"People Wherever I Go Believe that I am a Doctor, but in Thinking that they Flatter Me …": Black Community Health Intermediaries in South Africa, 1920-1959

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> Almost before the clatter of hooves heralded his approach, a Zulu horseman emerged from the chill winter mist which enshrouded the valley. He was dressed neither in blanket and skins nor in the less picturesque but more common rags of the "tribal" Native. His clothes showed him to be a man of some education, a teacher perhaps … He made his way up the steep hillside to the stoep of the clinic and with him on the horse was a very young Native child. This rider was one of the Native health assistants who do much of the 'field work' at the State's national health centres, and the child with him on this equine ambulance was from the huts down by the river. He was in urgent need of treatment. The arrival evoked little interest; it was simply another of the frequent comings and goings at Polela, where every day is a busy day.[1]

During the mid-1940s – in a climate of liberal health reform – the South African Department of Health trained and employed black "health assistants" who formed the frontline health care providers in the National Health Services network based on Health Centres. Rather than training large numbers of black doctors, which was viewed as a threat to the white medical profession, and too expensive and time-consuming in a situation of desperate ill-health in black rural areas, the South African State instead created a large force of subordinate black "health assistants" or "auxiliaries" to serve black communities in a racially segregated service.

However, the above quotation highlights the work of only one of several different types of subordinate black health workers who were trained and employed during the first 4 decades of the 20th century. While the bulk of my paper will be concerned with analysing the work and experiences of black State-trained community health workers (CHWs) in the first experimental Health Centre situated in a black rural reserve area in Pholela, Natal – upon which the others in the country could be modelled – I will also analyse earlier Christian missionary and official State attempts to train and use black auxiliary health workers. Although aware of the work carried out by indigenous African healers during this same period, my focus will not be on their contributions. This aspect of African healing has been actively researched by numerous scholars.[2] In this paper, I wish to focus on a far less researched area, namely the complicated experiences and relationships of subordinate black auxiliary health personnel who were trained and worked within "Western" biomedical systems in South Africa.

Throughout this paper, I will use the term "intermediary" as a place-marker to flesh out a range of social and hierarchical relationships that were "middle" in one sense or another. In recent years there

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[1] SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B, 1940-52. Native Health and Medical Services. Polela Unit. General Matters. "Social Medicine among the Kraals of Natal: Modern Methods of Health Propaganda oust the Old-time Witchdoctors of Polela by Alastair Matheson," n/d, 1. In the written sources, the Health Centre I will be focusing on was spelt in two ways: "Pholela" or "Polela". I will use "Pholela" even though both refer to the same place.

[2] See Steven Feierman and John M. Janzen (eds), *The Social Basis of Health and Healing in Africa* (California: University of California Press, 1992) and Catherine Burns, "Louisa Mvemve: A Woman's Advice to the Public on the Cure of Various Diseases," *Kronos: Journal of Cape History* 23 (November 1996). Burns' article explores the ambiguous and largely precarious existence of an African woman healer who traversed many boundaries between "Western" and "traditional" medical systems as she tried to create a niche for herself as a new kind of medical broker. While her practice as "midwife, healer, herbalist, diagnostician and innovator of cures" was eventually undermined by the growing exclusionary power of the racist S.A. State and medical profession during the 1930s, she provided a valuable health service to many people.

has been a growing number of innovative works about intermediary figures by historians and anthropologists in their efforts to understand the intricate web of relations in colonial and postcolonial encounters. In many of these works, colonialism was been viewed as a multi-layered and messy "engagement" or multi-sided dialogue, not between all powerful colonisers and weak colonised groups, but between ordinary people endowed with few resources and only partially coherent motives.[3] This was especially true of highly contested health spaces.[4] In this paper, I will explore the complex asymmetrical power relations between various groups of black health intermediaries, who engaged with, and importantly bridged the social, cultural and language divides between sections of the white ruling classes (its medical doctors and "Western" biomedical ideas and practices), and the racially, economically and politically oppressed rural black communities they served.[5] I am interested to explore both the situational but also individualised development of different health brokers. I will argue that in the rural peripheral health spaces of South Africa during the early 20th century, the emergence of health intermediary figures was simultaneously a method devised by individuals and institutions from "above" and a process of creative expression and brokered negotiations from "below". I will show that by straddling the "inbetween" spaces and mediating between white doctors and different levels of the black local community, some intermediaries were able to make gains in terms of social status and material privilege, but also faced a more difficult set of problems in managing the ties and gaining resources that went in both directions.

While the term "intermediary" was not used by medical or Government officials in the health records, the sources do imply that the racial segregationist State considered that these black auxiliary workers would serve in an in-between position in the public health service hierarchy. This would ensure a large black health work force but also prevent black health personnel gaining an equal professional footing with white medical doctors. Due to the largely official nature of the sources I was able to gain access to, it was very difficult for me to "hear" the individual voices of different black health workers, or to ascertain, their own views about their in-between and mediating statuses. I was also not able to access the views of the local black communities they served. It is only by using the mediated, but highly descriptive evidence presented in missionary and State accounts, that I have been able to flesh out something of these intermediary roles.[6] I will also use autobiographies, biographies, interviews and letters to tease out the importance and complexity of their work.

I will start my analysis of this paper with the early curative Christian missionary and then State "Medical Aid" forms of black health worker training and work, before discussing the approach

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[3] See Jean and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa,* Vol. 1 (Chicago and London: The University of Chicago Press, 1991) and *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier,* Vol. 2 (Chicago and London: University of Chicago Press, 1997) and Frederick Cooper and Ann Laura Stoler, eds., *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley, Los Angeles, London: University of California Press, 1997).

[4] See Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalisation, and Mobility in the Congo* (Durham and London: Duke University Press, 1999). Hunt's work on health "middle figures" in the Belgian Congo has been most enlightening in this regard. Also see Stacy Leigh Pigg, "Found in Most Traditional Societies: Traditional Medical Practitioners between Culture and Development," *International Development and the Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley, Los Angeles and London: University of California Press, 1997).

[5] While using the terms "traditional" and "Western" to refer to the different types and experiences of healing systems, this will be done in quotation marks to highlight my recognition that such terms were often imposed by people from "the West", had very different meanings for people encountering these systems on an everyday level, and that these categories were not homogenous but made up of diverse healing traditions.

[6] Official State, missionary and Health Centre terminology for these subordinate categories of black health workers varied over time, and were often used interchangeably in the records, such as "health assistant", "health auxiliary", "medical aid", "community health worker".

adopted by black CHWs at Pholela during the 1940s. This will help me to show the historical progression and shifting development of State and medical personnel thinking around the training and employment of subordinate categories of black health workers to remedy the large problem of much preventable ill-health in South Africa's segregated black rural communities. This historical approach will also facilitate my analysis of the shifting middle positions of health intermediaries in South Africa. During the first 5 decades of the 20th century, there were many different types of subordinate black health workers trained, who engaged in multi-directional relationships with white doctors and different social classes of local black communities. I will demonstrate this by tracing the life story of a Zulu intermediary figure, Edward Jali, who complicated the State's, and my own, understandings about the middle positions black health workers occupied over the years. I will analyse how Jali moved from being a Christian mission health assistant to a State-trained Medical Aid during the 1920s and 1930s, and later, during the 1940s worked as a senior level CHW at the Pholela Health Centre. What is interesting about these early Christian missionary and State-training health worker schemes was their relationship to one another. They did not simply follow each other sequentially either – as I will demonstrate in the life and work of Jali – but formed parallel, and often overlapping efforts to train different categories of black auxiliary workers. Jali's life history shows how the movement of black health workers from one institutional setting to another often blurred and complicated established boundaries. In this paper I hope to show some of the multi-layered engagements and complex webs of relationships between different categories of health workers and the communities they served in the peripheral spaces of a racially segregated country.

The Early Medical Missionary "Health Assistant" Tradition

Until the early 1930s, "Western" biomedical health care services for black communities were left to a small cadre of missionary doctors and nurses scattered throughout remote rural areas.[7] From the late 19th and early 20th centuries, Christian missionaries were also at the forefront of training black health assistants, nurses and eventually doctors. Missionary doctors provided curative biomedical treatments and trained various health workers in "simple" first aid work in an attempt to halt what they saw as the harmful "witchcraft practices" of indigenous healers and to spread Christianity. Many of the Christian health "recruits" had been early converts or had been treated by the missions for personal illnesses. These early black health auxiliaries were greatly influenced by their Christian beliefs in devotion, self-sacrifice and duty to work for their communities. As one early recruit asserted in a letter:

> My duty is not to examine patients and prescribe some wonderful drug but to teach people better ways to live. It is the kind of work a Christian should do, the work Christ did while here on earth. He wandered from place to place teaching the people. Now and again He healed the sick and raised the dead.[8]

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[7] See M. Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa* (Sandton, RSA: Mariannhill Mission Press, 1984) and Randall M. Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg: UN Press and James Currey Publishers, 1989). The history of South Africa's health care provision was directly influenced by unequal racist segregationist policies. Until the 1930s, South Africa was ill-served outside "white" urban centres by any organised form of health service. Health care provision for the majority of blacks in rural areas was not recognised (other than occasional sporadic campaigns to stop the spread of epidemic diseases) and was bandied from one department to another. Health services were based not on people's needs but on their ability to pay, and white doctors were not prepared to carry out their services in poor black rural areas.

[8] James B. McCord, *My Patients were Zulus* (New York and Toronto: Rinehart and Company Inc., 1951), 273. Letter from Edward Jali to Margaret McCord, 9 April 1940.

Missionary doctor records, such as those of Dr. James McCord (an American Board Missionary in Durban) provide important historical sources about medical mission work in South Africa as counterpoints to the official Government and medical documents. And importantly for my interests, McCord's autobiography, *My Patients were Zulus,* while a mediated text written through the eyes of a white medical missionary, provides a rich commentary on the lives and experiences of early black health intermediary figures. McCord was one of the first missionaries in Natal to train and employ African health assistants to "serve their own people" in a racially segregated health service as he realised that few white doctors were willing to work amongst poor African communities at the time. McCord hired many health assistants to ensure the orderly running and cleanliness of his clinic and as interpreters whose loyal and devoted service he depended upon, as he recalled:

> [Umqibelo] was a useful assistant. He washed bottles, kept the dispensary gleaming, served tea to patients who had sometimes walked as far as forty miles for treatment, and read the Bible and acted as a general evangelist in the waiting room …[9]

In his autobiography, McCord spoke a great deal about the important work of his "general female assistant and interpreter" – Katie Makanya – in the consulting and examination room: "with Katie in my consulting room, my knowledge of Zulu rounded out. And the hospital was more cheerful for her presence".[10] In McCord's view, Katie Makanya was a valued assistant as she helped enormously to calm new and nervous patients:

> Katie had proved a valued assistant … she didn't fail me now. I watched her approach the stranger, and though I couldn't hear what she said, her good nature had its effect, for the woman smilingly followed my assistant inside.[11]

Before Katie Makanya's death in 1955, Dr. McCord's daughter Margaret McCord, interviewed and recorded Makanya's oral testimony of her life experiences and opinions, which was used to compose her biography entitled, *The Calling of Katie Makanya.*[12] An essential part of the book is Makanya's life as Dr. McCord's nurse and interpreter during the early 20th century. With knowledge of "six native dialects," Makanya was invaluable to McCord in his consulting room. In this capacity, Makanya can be seen as an intermediary who helped McCord understand, diagnose and medically treat his African patients. Devoted and often in great awe of the work McCord did for numerous African patients, in her oral testimony Makanya also highlighted more of her experiences of the authoritarian and paternalistic nature of McCord's relationship with her. These asymmetrical power relationships were cross-cut by gender, race and class dimensions as is evident in McCord's assignment of menial medical duties to his assistants.[13] Although Makanya would assist Dr. McCord on his trips to remote rural homesteads, Margaret McCord argues in Makanya's biography that: "he never trusted her to give the ether. 'It's too great a responsibility', he said".[14] His concept of training so that people like Makanya could "serve their own people" was at one and the same time a tacit acknowledgement of the possibility that black people had the potential to become skilled medical personnel and yet maintained at its core the separateness of white-controlled medical knowledge and practice as the norm or standard, while blacks continued to remain a racial and professional "other".

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[9] McCord, *My Patients were Zulus,* 59.
[10] McCord, *My Patients were Zulus,* 60.
[11] McCord, *My Patients were Zulus,* 107.
[12] See Margaret McCord, *The Calling of Katie Makanya* (Cape Town and Johannesburg: David Philip Publishers, 1995). As a child, Margaret McCord had lived with her parents in Durban, and had grown up knowing Katie Makanya.
[13] McCord, *The Calling of Katie Makanya,* 156.
[14] McCord, *The Calling of Katie Makanya,* 162.

In her oral testimony, Katie Makanya also raises some of the tremendous difficulties she experienced as a working mother and wife, who because of her work in the city of Durban, was separated from her husband and older children living on the rural Adams mission station for long periods of time. Makanya had her small children with her, which made balancing all her responsibilities difficult, as she relayed to Margaret McCord:

> Margaret slept in one [bed] and Laura snored in the other, her arms cradling Sagila. Poor child! In the flickering light Katie could see that his face was still puffed up and streaked with tears. When the Doctor called her, she had promised to come back in just a while, but her work had kept her away. For a long time after she blew out her candle, she stared into the darkness wondering how often other women would have to wipe away Sagila's tears. She wondered, too, about Samuel coming home from school to an empty house, and Ndeya sleeping alone. She must have been crazy to leave her husband behind and divide her children.[15]

A tragic example of the great demands her work placed on her is evident by the death of one of her children from diphtheria. While in quarantine, McCord would visit Makanya and her family regularly to swab their throats. Katie Makanya testified about her anger at McCord at this time:

> [he] always brought her something – a bunch of flowers from his garden, toys for the children, a bag of toffees. He tried to comfort Katie with words, but she would not be comforted. What did he know of grief? It was her child, not his, who had been sacrificed for the work.[16]

She eventually stopped blaming Dr. McCord for unknowingly having kept her busy at work and for keeping her away from her sick child. Her strong Christian beliefs of self-sacrifice and devotion to serving her people influenced much of her testimony. This vocational nature of black health assistant views was a characteristic marker of missionary health work and is an important attribute to note for later comparison to professional State-trained health assistants. Despite these negative aspects, there were also glimpses of greater community respect endowed upon her because of her intermediary position. This is evident in her sister's comment that "I hear you are a big person among these Zulus" and another specific incident that Katie Makanya remembered:

> [the women] bobbed their heads in respectful greeting. Katie felt strange, she was not old enough for such deference. Even inside the store the other customers stepped back, clearing a path for her … [they had] heard she was nurse to the missionary doctor.[17]

James McCord, together with another ABM doctor, Alan Taylor, also provided the first private but professionally inferior attempt to train black medical students in 1921.[18] However, the medical authorities responsible for registering medical practitioners refused to recognise any inferior qualification for blacks that might undermine the high professional standards of the white medical profession and forced McCord and Taylor to abandon their efforts within a year. What was important

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[15] McCord, *The Calling of Katie Makanya,* 169. Margaret and Sagila were Katie's children. Laura was the child carer.
[16] McCord, *The Calling of Katie Makanya,* 199.
[17] McCord, *The Calling of Katie Makanya*, 159.
[18] McCord, *My Patients were Zulus,* 221-229. They believed that it was better to move slowly than make no progress at all. During the early decades of the 20th century, SA's existing medical schools were racially segregated and excluded blacks who were forced to go overseas for training. It was only in 1945 that black doctors qualified in SA for the first time after a great struggle to gain admission into "white-only" medical schools. However, their numbers did not exceed 5% p.a. as admissions into universities were riddled with reservations and quota systems.

about this failed medical training attempt was McCord's early association with Edward Jali, a Zulu man who came to work for McCord in his dispensary as a Christian health assistant. Jali's life and work highlights the various categories of health assistants that were trained to work in different capacities for mission doctors like McCord. As my next section will discuss how as a mission-educated African man, Jali was given the "opportunity" to train as a State "Medical Aid".[19] The fact that Jali was chosen to study further and not other women health assistants demonstrates the gender inequalities in operation in missionary and wider societal thinking at the time. When the first State "Medical Aid" training was offered in the mid-1930s, it was only educated African men like Jali who were given the "opportunity" to better their medical education. Women health auxiliaries, such as Katie Makanya were not. While Jali would move away from working with missionary doctors like McCord to work in the State public health service, Makanya remained as McCord's assistant until her retirement in 1940. But, as I will show in the next section on State Medical Aids, early Christian health assistants like Jali took their Christian teachings and values with them, as well as their ideas about health work as a vocational duty and self-sacrifice to the black communities they worked for. Figures like Jali blurred Christian missionary and State understandings about the nature of health work and professionalism.

The State "Medical Aid" Training Scheme

From the late 1920s, the State (working together with missionary and other medical bodies) legislatively attempted to close down what it saw as competitive, "harmful" and "backward" indigenous African healing spaces.[20] The impact of this, together with the lack of fully qualified black doctors in the country to have any appreciable effect upon the racially segregated medical services, forced the State to address the growing ill-health and inadequate health services in black rural areas as the years progressed. It was here that another type of black health intermediary would play a vital role. Having analysed the early small-scale and individual-based training of health assistants by missionaries, I will now analyse the State's Department of Public Health's (DPH) debates and attempts to train another form of health auxiliary – the black "Medical Aid" – on a large-scale basis. During the inter-war years discussion about the nature, distribution and cost of health services was a prominent feature of South African politics. Discussion over the kind of "State Native Medical Service" and profession to be established became embroiled in the dominant racial political battles of the day, where the preservation and dominance of white political power determined how the profession was "created" and how the health resources for communities were to be distributed. Analysis of the many early efforts and delays reveals that opinion was split over arguments for the provision of a full medical qualification and stronger arguments for an inferior or "second rate" Medical Aid scheme. This was aided by an increase in discriminatory racial segregation legislation during this period.

In 1933, a new course was recommended by the Interdepartmental Government Committee on Native Medical Education, which advised the establishment of a 5-year "Medical Aid" course similar to the French West Africa health scheme. In this scheme, large numbers of subordinate black medical "auxiliaries" were limited to "practice" in segregated and defined areas and worked under the control of white Medical Officers.[21] This recommendation was supported by missionary bodies who wanted to see an end brought to the work of "traditional" African healers, and by the white medical profession who supported a professionally inferior medical training scheme for black students who would work in

[19] During the early 20th century, the few S.A.-educated Africans had received their education from missionaries.
[20] See Burns, "Louisa Mvemve". The 1928 S.A. Medical, Dental and Pharmacy Act legislatively tried to exclude other competitive "traditional" healing systems that catered for the majority of black communities. However, these healing systems were never completely dislodged from their African communities despite legislation.
[21] See Karin A. Shapiro. "Doctors or Medical Aids - The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s," *Journal of Southern African Studies* 13, No. 2 (1987).

a segregated black health service in rural areas. The sources imply that the State considered that these black auxiliary health workers would serve in an in-between place in the public health service hierarchy, which would prevent their gaining an equal professional footing with white medical doctors. The course commenced in 1936 at the black University College of Fort Hare. It was not a registrable medical qualification comparable to a full medical curriculum, as the medical subjects were not as thoroughly treated. The course provided a special training along curative lines for a new category of health personnel who would work for the State in rural areas under the supervision of District Surgeons.[22] It was argued by the Secretary of Health, Edward Thornton that the course would be cheaper, would require a shorter training period and would be "better suited" to an "inferior" African secondary education than the full medical training courses offered at the "white" university medical schools:

> At risk of being considered reactionary, I venture to plead more for mass production to meet the urgent need of natives in the stage of development as it exists at the present in their Reserves, rather than a few specialised articles whose sphere of usefulness must of necessity be limited.[23]

The training was restricted to "Native males" who were judged "reliable", of "definite standing" and "good character".[24] Four black students were enrolled in 1936, including Edward Jali.

In 1940 Edward Jali, after completing his Medical Aid training, wrote two letters to Dr. James McCord and his wife Margaret. While there are problems with using these personal letters, which were chosen by McCord to include in his autobiography, they still provide some understanding of the experiences and work of early black health intermediaries in Natal.[25] One of the letters demonstrates some of the material social gains individuals like Jali could attain in ambiguous intermediary positions. The letters are also noticeable for Jali's enormous gratitude to McCord for giving him the opportunity to "better himself" materially through education, as Jali wrote:

> The contrast between my life now and what it might have been is not far to seek. My own brothers, less fortunate than me, work for two pounds and ten shillings a month. I work for fifteen pounds. On the other hand I have got the highest medical education South Africa offers the Bantu race.[26]

However, the letters also highlight how some black health workers such as Jali fit ambiguously into the ideal of professional health service as a paid State employee. In the next quotation, one can see how

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[22] SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. 1942 Medical Training of Natives Report, 4 and SAB, GES, Vol. 2271, Ref. 61/38B, 1933-38. Native Medical School. Training of Native Doctors, Health Inspectors. Letter from E.H. Cluver, Union Health Department regarding "Native Medical Aids", 10 March, 1936.

[23] Shapiro, "Doctors or Medical Aids," 248.

[24] See SAB, GES, Vol. 2271, Ref. 61/38B, 1933-38. Native Medical School. Training of Native Doctors, Health Inspectors. Letter from E.H. Cluver, Union Health Department regarding "Native Medical Aids, 10 March, 1936. None of these posts were available in the Public Service to "Native women students and Indian and Coloured students" (of either sex). It was argued that Medical Aids should undertake duties in "Native rural areas only" and that only African males were considered suitable for the conditions under which they would have to work in rural areas.

[25] See McCord, *My Patients were Zulus,* 217. McCord had been centrally involved in the training debates of black health personnel to provide health services for black communities. As McCord argues for the reason he included the letters: "[I included them] to give glimpses of the change the work has brought into the lives of the young men who became medical aides, of their unselfish work for their people, and of the useful medical service they are giving".

[26] McCord, *My Patients were Zulus,* 271-272. Letter from Edward Jali to James McCord, January 1940.

Jali's earlier Christian missionary values about health work overlapped with his new State-training as a Medical Aid:

> I have come to the end of my training. I am now fit to go out into the world. Now I have to begin life not for myself, but as you yourself have done. I will give myself for the service of my people. As I go about my work I will always remember how you went about yours. Everything done with a smile, love and devotion. You have been an excellent example for me.[27]

Black Medical Aid focus on devotion, duty and self-sacrifice to work for their black communities often complicated the State's understandings of black auxiliary professional and salaried work.

However, by 1942 only 12 of the anticipated 30 Medical Aids graduated, which led to another Government inquiry into the training scheme. A modified version was implemented in 1943.[28] It is difficult to gain access to the direct voices and opinions of these black health auxiliaries to this training scheme, but it is possible to extrapolate something of their dissatisfaction from the numerous reports of Government committees, which were set up explicitly to deal with black medical training problems. There were numerous reasons why the scheme floundered. Students and several overseas-trained Africans, such as Dr. A.B. Xuma objected to the unequal medical qualifications black students would receive. Xuma argued that the inferior qualification was racist and represented a "false economy" which was placed above ethics or professionalism.[29] The Medical Aid course proved to be very unpopular with black students as the "near-medical" training produced personnel with an incompetent curative training compared to white medical students. As the 1942 Government Committee of Enquiry Report noted:

> The first batch, or two were appointed to departmental institutions. There they were under the immediate control of resident medical officers, and their duties were in the main restricted to those of male nurse and orderly. This … produced dissatisfaction among them, as they had been trained to do very much more and had been led throughout their training to expect that they would be given independent posts where they would practise virtually as doctors.[30]

Many white doctors also objected to the scheme because of evidence that Medical Aids were diagnosing and treating patients in remote rural areas without the supervision of fully trained doctors.[31] From the beginning the State was torn between the demands of the white medical profession and its responsibilities to provide black health services to areas with growing ill-health. The greatest

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[27] McCord, *My Patients were Zulus,* 271-272. Letter from Edward Jali to James McCord, January 1940.
[28] SAB, GES, Vol. 2957, Ref. PN 5. Native Medical Aids. 1942 Medical Training of Natives Report. Training in diagnostic and curative procedures was carried far beyond what was permitted in conformity with the legal standards of medical practice in South Africa, and the Medical Council's guidance was never sought during the development of the scheme. In 1943 the Medical Aid course was converted into a 2-year B.Sc. (Hygiene) degree of the University of South Africa taken at Fort Hare, and after a year's further post-graduate training in the public health field under the DPH, the Medical Aids were employed in preventive and promotive health work which did not infringe on the Medical, Dental and Pharmacy Act.
[29] A.B. Xuma, "The Training of Natives in Medicine: Notes on a Native Medical Service in Rural Areas," *The Journal of the Medical Association of S.A* (24 January 1931), 41. Dr. Xuma received his full medical qualifications in the USA.
[30] See SAB, GES, Vol. 2957, Ref. PN5, Native Medical Aids. 1942 Medical Training of Natives Report, 5. Medical Aids were trained under this scheme until 1951 after which it was abandoned when the first black medical school opened.
[31] SAB, GES, Vol. 2272, Ref. 61/38C, 1937-40. Native Medical School Training of Native Doctors, Health Inspectors. Letter from H.J. Sutherland, District Surgeon, Tsomo, Transkei to the Secretary of the South African Medical Association, 8 July 1947.

dissatisfaction and bitterness came from black Medical Aids who felt that their 5 and later 3-year university training was a waste and did not fit them for the simple duties to which they were assigned.

Public Health Reform: South Africa's Pioneer Health Centre at Pholela, Natal

Having explored the early missionary and State black auxiliary health worker precursors, I will now turn to analysing the work and experiences of the black State-trained health assistants or community health workers (CHWs)[32] as they became called, in the first experimental Health Centre in Pholela, Natal. This section is based mostly on official Government and medical sources making it difficult to obtain individual opinions and experiences of different black health intermediary workers. But while using these official documents which highlight the role played by individuals and institutions from "above" in creating black health intermediary positions, this development was also a process of engagement and brokered negotiations from "below". The CHWs I will explore in this section actively sought to engage with white doctors and the technology of the Health Centre but also very explicitly negotiated for the advantage of their local communities. They bridged the social, cultural and language divides between white doctors and the "Western" biomedical Health Centre service, and the racially, economically, and politically oppressed rural black communities they served. I will also continue to trace Edward Jali's life story, as he came to work at Pholela during the early 1940s. I will explore how different his intermediary position was to those of the CHWs, as his elite and Christian perspective and self-identification with "Western" biomedical traditions and doctors complicated his middle position. At some moments he fitted into the intermediary category as mediator between the white doctors and the local community, at other times he did not. He did often "bridge the gap", but this was often done by working only with certain elite sections of the local communities and the Health Centre. In this section I hope to demonstrate that there were historically shifting and overlapping middle positions of black auxiliary health workers in rural South Africa.

The early 1940s were pivotal years for the development of black health care in South Africa. Many of the health and training schemes that were implemented during the 1930s (such as the Medical Aid scheme) had failed to deliver. The great social, political and economic ferment stimulated by the needs of wartime production, industrial expansion, and urbanisation had an enormous impact on South African society. The radicalisation and growing solidarity of black politics – often centred around dissatisfaction with Government services (especially health care) – precipitated a crisis for the white minority-controlled State who were forced to address inadequate black health care needs that might otherwise have been delayed until later years. With the inadequate number of black doctors to meet these needs and increasing numbers of Africans being treated in expensive urban hospitals – which increasingly worried the State as it was reluctant to pay the high medical costs – the DPH began to plan a different approach.[33] In 1938/39 the Government commissioned the first comprehensive "Native Bantu Nutrition Survey", which provided proof of the rampant disease and high mortality from malnutrition, STDs, malaria and T.B. in African areas.[34] The outstanding fact was that all was

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[32] Interview with Emily and Sidney Kark by Prof. C.C. Jinabhai and Dr. Nkosazana Zuma, Durban, 1992, 5. While the State called these black auxiliary workers "health assistants", the community health doctors in the field, and the local community called them CHWs.

[33] See Report of the National Health Services Commission on the Provision of an Organised National Health Service for all Sections of the People of the Union of South Africa, 1942-1944, Pretoria: Government Printer, 1944.

[34] See Sidney Kark, "A Health Service Among the Rural Bantu," *South African Medical Journal* xvi, No. 10 (23 May 1942) and SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. Native Health and Medical Services Polela Unit. General Matters. How South Africa Fights Disease among her Native Population, 1940-52, 1. This item was included with materials of the State Information Office, Department of Interior, entitled "Health Services for the Bantu in South Africa". It was estimated that in a general population of 12,400,000 (in the incomplete 1946 census) Africans made up ¾ or 8,400,000 people. At end

preventable.[35] What is important to note during this new wave of State health reform was the pivotal shift in thinking about the type of health services to be created and delivered. Thinking shifted away from the provision of training and services in expensive, urban, hospital-based services that cured established disease, to cost-effective rural, community-based, preventive and promotive health services that would promote and safe-guard good-health.[36] The DPH came to realise, as it was claimed in a 1942 Report: "that the problem of health in South Africa is far greater than the problem of training doctors for the treatment of disease … doctors should be trained as preserver[s] of health rather than as menders of diseased bodies".[37]

During 1939 the DPH proposed the establishment of three experimental "Native Health Units" to provide health services for rural black communities based on cost-effective preventive lines.[38] It was envisaged that the Health Centre would form an "intermediary technology" whose services and staff would provide a bridge between urban and rural health services. The DPH recommended that the best way to combat existing disease and prevent further disease in "native territories" was to employ three categories of medical personnel – white doctors, black nurses and black health assistants (skilled in preventive and hygiene work) – working in multi-racial teams that would integrate both curative and preventive medicine.[39] However, the outbreak of World War II delayed the building of the proposed three pilot Health Centres, and only the Pholela Health Centre was established 1939/40.[40] While the war hampered the initial establishment of the scheme, in the long run it provided a rare window of opportunity as a liberal political climate during the war largely stimulated the development of progressive health reforms. As Mervyn Susser, a community health doctor argued: "we were swept up by the euphoria and optimism about social reform in the world at large [and brought] to see that medicine might be a social service to people and community".[41] The new Health Centre was to work in the framework of "social medicine" – a more sophisticated understanding of the biomedical but also socio-economic and political root causes and treatment of disease – and was seen to represent a return to a "holistic interpretation [and treatment] of disease … as a unified and total process".[42]

Pholela was a black rural "reserve" area situated in the foothills of the Drakensberg mountains in S.W. Natal about 100 miles from Durban, and had a population of about "30,000 Zulu-speaking

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1947, it was estimated that there was 1 white doctor for every 1000 white patients compared to 1: 22 000 blacks in both rural and urban areas. Statistics were far worse in some rural areas.

[35] UN Archives, Pmb, H6/1/1. George Gale, "The Story of the Durban Medical School," 25/11/76, 4.

[36] Gordon Papers (GP). File 17, KCM 25841. UN Medical School. Minutes of the Meeting of the Curriculum Sub-Committee held on 20th June, 1952. "The Curriculum and the Organisation of Teaching for the Degree of M.B., Ch.B. of the UN," 1. S.A.'s health reforms were part of a growing world-wide shift from expensive traditional hospital-centred medicine to an interest in the promotion and teaching of community and "social medicine". In 1944 British Goodenough Report stressed the importance of social medical training: "a concept that regarded the promotion of health as the primary duty of the doctor, that pays heed to man's social environment and heredity as they affect health, and recognise that personal problems of health and sickness may have communal as well as individual aspects".

[37] SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. 1942 Medical Training Report, 8.

[38] H.S. Gear, "The South African Native Health and Medical Service," *South African Medical Journal* xvii, No. 11 (12 June 1943), 168-169.

[39] SAB, GES, Vol. 2957, Ref. PN 5, Native Medical Aids. 1942 Medical Training Report, 9.

[40] D. Harrison, "The National Health Services Commission, 1942-1944 - Its Origins and Outcome," *South African Medical Journal* 83 (September 1993), 682. Health Units at Bushbuckridge in the Eastern Transvaal and at Umtata in the Transkei would be established during the following year.

[41] Derek Yach and Steve M. Tollman, "Public Health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post-Apartheid Era," *American Journal of Public Health* 83, No. 7 (1993), 1047.

[42] Sidney L. Kark, *Epidemiology and Community Medicine* (New York: Appleton-Century-Crofts, a Publishing Division of Prentice Hall, Inc, 1974), 4 and Gear, "The South African Native Health and Medical Service," 168-169.

African peasants".[43] Because the migrant labour system drew most of the African men away to work in the urban industrial areas, there was a skewed distribution of women, old men and children in Pholela.[44] Many members of the community were Christian and thus had some degree of education, but the community was still, according to Sidney Kark, the first community health doctor sent to Pholela, influenced by "traditional" understandings of health.[45] The nearest hospital lay 45 miles away in the province's capital of Pietermaritzburg. Communications and transportation were difficult because of the mountainous terrain. According to the State Information Office, the first Health Centre was placed in Pholela because of the community's high incidence of disease and poverty, but also because it was situated in a reserve area conducted by the Native Affairs Department (NAD). The State intended to correlate Health Centre work with NAD "improved" techniques of agricultural production, stock improvement and afforestation.[46] The area was noticeable for its ill-health as was evident in statistics collected in 1942:

> The infant mortality rate was 276 per 1,000 live births, the crude mortality rate was 38 per 1,000 … Inadequacy of diet was evident in the fact that more than 80% of the people exhibited marked stigmata of nutritional failure and that malnutrition in the form of pellagra and kwashiorkor was rife. Frequent epidemics of typhoid, typhus fever, and smallpox contributed to the high death rate; tuberculosis, venereal disease, and dysentery were major problems.[47]

The Pholela "Multi-Racial Team": Health Intermediaries in a Black Rural Area

While the State initially established the Pholela Health Centre, its State-employed community health doctors were given much scope to develop the service to provide solutions to the rural health problems.[48] The early Pholela Health Centre ideas and work thus developed around a few innovative doctors. Sidney Kark became Medical Officer-in-Charge and director of the multi-racial medical team. Assisted by his wife Emily, who was also a doctor, they together started the Pholela Health Centre.[49] From the start, the Karks recognised that the treatment and prevention of disease could not be separated from each other in medical practice. Over the years they progressively developed an integrated approach for the improvement of individual, family and community health where health education and local community participation was essential. The aim of the Health Centre was to develop a comprehensive curative, but more importantly, promotive and preventive "extra-hospital" community health service. This, together with the Health Centre's focus on low-cost preventive medicine, developed along lines unlike anything established in South Africa up to that time.

Together with an analysis of black health care brokers in rural areas, it is also important to recognise that at that historical time, white community health doctors (such as the Karks) were also health intermediaries. Unlike many of their white medical colleagues practising in racially segregated private or hospital-based curative medicine in urban areas, these community health doctors, by

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[43] Sidney Kark, "A Health Service Among the Rural Bantu," *South African Medical Journal* xvi, No. 10 (23 May 1942), 197.
[44] Sidney and Emily Kark, *Promoting Community Health: From Pholela to Jerusalem* (Johannesburg: Witwatersrand University Press, 1999), 36.
[45] Kark, "A Health Service among the Rural Bantu," 197.
[46] SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. 1940-1950. Native Health and Medical Services. Polela Unit. General Matters. "Social Medicine in Africa" issued by Director, State Information Office, Private Bag, Pretoria, March, 1951, 1-2.
[47] John Cassel, "A Comprehensive Health Program among South African Zulus," Benjamin D. Paul, ed., *Health, Culture and Community: Case Studies of Public Relations to Health Programs* (New York: Russell Sage Foundation, 1955), 15-16.
[48] Gear, "The South African Native Health and Medical Service," 170-171, Interview with Emily and Sidney Kark, 4.
[49] Sidney L. Kark, *The Practice of Community-Oriented Primary Health Care* (New York: Appleton-Century-Crofts, a Publishing Division of Prentice-Hall, Inc, 1981), 197. Interview of Emily and Sidney Kark, 4.

practising unorthodox social medicine and working in black, poverty-stricken rural areas, deviated a long way from "the norm". The Karks could be seen as mediators between the white medical professional bodies they were associated with and the State. The records speak of many tensions the Karks experienced of maintaining ties to the white, "orthodox" medical profession and the kind of health service they wanted to develop for black rural communities like Pholela. The Karks medical philosophy challenged orthodox medical practice as their clinical methods de-emphasised the individual doctor-patient relationship in favour of wider community interests; they opposed special medical clinics to treat different diseases and called instead for a comprehensive health service in one centre; they aimed to shift funds away from expensive, high-tech hospitals; promoted the integration of medical and social welfare services; and emphasised the social investment in disease prevention.[50] The Karks also forfeited the material rewards and professional securities to be had from curative urban medicine by working to improve the health of rural, oppressed black communities. Their health work helped to bridge the gap between urban and rural forms of health care. As State employees, they fulfilled multiple roles as doctors and teachers who trained and supervised various health personnel, and as State administrators with policy-directed work. But while their medical and Government roles were often combined, they were not always identical. The scope they were given to work out new methods to approach rural health problems resulted in many of their policies going against the State's directives.[51] They were also often placed in ambiguous positions in a black rural community as white doctors associated with the racial segregationist and oppressive white society. But, to dismiss these community health doctors reductively as handmaidens of the State ignores the more complex and interesting reality where people's lives and histories intersected in multiple and complex ways.

The Karks founded Pholela with Edward Jali and his wife Amelia, whom they met through their personal and professional contacts at McCord Zulu Hospital.[52] Kark argued about their central importance to the new Health Centre developments in South Africa:

> [The Jalis] became very important to our lives, became … our closest friends … [Edward Jali] had worked at McCord for many years as a medical assistant … [and then] qualified … to be a Medical Aid; it didn't qualify him to be the fine person he was. … Amelia Jali was a qualified nurse from McCord, and a manageress of the four of us really. And a very skilful one … she organised us.[53]

The Health Centre scheme was the salvation for many Medical Aids like Edward Jali as it provided what the State viewed as overly-trained curative medical personnel, with field training in preventive and promotive work, and opportunities commensurate with their university training as senior health educators and demonstrators, laboratory technicians and teachers. As members of the Health Centre team and under the supervision of Medical Officers, Medical Aids were more successfully integrated into the State public health services. Their numerous duties included: mapping out and supervising CHW home visiting work (as will be discussed below); collating CHW reports; and making important contacts with school teachers, agricultural demonstrators and local chiefs and headmen to secure active co-operation in public health measures. They also gave public lectures on hygiene and health; executed

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[50] A. Jeeves, "Public Health and Rural Poverty in South Africa: "Social Medicine" in the 1940s and 1950s, Seminar Paper presented at the University of the Witwatersrand Institute for Advanced Social Research, 30 March 1998, 2.

[51] This is especially evident after 1948 when the Apartheid Government came into power. There are many instances of the Government's suspicions and investigations into what they saw as "radical" and even Communist ideas, such as their free distribution of food supplies to rural black communities surrounding the Health Centre.

[52] UN Archives, Pmb. 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, 10.

[53] Interview with Emily and Sidney Kark, 5.

in collaboration with officials of the NAD, minor works of public health importance such as protection of water supplies, communal gardens and orchards on irrigable sites; took administrative charge of epidemic outbreaks; and assisted doctors in the clinics with health examinations.[54] While in some ways Jali can be viewed as an intermediary or mediator between the Karks and the local Pholela community, his position needs to be qualified. Jali's mediation was with a very particular section of the local community, namely its elite or educated community leaders. He thus could be seen as bridging the gap, but not between all levels of the two communities, but between certain groups. As I will show below, Jali's intermediary position was very different to those of the CHWs.

Amelia Jali was the first black Health Centre nurse trained in South Africa and played an important role integrating preventive, curative and promotive nursing care and ran a well-organised clinic.[55] Of particular importance were her educational group demonstrations and discussions of pre-natal and ante-natal mother and baby health care. Little is mentioned of her in the official records and I was not able to determine if her intermediary position was influenced by elite preoccupations like her husband's. It seems unlikely though, as for many years she was the only trained nurse at Pholela Health Centre, which would have brought her into association amongst all levels and classes of the Pholela community. As a speaker of many local languages, her intermediary role would have been pivotal to promoting better health communications between the Karks and the local community.

In their book, *Promoting Community Health,* the Karks spoke about how, as a newly married couple together with the Jalis, and situated in an unfamiliar black rural community where they knew no one, they became more than colleagues, but close friends. Before one dismisses this rhetoric as a romanticised account of racial relations in South Africa, it is important to highlight the background of the Karks to understand their "friendship" with other racial groups. The Karks were Jewish doctors and their families had immigrated to South Africa during the early 20th century after being forced to leave their anti-Semitic Eastern European countries for fear of persecution. They thus came from a "non-conformist" Jewish tradition of socialist activism in South Africa that exemplified solidarity with the underdog against oppression, discrimination and racism.[56] Their pioneering health approach, which particularly served politically, economically and racially disempowered black communities, was directly influenced by this Jewish philosophy.[57] In their book, the Karks argue that they shared many experiences in their daily living and work situations with Edward and Amelia Jali. It was stated that Amelia and Emily even had their first babies around the same time, shared ideas around child raising, and their children attended pre-school together.[58] Thus, despite the couples' asymmetrical professional and medical responsibilities and power relations that existed between them, this did not prevent the development of lasting friendships as they shared their daily lives together in isolated and peripheral rural spaces in a growing racially segregated country.

Community Health Workers – A Pioneering Addition to the Health Centre Team

The State-initiated Health Centre programme had a bumpy beginning. Apart from the Karks, all the staff of the Health Centre were African (of Zulu descent), yet initially none came from the local Pholela community. Several months after their arrival, the Karks were sent 5 Zulu men (4 had been

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[54] SAB, GES, Vol. 2957, Ref. PN 5. Native Medical Aids. 1942 Medical Training Report, 15-16.
[55] Helen D. Cohn, "Family and Community Nursing," *A Practice of Social Medicine: A South African Teams Experiences in Different African Communities* (Edinburgh and London: E. and S. Livingstone Ltd, 1962), 41-43.
[56] Immanuel Suttner (ed). *Cutting through the Mountain: Interviews with South African Jewish Activists.* (London: Viking Penguin Group, 1997).
[57] See Karks, *Promoting Community Health,* xvi-xvii.
[58] Karks, *Promoting Community Health,* 27.

trained as malaria assistants in Natal) by the DPH, to be retrained as "health assistants" as the State called them.[59] In the beginning, the Karks recognised the need to meet with local chiefs and elders to explain the purposes of the Health Centre and outline its activities to gain their advice, participation and support. However, they encountered enormous initial suspicion, distrust and resentment from the local community who objected to what they perceived as Government interference. As many local community leaders argued, they had not been counselled about the Government's purchase of land for the clinic. The appointment of male "outsiders" rather than local people as CHWs and the suspicious nature of their visits to people's homes "like spies" rather than allowing people the choice to use the clinic when they pleased was also not appreciated.[60] Part of the community resistance was caused by the introduction of male health assistants who would visit people's homes when many men were away working in the towns. In a newspaper article written at the time, it was asserted that the early Health Centre programme "start was not auspicious" and that "the Natives were uncooperative."[61]

Community resistance to the Health Centre showed that there were tensions between the State health service and the local community, but also between different groups within the local Pholela community who accepted or rejected the Health Centre service. These tensions are evident in the clash between Margaret Nzimande Shembe a headmistress of the local school and an elder in the Church. Both were influential members of the community. It was Margaret Nzimande Shembe who had an enormous impact on gaining acceptance for the work of the Pholela Health Centre. In the following quotation from Sidney Kark, one can see some of these local tensions, but more importantly, the powerful and persuasive role that some African women played in the Pholela community:

> The arguments she [Margaret Nzimande Shembe] had with Joseph [an elder in the Church], the enemy of the centre, were fantastic. I literally think that … she did more to change Joseph than anybody else. Because changing Joseph as very important, because … a couple of years later, Joseph blessed us in his church.[62]

Shembe's discussions with the Karks led them to recognise the vital need to employ local CHWs to carry out health education propaganda work in their own communities. What is interesting about the training and work of these new CHWs, was the interesting gender dynamic. CHWs were not restricted to men as the earlier Medical Aid scheme had been. In a community where women far outnumbered men due to prolonged absences through migration to industries and the mines, it was to other women that the community turned to provide community services, including those of health care. These leadership roles assumed by African women for health development were not in accord with their subordinate status or expected behaviour in this patriarchal society, but their health contributions were essential to the community.[63] Shembe was an important intermediary as by negotiating with the Karks, she instigated the introduction of health-related changes that benefited both the operation of the

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[59] Karks, *Promoting Community Health,* 23. The first five health assistants were: J. Mngoma, A. Ngcobo, C. Shembe, E. Dzanibe, and J. Mbele.
[60] See Kark, "A Health Service Among the Rural Bantu", 197, SAB, GES, Vol. 2703, Ref. 1/62A. Medical and Health Services for Natives. "Native Health Units and Medical Missions" by G.W. Gale, Assistant Health Officer, 30/6/1941, 2.
[61] SAB, GES, Vol 2704, Ref. 2/62 and 1/62B. Native Health and Medical Services Pholela Unit. General Matters, 1940-52. "Pholela Centre Provides 'Pilot Plan' for Native Health Schemes". *The Natal Daily News,* 10/3/1945.
[62] Interview with Emily and Sidney Kark, p.6.
[63] However, the salary scale at Pholela for these CHWs was divided by gender and race as follows: Medical Officer-in-Charge £720x30-960, black sisters £156x12-192, Medical Aids £200x15-350, health assistants (male) £120x12-192 and (female) £108x12-144.

Health Centre service and the local Pholela community. Shembe[64] was the first woman appointed to the Health Centre staff, as Kark maintained:

> we were able to appoint all our subsequent health assistants from among the people of Pholela itself … these were people born and brought up in Pholela, some of them very senior, like the headmistress of school there, who moved from being headmistress of the school to being the first woman health educator that we trained in this country.[65]

As a teacher who was well educated, had a good standing in, and was respected by the community, Margaret Nzimande Shembe was a good example of the type of person chosen by the Health Centre to work for them as CHWs. The importance of appointing local people, especially those from prominent families and kinship groups in the area proved a very successful move that slowly won the Health Centre trust and community participation in various activities.[66]

As frontline health care providers – the first link in the health chain – in under-serviced rural areas, three types of CHWs were trained: health educators who visited people's homes, monitored their environment and other social factors that worked against health, and advised families about hygiene and nutrition issues; laboratory technicians or side-room workers who did microscopic and specific biochemical examinations; and health recorders who compiled, analysed and interpreted health records to produce correlated statistical data.[67] Because no training facilities existed to train these particular CHWs, they were given an in-house training at Pholela in aspects of physiology, infectious diseases, an intensive practical course in rural personal and environmental hygiene, sanitation, nutrition, epidemiology and methods of survey work. As Kark argued, this training scheme facilitated much interaction and discussion between different races, genders and professional levels of health providers:

> we began training those … health assistants to suit them to community health work and although I say we began training, it was a question of learning together, we did our field work together, we visited homes together, we began to work out an approach to health care in a rural area like Pholela in which we ourselves learned that the training we'd been given was quite unsuited to the needs of people in that area.[68]

The Health Centre's "Family Welfare Service" was developed to identify, record and continuously monitor the social, material, cultural and environmental influences on health in a defined area and stable group of households, which could then be used to develop policies and practices to treat and prevent disease.[69] CHWs were each allocated between 25 and 30 homes each. Their job was to collect and record demographic information, types of housing, census of livestock and seasonal crop production, and information about water supplies. Frequency of home visits depended on household accessibility and difficulties of travelling on foot or horseback but usually occurred once every 6-8 weeks. Other than collecting data, their multi-purpose home visits were also used to "educate" families

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[64] SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. 1940-1950. "Social Medicine in Africa", 3. The Karks appointed two local women: Nzimande and a her cousin, Audrey Bennie, and four men: Raphael Zaca, Benjamin Nzimande, Edward Bennie and Fred Madlala in addition to the other initial 5 health assistants appointed.
[65] Interview with Professor S. Kark and Professor Gordon, 11-12.
[66] See Karks, *Promoting Community Health,* 36 and Kark, "A Health Service Among the Rural Bantu," 197.
[67] Kark, "A Health Service Among the Rural Bantu," 197.
[68] Interview with Professor S. Kark and Professor Gordon, 11. See Karks, *Promoting Community Health,* 23.
[69] See Kark, *Epidemiology and Community Medicine,* 1-3. Due to budget and staff constraints, the health promotive part of the programme was confined to a small defined area. The service first covered 130 families comprising about 900 people and later extended to 1,000 homes within a 12 mile radius comprising 9,000-10,000 people.

about health and hygiene, to encourage families to go to the Health Centre for regular examinations and to spot early evidence of disease to allow for early and effective treatment.[70]

While regular examination sessions held at the general clinic and vaccination programmes were important to the improvement in the community's health, it was the health educational work of the CHW which had the greatest impact. CHW facilitated a more "bottom-up" approach and decision-making by the rural community most affected by the service. This included their initiation and participation in a range of formal and informal group discussions to explore what the community felt about their health needs and to promote changes around "unhealthy" practices. Community health educator Guy Steuart argued that the success of the health programme depended on CHWs promoting a recognition of the need for changes to be made and helping to empower local community members to improve their own health.[71] CHWs worked through community organisations such as co-operative buying clubs, women's clubs and church groups, which provided valuable vehicles for the promotion of "good health practices". CHWs drove numerous Health Centre activities. For example, under the initiative of people such as Margaret Nzimande Shembe, a successful system of "pre-school" child centres was pioneered, where children were regularly examined, vaccinated against diseases, received proper balanced diets and taught habits of "good hygiene".[72]

While working daily with people in their homes, these CHWs also had regular discussion group meetings with teachers and gave special educational sessions at the schools on health, hygiene and nutrition.[73] The entire Health Centre was situated and designed for demonstration purposes, including model huts, compost heaps, vegetable gardens (whose produce was used for the school feeding schemes), and pit latrines. CHWs used these as practical examples to demonstrate to the Pholela community "good" housing, water supply, hygienic refuse disposal and sanitation, and methods of soil conservation.[74] As Emily Kark argued about the work of these CHWs:

> they're a terribly important element of the team … 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 out on horseback in Pholela going round homes to homes, help[ing] people protect their springs, and digging the latrines and helping with gardens and giving the health education.[75]

The Pholela Health Centre was the first to pioneer a preventive and promotive health training for CHWs. These CHWs were intermediaries, but in a very different sense to that of Medical Aids such as Edward Jali. While their health intermediary positions were initially created by the State, CHWs also actively sought to engage with the white community health doctors and the technology of the Health Centre and served as mediators and negotiators for the whole Pholela community. Unlike Medical Aids such as Jali who worked as senior Health Centre auxiliary staff, CHWs did not mainly work with the local chiefs and elite classes of the community. These CHWs were in daily contact with their black communities, on a one-to-one basis and worked closely with them to "reform" their health practices.

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[70] Sidney L. Kark and John Cassel, "The Pholela Health Centre: A Progress Report," *South African Medical Journal* 26, No. 6 (9 February 1952), 102.
[71] Guy W. Steuart, "Community Health Education," *A Practice of Social Medicine. A South African Teams Experiences in Different African Communities* (Edinburgh and London: E. and S. Livingstone Ltd, 1962), 65.
[72] UN Archives Pmb. H6/1/1. Interview with Professor S. Kark and Professor Gordon, 12.
[73] SAB, GES, Vol. 2704, Ref. 2/62 and 1/62B. 1940-1952. Native Health and Medical Services. Polela Unit. General Matters. "The Pholela Health Centre", 1951/2?, 5. A school meal scheme also supplied balanced diets to school children.
[74] Kark and Cassel, "The Pholela Health Centre. A Progress Report," 101-102.
[75] Interview with Emily and Sidney Kark, 56.

"Western" Intermediary Relationships with Indigenous Healers

However, like the largely silent voices of black CHWs or the patients of the Health Centre, there are also silences around the health work of "traditional" healers in the Government and medical documents. Thus, while the CHWs, when they do "speak" in the records, importantly give a voice to the local experience on the one hand, they also produce new silences within that local voice on the other. The *inyanga* and/or *isangoma* are examples of health actors who was not chosen by the State or white community health doctors to act as an intermediary between the Health Centre and local communities. Healing was a site of enormous tension and power struggles between and within particular cultural groups. One of the most noticeable differences in the intermediary role of CHWs and Medical Aids such as Jali, were their different relations to the practices of local indigenous healers in the area. This section will raise some of the tensions between the beliefs and practices of "Western," Christian trained health workers and "traditional" healing systems in the local Pholela community. It will also highlight something of the complicated nature of black intermediary "middle" positions.

Unlike highly educated Medical Aids such as Jali, who were often brought from "outside" the local community they served, CHWs, by coming from within, and constantly interacting with, the local community were able to provide valuable insight into the devising and implementation of culturally-sensitive Health Centre programmes.[76] As part of the local community, CHWs did not simply reject "traditional" practices outright as "backward" and "superstitious". Their intimate knowledge of the local community was important for slowly changing long-held culturally accepted health practices and beliefs.[77] As is evident in the medical reports written by community health doctors such as the Karks, where community attitudes were resistant to change, CHWs had to have much patience and tact to persuade and modify people's health habits and behaviours. As Cassel, another community health doctor argued a CHW's most difficult problem was "trying to change those cultural features, which stood as symbols of fundamental moral codes governing interpersonal relationships".[78] Various examples demonstrate how CHWs encountered higher levels of community resistance when trying to encourage the greater production and consumption of foods such as vegetables, milks and eggs, the treatment of pulmonary T.B. and attempts to combat soil erosion.[79] It is important to remember though, that while these CHWs represented an important bridge between different health practices and beliefs in Pholela, they were "Western-trained" health agents of the State, which distinguished them from the local community. Yet they were also intermediaries as they both worked with the local community to effect health changes but also stimulated changes in Health Centre staff thinking and practices.

However, Edward Jali's status as a health intermediary is more ambiguous than that of the CHWs like Margaret Nzimande Shembe. Jali's case demonstrates that biomedically-trained health workers were often brought into conflict with the work of indigenous healers who, it was claimed, tried to ridicule and undermine their work.[80] This passage from one of Jali's letters highlights many interesting aspects about the ambiguous nature of his intermediary status in the black rural areas:

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[76] Interview with Emily and Sidney Kark, 29.
[77] See Steuart, "Community Health Education," Kark and Cassel, "Pholela Health Centre: A Progress Report," 103 and Kark, "A Health Service among Rural Bantu," 197.
[78] Cassel, "A Comprehensive Health Program among South African Zulus," 15.
[79] Cassel, "A Comprehensive Health Program among South African Zulus," 16-36.
[80] SAB, GES, Vol. 2704, Ref. 1/62B and 2/62. 1940-52. "Social Medicine among the Kraals of Natal," 2. Most of Pholela's health care were provided by female i*sangoma* (or diviners) and male *izinyanga* (or herbalists) who were either itinerant or resident in the area. Matheson's article presents their work as negative, "backward" and "superstitious".

> Every day I visit the people in the kraals. I find out about their health … Then my lessons commence … I tell them about the spread of disease. … Yet it is not always possible to teach [them] and we have much to contend with. In one place I was told that the district was swarming with inyangas … Actually I was refused permission while there to see a patient I had come ten miles to advise. I do not know whether I was suspected of being a Government spy, or what, but I was told that only the inyanga could cure the women's sickness … I discussed with them the need for their sick to come early to doctors for treatment, explained how useless and ineffective were their inyangas. They [the chiefs] seemed to understand and believe me, but whether they will act as I advised is the question. I fully believe that if the chiefs could be convinced that better medical care was necessary that they could easily drag their followers to the same belief. But while they are as uneducated and childlike as I found them, the battle will be a long one.[81]

As mentioned in an earlier section and is clearly visible in this quotation, Jali carried his Christian mission teachings and health work values with him into the State public health service. One can see much of his Christian moralising health work here, as well as his elitist position with regard to dealing with the upper echelons of the local black community. This passage suggests someone who did not understand or respect the local people's approach to health and healing but dismissed it outright as "uneducated" and "childlike". In this instance, one can see how Jali's aim was to impose "Western" biomedical practices onto the African community. He also seems to locate himself far more with white missionaries and doctors than with the local community. And if his identification is to be established with the rural black community, it is only with certain groups in the local community, such as the leaders or educated members. When Jali acted as an intermediary or mediator, it was mostly skewed towards certain sections of the local community. Finally, the letters also bring to the surface the many tensions experienced by ambiguous auxiliary health workers like Jali, who lacked professional recognition and status for their training:

> People wherever I go believe that I am a doctor, but in thinking that they flatter me. Others call me Inyanga. But isn't the inyanga, or witchdoctor, of higher status than me? He is licensed. I am not. He practices freely on his own. I cannot. He has the confidence of his people. I have not. Yet in spite of all this I am styled a doctor and am often called on to examine and prescribe. Every day I see several patients and they think well of me.[82]

Jali's comment demonstrates his frustration and dissatisfaction (directed at the Government and white medical profession) for not recognising his training and professional status, resulting in his lower professional status than the *izinyanga*. In this instance, Jali's Christian missionary work ethic was undermined by demands for State professional recognition. Jali life story, as compared to other CHWs in Pholela, highlights the ambiguous health intermediary positions that existed during the early years of the 20th century.

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[81] McCord, *My Patients were Zulus,* 273-274. Izinyanga are indigenous healers.

[82] McCord, *My Patients were Zulus,* 275. Before the 1928 Medical, Dental and Pharmacy Act was passed, *izinyanga* were licensed by the Government to practice their medicine in black communities because of the lack of provision of alternative "Western" health services. After 1928, these licenses were revoked in most of South Africa, except Natal, which had been exempt from the new law because of an agreement reached with "traditional" authorities there.

Conclusion

While I do not have the space to go into the fascinating developments around this complex branch of community medicine during the late 1940s and 1950s, I will end this research paper with a brief glimpse of developments and disasters to come. By the mid-1940s, the successful small-scale Pholela Health Centre experiment captured the imagination of the National Health Services Commission (NHSC). Appointed to investigate the inadequate health services in South Africa at the time, the NHSC was established to develop a National Health Services plan for the whole country. Pholela Health Centre's low cost, comprehensive health service, using locally trained black CHWs in multi-racial teams provided vital answers to the DPH's searching health questions. From 1944 to the late-1950s a network of integrated promotive, preventive and curative Health Centres were set up throughout South Africa based on the Pholela model.[83] A large training institute was established in Durban to train doctors, nurses and various categories of CHWs in an expanded, racially, culturally and socio-economically diverse service.[84] The framework of a revolutionary new public health service was put in place, which if completely implemented would have reorientated the way modern medicine delivered health care to impoverished communities. It even attracted international recognition, as Britain's Minister of Health, Malcolm MacDonald was quoted as exclaiming: "here is a report that shows us what we should be doing!"[85]

However, by the late-1950s the scheme floundered for several reasons, not least of which was the shift in Government in 1948 to one based on more rigid racial "apartheid" policies under the Afrikaner Nationalists. This Government did much to undermine what they viewed as "progressive" and "liberal" health policies for the black underclasses.[86] After massive cuts in funding and emigration of leading community health doctors overseas, the Health Centre scheme came to its end. By 1960 most Health Centres were forced to close their doors, or like Pholela, were converted into detached out-patient curative clinics. Many black CHWs were retrenched or used as lowly hospital orderlies. They never received the professional recognition they deserved for their training in community health care. This was a particularly contentious point for Sidney Kark:

> many excellent men and women health educators, health records and statisticians and laboratory workers who had been trained and worked over a number of years … received no official professional recognition of their status. We feel deeply to this day for these former co-workers who suffered frustration and deep resentment at this lack of recognition. The loss to South Africa of this highly trained and motivated cadre health professionals was a tragic outcome.[87]

The end of the Health Centre scheme was a retrogressive step for South Africa and a great loss to people in desperate need of health services. Instead of South Africa becoming a world leader in the

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[83] Henry Gluckman. *Abiding Values: Speeches and Addresses.* (Johannesburg: Caxton, 1970), 504.
[84] See Vanessa Noble, "'A Laboratory of Change': A Critical Study of the Durban Medical School and its Community Health Experiment, 1930-1960" (Masters Dissertation: University of Natal Durban, 1999) for details about the work of this Institute of Family and Community Medicine.
[85] See Shula Marks, "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics", *American Journal of Public Health* 87, No. 3, 1997, 452.
[86] Marks, "South Africa's Early Experiment in Social Medicine", 455. While the role played by the new Afrikaner Government was pivotal in leading to the demise of the scheme, other factors also undermined the scheme, such as earlier rejection and non-implementation of key administrative and financial elements of the NHSC Report. The conservative white medical profession also helped undermine the unorthodox medical approach the Health Centres scheme promoted.
[87] Karks, *Promoting Community Health,* 195.

field of preventive, social and community medicine, health services remained underdeveloped and in a dismal state.

This paper has tried to show the important work and some of the complex experiences of different "Western-trained" black health intermediaries, who were trained in South Africa during the first half of the 20th century. The importance of their health contributions cannot be underestimated as Sidney Kark asserted with regard to the CHWs:

> I think what Guy Steuart said many years ago when we were having a discussion in Durban [is pivotal]: 'Health is much too important a subject to be left to doctors … community health care urgently needs other professional groups'.[88]

I have tried to explore the asymmetrical but no less multi-layered and multi-sided power relations between various categories of health personnel in a remote rural area of South Africa. Complex institutional and individual characteristics facilitated how and why health brokers emerged who appropriated and engaged with white doctors. I have analysed early Christian missionary and State Medical Aid schemes as precursors to CHWs trained at Pholela, and also to demonstrate how the middle position of black health intermediaries was not fixed or uncomplicated. The Pholela case study, which forms the bulk of my paper, highlights different categories of health intermediaries that worked to bridge the cultural, racial and language divides between the white community health doctors and the black rural community. However, while some definite gains were made, their ambiguous positions also created professional tensions between various health workers as to the recognition of their professional status, as well as tensions in the communities for whom they worked. Intermediaries who occupied "inbetween" spaces faced a more difficult set of problems in managing the ties that went in different directions. They were more vulnerable to being cut off at either end, by the dominant groups that could deny them access to resources (as can be seen with the demise of the Health Centre scheme), or by subordinate groups that viewed them as outsiders. Healing can thus be seen as a site of enormous negotiation, appropriation and tension. Power struggles for control over medicine's knowledge and practice was fought at many levels. By focusing on the complex blurred boundaries and multi-layered engagements between different biomedically-trained black auxiliary health workers and the communities they served, I hope to have shown that people's lives and histories were necessarily intertwined in complex webs of relations in peripheral health spaces of early 20th century South Africa.

[88] Interview with Professor S. Kark and Professor Gordon, 25.