's concern, and though he surely understood the connection between the two, the health centres never acknolwedged it directly. (Geiger, 1987).

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[503] However, of the 13 interview subjects, only 5 were still employed at the time of the IFCH's downgrading and consequent "retrenchment" of HEs. The remaining 8 HEs had already left the IFCH, and thus would have been unaware of the lack of a final payout.

[504] Both quotes: Interview with Neela Govender, 7 Feb. 2003.

[505] Interview with Pat McLeod, 5 July 2000.

[506] Interview with Maureen Michau, 14 Mar 2003.

While a minority of HEs might dispute Geiger's interpretation, most would probably agree, for their narratives also attest to the IFCH's "cautiously and carefully apolitical" approach. When primary group sessions veered into non-health matters (i.e. education, specifically lack of schools), HEs tended to present this issue as a "community" problem: "It was okay to say, 'You're right to want your children to be educated, it is their only hope...[but] accept the fact that the government is not going to build [schools] for you".[507] The only solution within this framework of non-state intervention was local action: "...so we have to work harder to get schools built, and that may mean making sacrifices".[508] As Butchart and Seedat point out (1990), the apartheid government often wielded the notion of "community" in fragmenting and diversionary ways, placing the onus for change or improvement on people themselves rather than on the state. Similarly, messages about diet and nutrition could imply that eating habits were primarily a matter of individual choice, regardless of socio-economic constraints. Maureen Michau's comment that "you tell people to eat healthily...and often they didn't even have the means to buy the fuel to cook healthy foods"[509] corroborates what an African nurse, Mina Soga, told the NHSC: "I feel that it is cruel to tell a Native child that he should eat this or that because it is necessary for health, while we know and those children know that they have not got that food to eat. One can almost see the look of

[507] Interview with Violet Padayachi Cherry, 14 June 2002.

[508] ibid.

[509] Interview with Maureen Michau, 18 July 2000.

agony on the faces of those children when we mention those things which they should eat".[510]

Despite the IFCH's limited ability to change or even fully address the unequal distribution of resources contributing to health and illness, the health education programme nevertheless held radical implications. By fostering a sense of community and encouraging group efforts such as seed clubs, milk clubs, preschools and, especially, joint planning councils, the IFCH attempted to develop the collective muscle required for broader change. Furthermore, the engagement of primary groups in which the HE played the role of facilitator rather than teacher, enabled the IFCH to establish a forum of discussion and action along lines that would later be identified with Brazilian educator Paulo Freire.[511]

However, even the non-authoritarian IFCH approach did not preclude a sanctioning tone in the health education messages of some of its workers. Pramda Ramasar, who evoked the "stigma of unplanned pregnancy"[512] to induce participation in the menarche survey, could be assailed by a Foucauldean for exercising the coercive mechanisms of bio-power and governmentality. When Maureen Michau instructed

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[510] NHSC, vol. 7, P. 7478, evidence Mrs. MT Soga, President of the National Council of South African Women, cited Marks, 1994, 208).

[511] HEs' role was analogous to Freirian "teacher-learners" who facilitate the dialogical method of "conscientisation" or development of critical consciousness in oppressed groups. According to the Freirian approach, groups of individuals engage in a multi-level process: a) reflecting upon onerous aspects of their daily lives (e.g. problems of poor health, housing, etc.); b) looking behind these immediate problems to their root causes (e.g. the political economy); c) developing a plan of action to deal with these problems. While this programme of awareness is similar in many respects to more traditional approaches to organising for change, such as inculcating a belief that collective action can yield positive results, Freirian methods attempt to eliminate the asymmetrical, often paternalistic aspects of the leader's role in other social action movements (Minkler and Cox, 1980).

[512] Interview with Pramda Ramasar, 23 May 2000.

African HEs in Lamontville that "poverty...can undermine almost everything you do"[513], she conveyed a message with distinctly "disempowering" implications. Neela Govender, in describing the IFCH's work as "a service for the good of the people, maybe the people who deserved it"[514], expressed some of the moralistic tendencies lamented by contemporary critics of public health. While the IFCH may not have intended such elucidations of its principles, it must be considered "responsible" for the various means—coercive as well as empowering—by which its objectives were conveyed and carried out.

Conclusion

By exploring past ventures in community health, it is hoped that contemporary practitioners can draw inspiration from the experiences of the IFCH HEs. In South Africa as elsewhere, health education remains critically important, not only because it might allay some of the ravages of the AIDS pandemic, but also because it could help combat rising rates of non-communicable disorders such as obesity, hypertension, diabetes, stroke, cancer and other "diseases of lifestyle". While such conditions are a relatively new development in South Africa's epidemiological profile (Walker, 2001), other issues reflect the tenacity of certain types of health problems. For example, many communities in rural areas and urban squatter camps still lack clean water supplies and sanitation, and would benefit from the kind of instruction regarding "do-it-yourself" environmental hygiene that HEs gave to residents in Pholela and peri-urban Durban decades ago. Communicable diseases, particularly TB, are again a growing concern, and diseases

[513] Interview with Maureen Michau, 14 March 2003.

[514] Interview with Neela Govender, 7 Feb. 2003.

associated with malnutrition in the young are a persistent blight (South African Health Review, 2002). Above all, despite the advent of democracy in 1994, large sectors of the population remain economically disenfranchised. Thus, the role of poverty as a contributing factor to ill-health is as distressingly evident in the new South Africa as it was in the old. With equity an elusive goal, the IFCH's message regarding "self-help" for disadvantaged communities is still acutely relevant.

To be sure, there are notable differences between the specific roles of the IFCH health educators and CHWs operating in South Africa today.[515] For example, the absence of first aid provision from the HEs' roster of duties demarcates the IFCH paraprofessionals from CHWs who now provide such "outreach" services in areas where formal health care is unavailable. With the urgent necessity of providing palliative treatment for people with HIV/AIDS, many CHWs are overwhelmed with immediate concerns and have insufficient time to do in-depth health education. Another dissimilarity between past and present involves the use of women-focused "primary groups" as a means of enlisting community participation. The emphasis on primary groups in the IFCH health education programme hinged on the availability of women during the day. Until ten or twenty years ago, organisers of grassroots health programmes could rely on such forms of community involvement, for example the volunteer women's "care-groups" who successfully reduced trachoma in the Gazankulu homeland (Sutter, 1979; 1984). However, recent experiences of CHW projects suggest that it is increasingly difficult to arrange group gatherings of women, particularly in rural areas where transport and safety are pressing issues (Knight, 1996). But perhaps the most significant contrast

[515] See Chapter 2.5 for a discussion of the wide variety of CHWs.

between the IFCH HEs and the majority of CHWs presently operating in South Africa is the degree of institutional acceptance enjoyed by the former. Whereas the IFCH gave paramount importance to the inclusion of HEs as valued members of a health team, and fostered intensive group collaboration between HEs, nurses and doctors, current CHW projects are often hampered by inconsistent support from medical personnel, and inadequate linkages with district health systems. National, provincial and district health departments evince a rhetorical commitment to community-based auxiliaries, but their policy is often one of benign neglect (Friedman, 2002). Despite these disparities, there remain many aspects of the IFCH HEs' experiences—particularly the tensions and rewards of their day-to-day duties—that might resonate with their latter-day counterparts. The HEs' perceptions of how communities responded to the IFCH's interventions could kindle constructive debate for policy-makers and practitioners who must consider whether new public health projects will be effective in the long term.

And what of the broader implications of the IFCH vision? As many previous analysts of the IFCH and other NHSC-inspired health centres have noted, South Africa ultimately proved a fallow ground for social medicine and variants such as COPC.[516] Intrinsic to the philosophy of these movements is a reformative relationship between the health sector and the socio-political structure of a particular country. For such approaches to "succeed", there must be discernible results to their efforts to redress inequality. As Victor and Ruth Sidel concluded in their study of primary health care in various developing countries, there is evidence that "only in countries in which there has been a fundamental shift of wealth and power to those who previously had least and in which

[516] See Chapter 2.3 for scholarship about the demise of South Africa's "health centre movement" and later failures to implement COPC on a national level. See also Walt (1990) for a consideration of how few international COPC programmes have fulfilled their promise.

there has been an exercise of that power for the strengthening of equity and community is the model of primary care approached" (Sidel and Sidel, 1977). That the IFCH model of social medicine implemented from 1940 to 1960 failed to foster the kind of transformation advocated by the Sidels does not diminish the palpable benefits which HEs brought to families and communities in KwaZulu-Natal. The IFCH's achievements did not appear limited to the health educators who bore witness to the impact of the Karks' work, and who were profoundly changed in the process.

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Appendix Guide

Appendix 1

Location of Health Centres in South Africa

A 1952 DOH source lists the following 37 health centres[517]:

Cape Province
Walmer
Grassy Park
Cradock
Fort Beaufort
Grahamstown
Knysna
Orange River Settlements
Sandflats
Upington
George
Mossel Bay
Stellenbosch
Alelaide
Kingwilliamstown.
Umtata

Orange Free State
Thaba 'Nchu
Bethlehem and Hobhouse

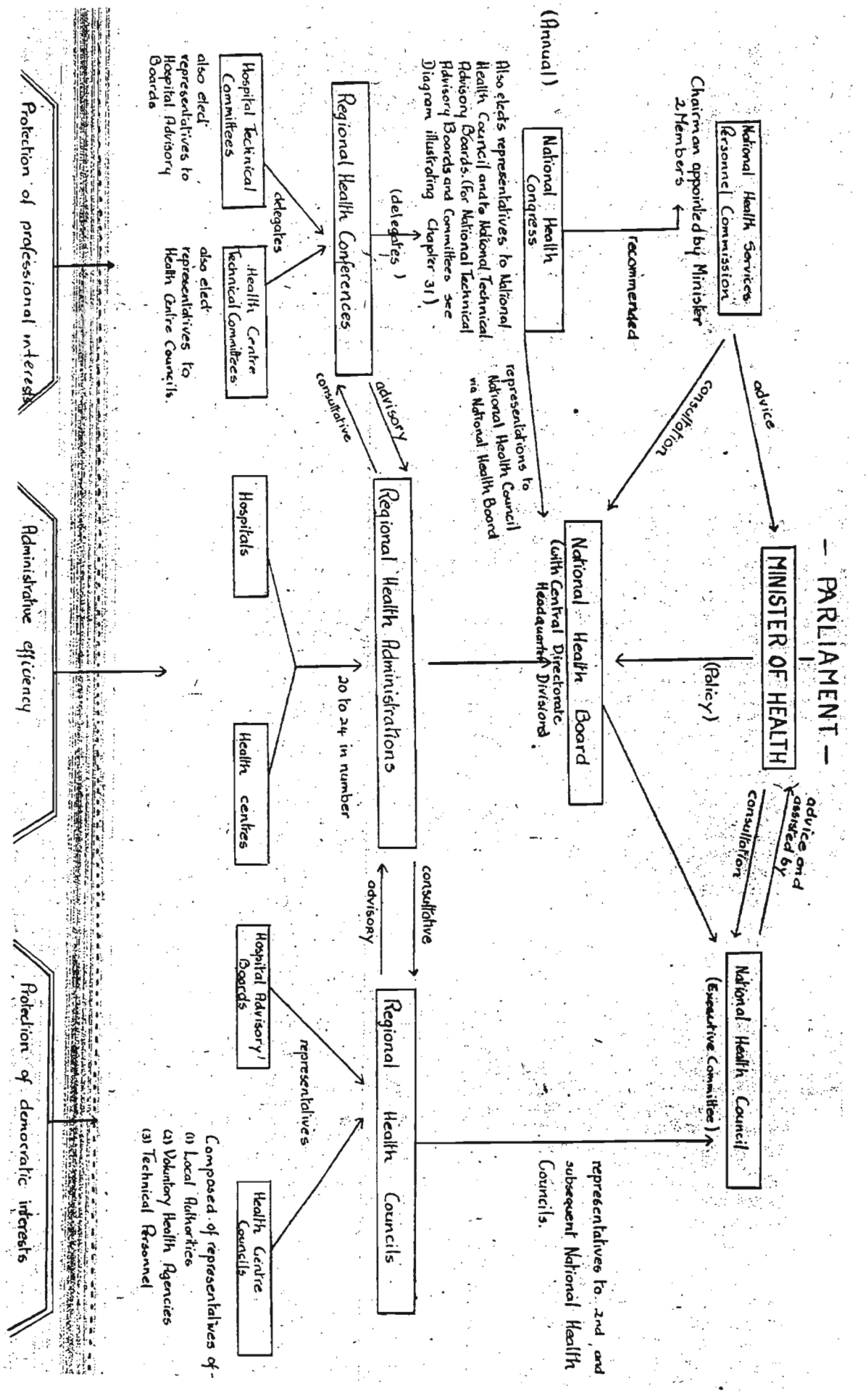
Natal
Gcilima
Newlands
Polela
Springfield (Clairwood: Merebank, Lamontville, Woodlands, Mobeni)
Tongaat
Nottingham Road
Ixopo

Transvaal
Bushbuckridge
Lady Selborne – Pretoria
Alexandra Township
White River
Evaton (Vereeningen)
Randfontein
Groblersal
Bloemhof Ellis Ras

[517] GES 2957 PN5, Letter from Sec. for Health Du Plessis le Roux to the Under-Secretary, 28 Feb. 1952. See also GES 2957 PN5 "Native Affairs Fact Paper VIII, Social Medicine in South Africa", March 1951; GES 2727 1/70A Health Centres. 20 Jan.1948.

Appendix 2

Chart 1: Proposed Chain of Command for National Health Service
(Source: Report of the National Health Services Commission, 1944)



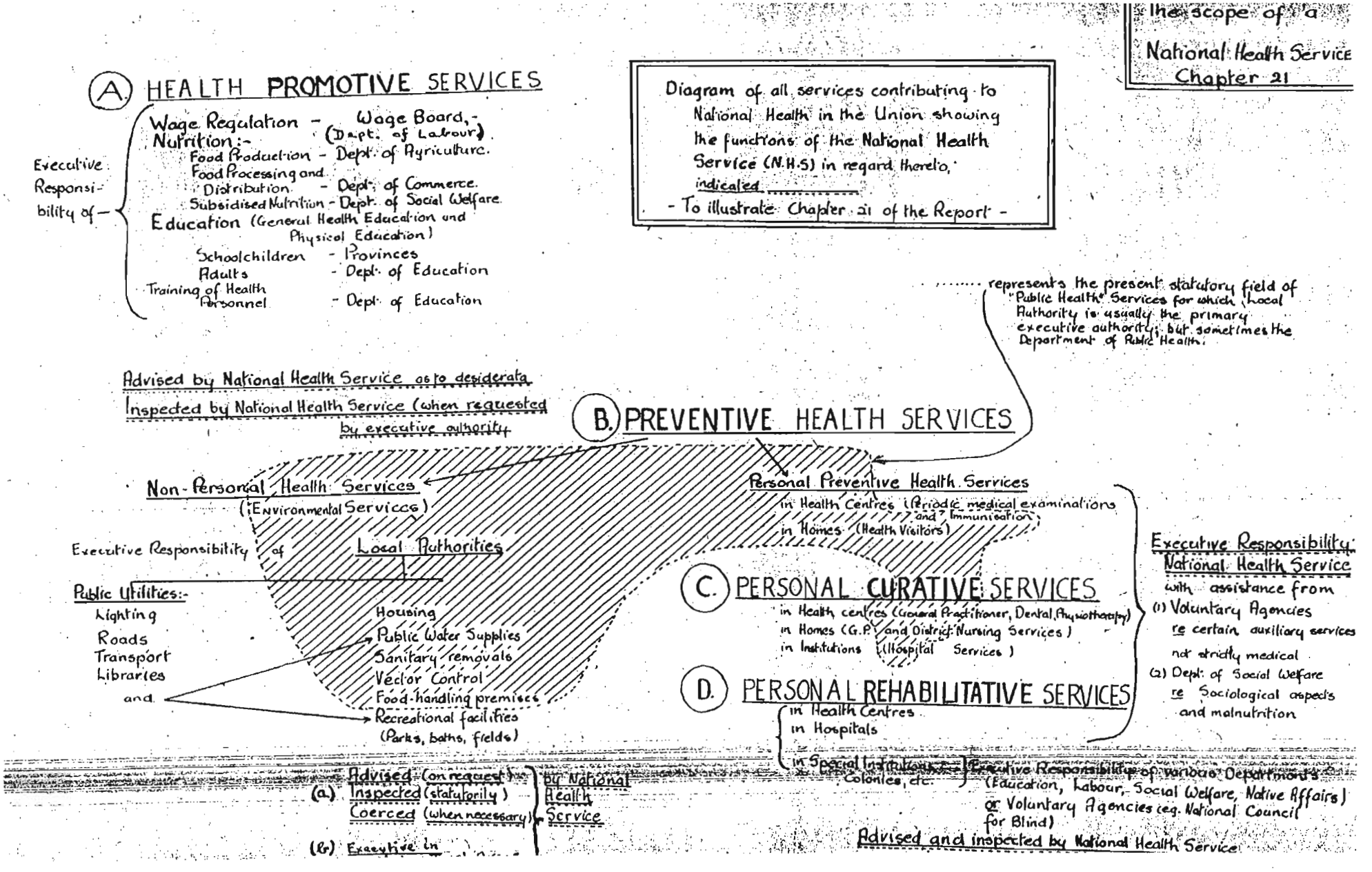
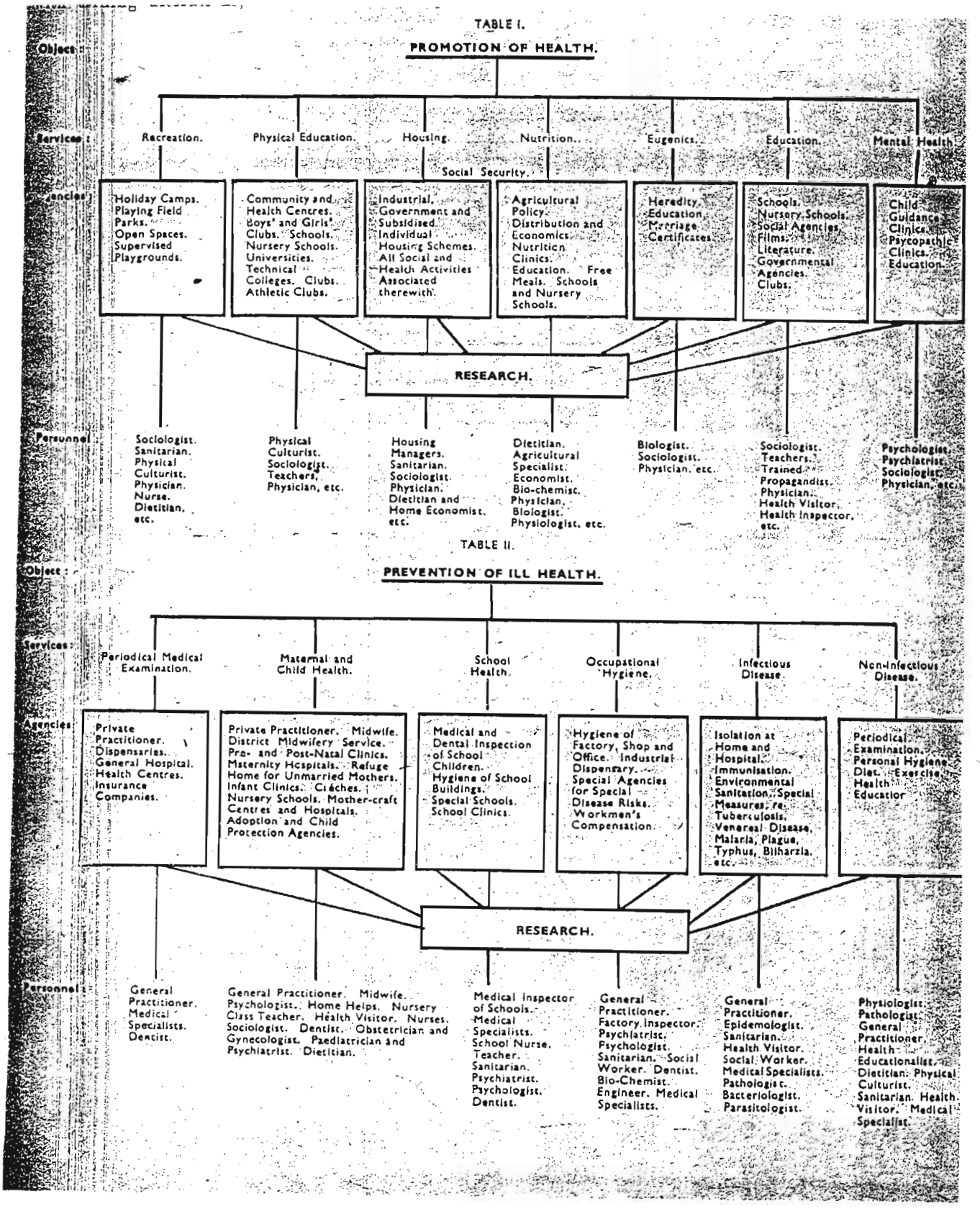


Chart 2: NHSC diagram of division of services
(Source: Report of the National Health Services Commission, 1944)

Chart 3: NHSC definition of research and delivery mechanisms
(Source: Report of the National Health Services Commission, 1944)



Appendix 3

HEs' examination – clinical sideroom

(Source: GES 2727 1/70A Training Scheme for Health Personnel)

TRAINING SCHEME FOR HEALTH PERSONNEL.

FINAL WRITTEN EXAMINATION FOR HEALTH ASSISTANTS (CLINICAL SIDE-ROOM).

22nd March, 1948. 3 Hours.

1. Describe the various types of casts which may be found in urine. Name the various structures sometimes found in urine which have to be differentiated from casts. (20 marks).

2. Describe the cysts of Iodamoeba butschlii. How may these be differentiated from the cysts of Entamoeba histolytica? (20 marks).

3. Write short notes on the following:-

   (a) The Mean Corpuscular Volume. (5 marks).

   (b) Anisocytosis. (5 marks).

   (c) Reticulocytes. (5 marks).

   (d) Leucopaenia. (5 marks).

   (e) Polychromatophilia (5 marks).

4. Describe the lesions which may be produced in the course of infection with Entamoeba histolytica and correlate these with laboratory findings. (20 marks.)

5. (a) What is meant by Acquired Immunity? Describe how immunity may be acquired. (12 marks).

   (b) Describe the laboratory methods used in diagnosing Typhoid fever. (8 marks.).

TRAINING SCHEME FOR HEALTH PERSONNEL.

FINAL PRACTICAL EXAMINATION FOR HEALTH ASSISTANTS (CLINICAL SIDE-ROOM).

1. (a) Make and stain a blood smear.

(Marks were given on the quality of the smear and on the quality of the staining).

(b) Report on the red cells in the numbered slide.

(The slide was that of a case of anaemia showing hypochromia, anisocytosis, poikilocytosis and microcytosis).

2. (a) Stain by Gram's method and report on slides X and Y.

(X was a smear taken from a pure culture of staphylococci; marks were given on the quality of the staining and for identification of the organisms. Y was a cervical smear showing numerous pus cells, epithelial cells, gram positive cocci and gram pos and gram negative bacilli).

(b) Stain sputum specimens A & B by the Ziehl-Neelsen method and examine for Acid-fast bacilli.

(A contained acid-fast bacilli: B did not).

3. Examine chemically and microscopically Urines A,B&C.

(Abnormal Constituents: Urine A: Alb: Trace
Sugar + + + +.
Acebone +
5 pus cells/HPF
3 r.b.c's/HPF.

Urine B: Nil. abnormal.

Urine C: Alb: Trace.
Numerous r.b.c's.

4. Examine microscopically stool specimens A + b.

(A contained Cysts of E. histolytica, E. Coli and I. butschlii.
B contained nil abnormal).

Appendix 4

Sample of IFCH health educator home-visit
(Source: Steuart, 1959 PhD thesis).

INTERVIEW/OBSERVATION SCHEDULE

Introduction

I would like to ask you some questions about what you think of certain matters which might help us give you a better health service.

Date: Name: Address:

Reading Habits

1. Do you ever read?

2. What books, magazines or newspapers do you read? How often?

3. What do you read in these?

News items.
Topical articles.
Fiction.
Religious matters.

Community Needs and Participation

1. With regard to Lamontville as a whole, what would you say the community lacks in the way of amenities or services?

2. To what organisations/clubs do you belong at the moment?

3. Taking those organisations of which you are or have been a member, do you or have you ever occupied a special position such as member of an executive committee or been a chairman, secretary, treasurer etc.?

Illness and Medical Services

1. Who was last ill in your family? How long ago?

2. What seemed to you to be the matter? Describe the symptoms.

3. Was it necessary to go to bed or hospital or did the person carry on as usual?

4. What action was taken?

If an outside service was used, what service was it?

5. In respect to the Institute of Family and Community Health, I shall mention various aspects of its service. Would you tell me about each, whether you think it is very satisfactory or very unsatisfactory, just satisfactory or unsatisfactory, or whether you do not know?

(1) Doctors' clinical care.
(2) Nurse-public relations.
(3) Appointment system.
(4) Nurses' care in the home.
(5) Midwifery service.

(6) Antenatal sessions.
(7) Mother and baby sessions.
(8) Health education service.

Diet.

1. Do you give your children fresh milk daily? If so, at how many meals?

2. Do you use sweetened condensed milk?

3. What foods do you ordinarily serve at each meal of the day? Give a typical menu for each.

Infant Care

1. Do you have at this moment a baby under 2 years of age?

2. How do you usually breast-feed your babies? When you feel they are hungry or need it? or at certain set times, such as every 3 or 4 hours?

3. Place these items in the order in which you think they are important for young children, saying the most important first and the least important last:-

Clothing.	Good discipline.
Diet.	Cleanliness.
Physical Safety.	Protection against illness.

Knowledge of Communicable Disease

1. Against which TWO of the following diseases may we be immunised by injection?

(1) Measles.
(2) Dysentery.
(3) Diphtheria.
(4) Common Cold.
(5) Whooping Cough.

2. Which TWO of the following diseases are infections of the respiratory tract?

(1) Smallpox.
(2) Tuberculosis.
(3) Typhus.
(4) Diphtheria.
(5) Bilharzia.

3. Which ONE of the following diseases can be carried by flies?

(1) Whooping Cough.
(2) Dysentery.
(3) Smallpox.

4. Which ONE of the following diseases can be carried by lice?

(1) Typhus.
(2) Ringworm.
(3) Typhoid.

5. Which ONE of the following diseases can be contracted by wading or swimming in infected water?

(1) Worms.
(2) Scabies.
(3) Bilharzia.

6. Which TWO of the following are diseases of the alimentary tract?

(1) Smallpox.
(2) Dysentery.
(3) Worms.
(4) Measles.
(5) Common Cold.

7. Which ONE of the following diseases may be caused by drinking contaminated water?

(1) Typhoid.
(2) Tuberculosis.
(3) Worms.

Friends

1. Who are the 3 people, in order of preference, with whom you are most friendly? How long have you been friendly with each?

2. If you had a problem of any kind, concerning yourself or your family, to which 3 people in order of preference would you go in the hope of receiving help?

(Give the name and address of each person and also whether they are related to you).

General Comments

Listen carefully to this list of people you know. (Read names of those selected for group inclusion). Try to think of them together, then tell me:-

1. Do you think this group is different from others in the community? If so, in what respects?

2. What topics do you usually discuss with these people when you see them?

3. Do they try to change your and each other's opinions about any matters? Do they ever succeed?

Sanitation
(Observation)

The following items to be scored:-

1. Are there any signs in the garden of this home, of garbage thrown about indiscriminately? If not, is there a receptacle or hole where garbage is placed?

2. Examine the home interior and kitchen, write a short description and rate as follows:-

Very Satisfactory :	Satisfactory:	Unsatis-factory :	Very Unsatisfactory
Walls and floors clean.			Walls and floors dirty.
Kitchen: Dishes clean and stacked.			Kitchen: Unwashed dishes and remains of food left exposed.
Relative absence of flies.			Unusual number of flies.

3. With reference to food and water storage, say whether each is adequately protected at the time of the visit, from flies and dust.

Appendix 5
Theoretical Approaches to Health Education
(Caplan 1990)

Radical Change

RADICAL HEALTH EDUCATION

CORE VIEW

Society is oppressive and alienating. It is characterised by hierarchical and authoritarian institutions of the state, business corporations, the professions, science, work and the family, which cognitively dominate people (political and ideological domination). The very language we have to speak creates and sustains our participation in this form of oppression.

SOURCES OF PROBLEMS

Institutions we inhabit, which socialise and train us, and in which we work. The order which these institutions define devalues, discredits or invalidates alternatives. It affects human consciousness, relationships, and potential, producing alienation and frustration of full personal and communal fulfilment

HEALTH EDUCATION AIMS

Self-discovery through mutual aid and non-hierarchical projects which challenge the necessity of institutional processes. Radical self-help and deprofessionalisation of health care which changes social control systems instead of so-called deviants. Reveal and change the "political" in health.

RADICAL STRUCTURALIST HEALTH EDUCATION

CORE VIEW

Fundamental conflicts and contradictions arising from the economic system which give unequal wealth, power and opportunity to different classes. This determines broadly, the form of social institutions and the state, of which the health and welfare services are but one example. Society is characterised by class conflict and struggle to redress the economic basis of class inequality.

SOURCES OF PROBLEMS

The demands of production and the reproduction of these conditions for capital accumulation (of which profits are a part). Production – occupational diseases and injuries; unemployable and unemployed; occupational stress. Consumption – lifestyle patterns and consumer habits determined by what is produced, e.g. advertising which induces consumer preference. distribution – artificially maintained scarcity for basis needs e.g. inadequate housing, heating, food and clothing.

HEALTH EDUCATION AIMS

Provide a theoretical analysis of the relationship between health, illness and the economic class structure. Link health education to those initiatives which challenge capitalism.

HUMANIST HEALTH EDUCATION

CORE VIEW

Social life is meaningful and proceeds on the basis of the subjective interpretations of participants. Social structures, institutions, roles and concepts of normality are socially created, sustained and changed by people through their interactions with one another. Implicit orientation to integrated, harmonious and enduring social units since it does not focus on political or economic consequences or causes.

SOURCES OF PROBLEMS

Meanings and definitions that people give to their actions or identities are disrupted by events, or reinterpreted or so labelled by others that disorganised or deviant roles, identities and health careers are created. Loss and disruption of taken-for-granted reality produces disorientation and distress.

HEALTH EDUCATION AIMS

Improve understanding of self and others; improve communication by exploring the meanings of problems and events to all relevant parties, reconstruct identities by reframing accounts, representing unheard or unexpressed versions, challenging key labellers, correcting stereotypes.

FUNCTIONALIST HEALTH EDUCATION

CORE VIEW

An enduring and integrated system based on a harmony of interests and common value system. Models and methods of natural science applied to the understanding of human affairs (medical science and epidemiology). The social whole is sustained by social institutions which function in the interests of individual and society, and which is adaptable to change.

SOURCES OF PROBLEMS

Pathological, maladaptive or incorrect (irresponsible) behaviour, habits of lifestyle, or pathological or faulty functioning of organisational and environmental processes.

HEALTH EDUCATION AIMS

Behaviour and attitude modification; or, administrative, legislative and environmental change (social engineering). Social change is not precluded as long as it is based on acceptance of the rules and legitimate institutions of liberal democracy.

Regulation

Appendix 6

Interview Guide

Since a written questionnaire filled out by informants will provide basic information such as age, birthplace, date and location of IFCH training and work, types of courses during training, and summary of post-IFCH job/life, such questions will not be asked during interview.

The interview is organised around the following topics: goals and methodology of the IFCH, gender and race. Given the fluid nature of interviews, questions won't necessarily follow this sequence or wording.

(Note: I will determine what terminology the informants prefer and will use that throughout the interview. For example, informants may use the term "health assistants" rather than "health educators", or refer to the "health centre" rather than the "Institute of Family and Community Health").

Background
How did you find out about the position at the IFCH?

What was it about the IFCH that made you want to get involved?

How did your family view your decision to train and work there?

Goals and Methodology
Describe the goals of the IFCH.

What messages about health was the IFCH promoting?

What were your duties?
(To get a fuller sense of activities, I may ask informants to describe a typical work-day).

What other kinds of activities would you do occasionally?

What kinds of families lived in the area where you worked?

How many people typically lived in a single house? What was their income? How many were employed/unemployed?

What kinds of health problems did people have?

Did you work with groups? In what ways?

Success/Failure

How did people in the community respond to your work?

Did you see changes in how the what people did or how they thought about their health as a result of your work?

Did you see some things staying the same?

If they stayed the same, why do you think they did?

[If HEs characterise their interventions as successful/unsuccessful] what factors do you see as important to that success/failure?

Community Development and Political Aspect of IFCH

Did you see you work at the IFCH as political? In what ways?

Did people ever come to you to discuss non-health related matters? If so, what kinds of issues did they want to discuss?

Self-perception

Do you think that you changed as a result of your work at the IFCH? In what ways?

Did you see your work as leading to something else?

What were the most important challenges to you in doing this work?

What was it that kept you involved?

How did your work affect your personal life and outlook?

Race/Ethnicity

Describe your interactions with members of other racial groups at the IFCH.

Was this the first time you were exposed to other groups in a work setting?

How did you view the health status of the (Indian/African/white/Coloured) community in Merebank and Springfield in relation to other racial groups?

What cultural factors in the [Indian/African/white/Coloured] community in which you worked facilitated your work? What factors made it more difficult?

Gender
Were male and female health educators paid the same? [leading question: they weren't].

Did female health educators perform different activities than male health educators?

Did men and women work together?

Do you feel that your work was easier or harder for you because you are a woman/a man? In what ways?

Memories of the Karks

What are your personal memories of the Sidney and Emily Kark?

Appendix 7

Biographical Sketches of Interview Subjects

Audrey Bennie. (neé Sabela)

Audrey was born in KwaMondi (Norwegian Lutheran) Mission station in Zululand, where her father was an assistant pastor (he later became a pastor in the New Jerusalem church). Audrey met Edward Bennie, one of the first Pholela health assistants, through the church. She came to Pholela in 1936 following her marriage to Edward, whose Scottish surname reflected his mixed-race ancestry. Dr. Kark, having heard that Audrey studied domestic science at the mission school in KwaMondi, suggested to Edward that Audrey work as a HE. She joined the Pholela team in 1943, and continued her work as a HE until 1958, when she decided to spend more time at home with her children. In 2000, Audrey Bennie spoke of her experiences as a Pholela HE at a commemorative session in Bulwer for the University of Natal's International Workshop "Social Medicine and Reform of the Health Care System in South Africa 1940-2000". Audrey was also an honoured speaker at the 2001 opening of the new Pholela Clinic.

Gertrude Sibisi (neé Mpondo)

Prior to training at the IFCH, Gertrude worked as a teacher in various schools in Natal (Clevelands, Georgedale, Newcastle and KwaMashu). She became a HE in late 1940s because it paid more than teaching: Gertrude cited a HEs' starting salary of 5£/month, as opposed to an experienced teacher's 3£/month. (Archival records show that by 1951, African female HEs earned 8.5 £/month). Gertrude worked as a HE with

African families in Springfield (a predominantly Indian area, but with some African shack dwellers), Newlands (African shack settlement, also inhabited by Indian and Coloured families). She did not recall what year she left the health centre but thought it may have been in the mid-fifties. She remained in the health sector, working as a nurse aide at King Edward VIII Hospital in Durban until she was pensioned.

Bala Govender

Bala worked at the IFCH since its inception in January 1946 in Springfield. Previously, he had worked since 1942 as a health assistant for the Edendale Local Health Commission (LHC), directed by Dr. David Landau. While working with the LHC, Bala helped establish an (illegal) health workers' union for African and Indian staff; he went on to became Secretary of this union. He continued to be politically active through his membership in the Anti-Segregation Council. In 1945, Bala saw an advertisement in the Natal Witness for "health assistants" in Durban; he applied and was accepted. While working at the IFCH, Bala met and married Neela Perumal (see below). Bala enrolled in evening courses for a Social Science degree at the University of Natal in the "non-European" division started by Dr. Mabel Palmer, but family and work responsibilities made studying difficult, and Bala did not finish his degree. He later became a lab technician at the IFCH (Clairwood). Bala continued working for the provincial health department as a technician after the IFCH's closure. As a non-white, he was not permitted to write the state medical technology exams until 1960. He passed the exam and worked as a technician in histopathology until retirement. An ardent Christian

Scientist, Bala believes the model of care implemented by the IFCH was essentially non-medical, since it placed so much emphasis on promotive and preventive health.

Neela Govender (neé Perumal)

Neela began HE training at the IFCH in 1949, part of first group of 3-year trainees; she subsequently worked in Clairwood and Merebank health centres. Neela collaborated with Dr. Sidney Kark in the "professorial" unit (CSIR) as a field researcher. She continued working at the IFCH until its closure in 1958. Afterwards, Neela worked for ten years as a "ward clerk" at King Edward Hospital, registering patients. She did not feel her role there was appreciated by the ward nurses, who expected her to be more of a nurse aide. Left the hospital, and found more congenial work as a health educator with the Nutrition Advisory Council (NAC), a consortium of various Food Boards. Based in the Durban area (Chatsworth and Phoenix), Neela conducted a range of activities for NAC, including health talks at schools and community centres, counselling of diabetic groups in hospitals, prenatal and antenatal health, and craft cooperatives. Neela found the NAC's community health education programme quite similar to IFCH approach.

Dayanthee (Daya) Pillay (neé Moodley)

Daya was a member of the final group of HE trainees (1952-55). She stayed on at Clairwood centre until 1956. Daya was the 10th of 12 children; grew up in the Point in Durban (Shepstone St.) While still at Indian Girls' High School, she had formed an Indian Women's Friendly Circle, which organised sporting and cultural events. Daya considered nursing, but decided she was too squeamish to work with any patients except

children; at that time she did not know that nurses could specialise in paediatrics. Prior to joining the IFCH, she worked as a receptionist at Mercantile Printing; she wanted desperately to become a printer, "but because I was a girl, they wouldn't let me." A friend who thought Daya had "good social work skills" suggested that she apply to the IFCH as an HE. Daya worked in Mobeni and Newlands, in the Indian FOSA (TB) settlement. She left the IFCH in 1956 when she got married; thereafter she stayed home with her children.

Salatchee (Sally) Chetty (neé Naidoo)

Sally's father had come to South Africa as a passenger Indian, from an educated family—her uncle was a magistrate. Although her father was not averse to girls' education, Sally was the only one of four sisters to go through high school and work outside the home. After finishing matric in Pietermaritzburg, Sally wanted to study medicine, but her family was unable to afford the fees. As a second choice, Sally applied to IFCH. She began training in 1951 in Clairwood, then worked at Springfield health centre until the following year, when she left in order to get married (an arranged marriage). Her mother-in-law did not approve of women working outside the home, and prevented Sally from writing exams at the Technikon. Many years later (1972-74), Sally did field work research for the University of Durban Westville, Dept. of Socio-Economic Studies. She collected statistics on Indian housing, salary, employment, and education. Sally also had a temporary job with the City Health department in the 1970s, as a family planning counsellor.

Pramda Ramasar

In 1948, Pramda was a 2nd-year B. Soc. Sci (Social Work) student at the University of Natal. Dr. Hansie Pollack, Pramda's professor, assigned Pramda to the IFCH to conduct research with the CSIR unit, as it was one of the few opportunities for field-work training available to "non-European" social work students. Soon after, the Nationalist government cut subsidies for Indian social workers. In 1950, Hansie Pollack set up a trust that funded Indian social workers, and in 1952, subsidies were re-instated, but as Pramda said, "the damage had already been done. After my class graduated, there were no further UND Indian social work graduates for another twelve years." Pramda did not train as a HE at the IFCH; once her work on the menarche survey in Merebank was complete, she returned to her university studies. Pramda joined her husband, a doctor, when he took a post in Umzinto (southern Natal) in the 1950s. For nine years, Pramda worked as a volunteer social worker for the Child Welfare Society, serving Indian sugar-cane cutters. She had to overcome "hurdles with the other members [of the Child Welfare Society], who had narrow ways of thinking about family, about girls." When Pramda and her family returned to Durban, she joined the Department. of Welfare as a social worker. In 1965 Pramda participated in an international study programme at Case Western University in Cleveland, PA, where she subsequently obtained her doctorate in Social Work. Pramda taught in the social work department at the University of Natal and at community colleges.

Violet Padayachi Cherry (neé Naicker)

Immediately after matriculating in 1949, Violet began training at the Clairwood IFCH, where she worked primarily in Merebank. Violet left IFCH in 1956 for the Meyrick Bennett Children's centre, a UND Dept. of Psychology-affiliated Child Guidance clinic for "non-white" children. She obtained her B. Soc. Sci (Social Work) degree through UND while at the Meyrick Bennett centre and later rose to the position of Chief Psychiatric Social Worker. Through scholarships, she began summer training sessions at various psychiatric institutions in England and the U.S. Violet found racism in South Africa increasingly insupportable; in 1967 left permanently for United States. When she arrived in New York, Violet was summoned to the South African consulate where officials confiscated all of her identification papers, rendering her a "stateless person" until she obtained U.S. citizenship in 1976. As a scholarship student, Violet completed her M. Soc. Work at Columbia University (1969) and later her MPH at the same institution, while working as Chief Psychiatric Social Worker at Columbia's Adult Psychiatric Clinic. After leaving Columbia's clinic in 1973, she served for a year as acting director of the Inwood Mental Health Centre in Washington Heights. From 1974 until the present Violet .has been the Health Officer and Director of Health Services for Englewood, New Jersey.

Joan Maryana (Maureen) Michau

Maureen was a social work graduate in 1949 when she began working as a HE in the Clairwood IFCH; she stayed until 1954. She trained African HEs who were working in Lamontville or who were waiting to be assigned to rural health centres. She left the

IFCH "not because [she] thought the end was in sight, but because [she] got a much better paid job at the Durban Museum, where [she] was a museum educator to 15 years." She later received a Masters of Social Work from the University of Natal and her doctorate in Social Work from UNISA, after which she taught social work at the University of Zululand. However, she came to believe that "social work in this country was predominantly palliative because of the overwhelming case loads and lack of resources." She decided to switch to education, because "if you educate one teacher, that person can do so much." She qualified as a teacher and took a Masters degree in Education at the University of Natal, staying at that faculty as a professor until she retired.

Pat McLeod (neé Lewis-Boardman)

Pat had a Bachelor of social work degree before joining the IFCH in 1950, staying until 1954. For the first two years she worked in the Industrial section of Mobeni and for the latter two years did nutrition research in Lamontville and Woodlands under the direction of Emily Kark. She worked extensively with teachers in Lamontville, enlisting their support for IFCH programmes and reserach. After leaving the IFCH, she did her Honours in Social Work, and worked part-time as a social worker with various agencies including Child Welfare, Rand Aid (rehabilitation for alcoholics), Midlands Hospital, Umgeni (mentally challenged adults) and in personal care facilities for the aged.

Sheila Shearer

Sylvia worked at the IFCH in Woodlands between 1949-51. As a Masters graduate in Psychology, Sylvia worked closely with IFCH psychologist Dr. Guy Steuart (also head of the Health Education programme), serving the white population of Woodlands. After leaving IFCH, Sylvia worked as a psychologist for "non-white" children at the Meyrick Bennett Child Centre and later at the Children's Assessment and Therapy Centre. Since the 1970s, Sylvia has directed the Child Guidance Clinic, where she put into practice lessons learned at the IFCH about "a preventive approach: working with parents to prevent problems."

Charmaine Philcock

In 1948, having recently completed her Social Sciences degree, Charmaine was assigned to the IFCH for a year of field experience. In contrast to the three-year training of "non-white" HEs, Charmaine and her fellow white social work graduates trained for about a year under the tutelage of Nancy Cauverel (Ward), though Sidney Kark also lectured. Nancy worked as an HE out of two IFCH health centres: Woodlands, a "brand-new area that provided cheap housing for ex-servicemen" and the Coloured centre at Merebank (which also served Merebank's large Indian population). Charmaine also worked at the IFCH-directed nursery school in Clairwood, observing children with behavioural problems. After leaving Clairwood in 1950, Charmaine married and lived in Zimbabwe for twenty years, where she worked as a voluntary social worker, doing child welfare. She returned to South Africa in the mid-1970s.