sonnel in health center work and to conduct relevant research. By 1949, 44 health centers had been established around the country; a few more were operating by the time the National Party government was reelected in 1952. This event was the beginning of the end of an exciting experiment in the delivery of *health* care, as distinguished from medical care.

In those brief years, the establishment of new health centers provided excitement and inspiration, accompanied by an almost missionary zeal. It is difficult to assess the long-range effects of the South African Health Centre program after its demise. Without question, visitors and departing staff took with them ideas that influenced the development of programs in Israel, the United States, and other countries. For many of those who participated in the program, the experience shaped their orientation to health care for the rest of their lives. □

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A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark

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This memoir celebrates the accomplishment of Sidney Kark as I personally experienced it. His accomplishment is to have made primary medical care an instrument in and for public health. Kark assembled the girders on which, at some remove, the famous declaration of Alma-Ata rests. At this meeting in 1978, 40 years after Kark began his work, the World Health Organization and the United Nations Childrens Fund endorsed community-oriented primary health care as policy.[1]

Almost from the beginning of his medical studies (which in South Africa normally follow immediately after high school), Sidney Kark seems to have had a comprehensive view of health in society. He was an outstanding student at the Witwatersrand University Medical School, where the education provided was strictly for Whites. Students were taught about the medical disorders that the dominant White minority shared with the more developed world. That was the medicine that their teachers had learned abroad and that the students continued to learn from British and US texts and journals. The configuration of disease peculiar to the majority but fiercely segregated Black population was seldom if ever mentioned. That configuration, where it was not idiosyncratic to the local cultures, was better described in the texts of a half-century earlier, before rising productivity and public health measures had begun to ameliorate the living conditions of the developed world.

Despite the blinkered life and education normal to medical students in that rarefied setting, some, under the guidance of a few remarkable members of the faculty like Raymond Dart and Joseph Gillman, did not neglect the broader issues of a multilayered society. Thus, before graduating in 1935, Kark and Emily Jaspan (later his wife and lifelong collaborator) had founded the Society for the Study of Medical Conditions among the Bantu (then the polite and "scientific" way to describe Black Africans). With fellow students, they carried out a health and nutrition survey of African schoolchildren in Johannesburg and its environs. And in 1938, Kark was recruited by H. S. Gear, the deputy chief medical officer of the government, to carry out a Bantu nutrition survey, together with Harding le Riche as anthropometrist and John Sebonyone as assistant. Their report on this 1-year national survey covered 1000 children in each of nine urban centers.[2]

In 1940, Gear gave the newly married Karks the chance to initiate a plan for a health center at Pholela in rural Natal. This center began with primary care as the

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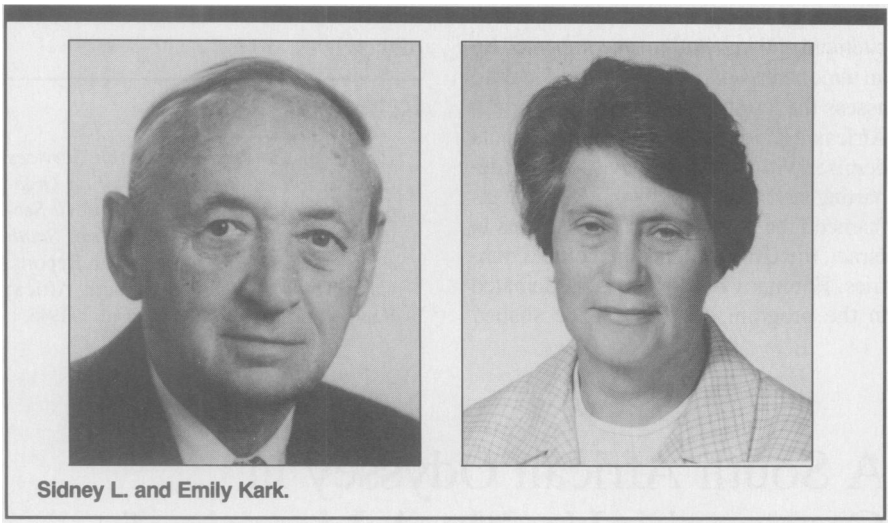
Editor's Note. See related editorial by Geiger (p 946) in this issue.



Sidney L. and Emily Kark.

substrate from which preventive medicine and the care of the community (defined by a purpose-built census since no other census existed for Africans) were developed. To comprehend the nature of the community and its strengths and ills was a major endeavor in the tradition of John Simon in the latter half of 19th-century Britain.[3,4] What was new, however, was that this understanding came not only from demographic and epidemiological counts but also from ethnographic, sociological, and psychological study. The bearers of parochial knowledge recruited from the community as health workers and voluntary health "activists" were not neglected as a vivid source of information.

The health center was the first major innovation of the Karks.[5] In 1944, the National Health Services Commission under Dr. Henry Gluckman MP, moved by the spirit of reform that swept over the Britain of World War II and into its former dependencies, issued its report. Holding up the Pholela Health Center as a model, it recommended that a network of local health centers linked with a nationalized hospital system should be the foundation of a national health service.[6] Soon after Gluckman became minister of health, Dr. George Gale was appointed secretary for health and chief medical officer, and the health center plan was initiated although the government did not commit to the hospital plan.

The idea was still novel. A version of a national system of health centers had been envisaged in the Dawson Report of 1920,[7] but it was less comprehensive in its goals. Trained staff to implement this ambitious plan did not exist at any level and the lack demanded further innovation. Thus, early in 1945, the Institute of Family and Community Health was set up in Durban to train the health workers who were to staff the new health center. Sidney Kark was appointed director of the institute. (Pholela thereby came under the direction of John Cassel, who as chair of epidemiology at the University of North Carolina from 1960 until his untimely death in 1978 was renowned for his work in conceptualizing and operationalizing the field of social epidemiology.)

It was as director of the Institute of Family and Community Health that Kark made his second major innovation: to recruit and train community health teams who would care for families as a whole in demarcated service areas. Besides doctors, nurses and midwives, and laboratory technicians, health workers were recruited from local communities and served as key team members in the several divisions and in the practicing family and community health centers that were a main feature of the institute. Multidisciplinary curricula, built on a base of epidemiology and the psychosocial sciences as well as on the substantial research program, were designed and used to give a comprehensive education in all important aspects of primary care and community health.[6]

In the immediate postwar period (1946 to 1948), some 40 of the 400 envisioned health centers were founded, predominantly in Black communities. But with the advent of the Nationalist Party government, first entrenched in 1948 but always threatened by ideas of social reform, the health center development began to wither.

In 1940, Raymond Dart, as dean of the Witwatersrand Medical School, admitted the first Black students to be trained in South Africa. (One of the few faculty with an international if then controversial reputation, Dart was a noted paleontologist who discovered Australopithecus or Sterkfontein man, famous as potentially the "missing link" in human evolution.) Then, in the early 1950s, the first Black medical school was set up in Durban at Natal University despite the fervent opposition of progressive student organizations to one more segregated educational institution. (In a bow to the opposition, the segregation was not de jure but de facto.) George Gale left the Department of Health to become founding dean, and the school attracted some first-rate faculty and socially conscious students.

Ironically, perhaps, the new medical school provided the testing ground for a third major Karkian innovation. In 1954, the Institute of Family and Community Health was affiliated as a teaching health center with the school.[8] Sidney Kark was appointed professor of social, preventive and family medicine. Over the 3 clinical years, he was given an extraordinary share—equal with that of each of the three traditional major clinical departments—in teaching both academic courses and clinical clerkships in family medicine (served in the practicing health centers). The content had been developed and honed since the years at Pholela. Sidney Kark, inveterate pedagogue, was ideally suited to the work.

In all this, Kark was direct or indirect mentor to many. His role in my own development will serve to illustrate. After 5 years in the armed forces during World War II and looking to resume civilian life, I shared the widespread euphoria about reforming a devastated world. Through friends and the writings of Henry Sigerist, I was brought to see that medicine could be a service to people and communities. In the race-ridden South African scene, I saw it also as a potential instrument for social and political change.

Late in 1945 I entered the Witwatersrand Medical School. Soon it became clear that, in the formal curriculum, concerns for health in the larger sense were hardly to be found. And although the regular medical journals yielded much talk of family medicine and communities, it was really talk about routine general practice rooted in one place. A theory and a concept to guide these activities seemed to be entirely lacking. One of a few exceptions among our teachers was Joseph Gillman. A man rich in concepts and a passionate scientist, he taught or influenced several students who attained international prominence in the biomedical sciences. He at once agreed to my request that he lecture about health and society outside the curriculum.

With the excitement of discovery, I learned that something called social medicine was being both practiced and taught 400 miles away in Durban. Encouraged by Gillman, who a decade and more before had been a support and friend to Sidney Kark, my fellow student Zena Stein and I very soon visited the Karks in Durban. Already primed, we were enthralled by that first intellectual exchange. To our delight, like true evangelists the Karks volunteered a month-long course on social medicine in the impending winter vacation in July 1946 at the newly formed Institute of Family and Community Health.

In a short time, some 20 students proved willing to join. The highlight for me was Sidney Kark's lecture on the social pathology of syphilis (later to become a classic paper of social epidemiology[10]). Many of us came to understand that an integrated view of medicine in a societal context must be multidisciplinary. Such a view goes beyond the biological sciences to encompass not only the new epidemiology but also the social and psychological sciences. To see and to treat patients and the community in the light of that knowledge was—for us and for the great part of the world of medicine—revolutionary. The impact of that course on the hungry minds who took it might be gauged by the fact that seven and perhaps more of the participants entered careers in the field of social medicine.

Later, when we had acquired a modicum of clinical training, a number of us did clerkships at Pholela (with Drs. Bert Gampel and Julia Chesler, a couple who had been given charge of the fabled place where the Karkian model of the practice of social medicine began). There we learned much: how to diagnose and treat childhood malnutrition from skin and hair signs and from social and diet histories, which our teachers in medical school never mentioned and probably had no notion of; how to go about the epidemiological business of containing a typhus epidemic; how we needed to understand the daily life, beliefs, and ways of sustenance of the people we would presume to care for; and how much it mattered to teach new science and practice in hygiene, sanitation, child rearing, and food production to people facing their rapidly changing world untutored.

On graduating, Zena Stein and I decided to join with fellow students Margaret Cormack and Michael Hathorn in the practice of social medicine. Actively engaged as we were in the political struggle against the apartheid regime, we concluded that we should not join the Institute of Family and Community Health. Even in the event that, as a government institute, it could accept us, we well knew that we could not join government service and survive in it. Instead we decided to find a place to develop a health center on our own once we had completed our internships.

Remarkably, and despite our inexperience, we were taken, as a collective of four more or less on our own terms, by the Alexandra Health Center and University Clinic near Johannesburg. One would like to think that the prestigious committee of the board, consisting of a justice of the Supreme Court and the chairs of the three major clinical departments of our medical school, was perspicacious. On the other hand, it must have been somewhat desperate. Joel Krige, the newly appointed and excellent young superintendent (and Kark alumnus) had died suddenly. Moreover, there were two and a half poorly paid medical staff positions that needed to be filled, and no other likely candidates had come forward. Thus, the committee listened with seeming understanding to our particular blend of Karkian and related ideas and plans.

The health center we inherited served a periurban township of 80 000 Black people crowded into a slum of 1 square mile. It already provided a fine and well-run array of services. (Its development over the previous few years owed much to Sidney Sax and his wife, Gwen Greenman. Sax is credited as being the architect of the national health insurance system in Australia.) It also provided a memorable experience for every final-year medical student, each of whom spent a 17-day live-in clerking assignment there. Naturally, once installed, we turned to the Karks for advice on periodic visits to Durban. It was to them we owed the most fundamental change we introduced.

We made our first visit after a few hectic, anxious, and satisfying months of coming to grips with our ignorance and overcoming our fears. We recounted our development and plans. Sidney Kark looked dour. The tenor of what followed remains vivid in my mind. "That's all fine and well," he said, or words to that effect, "but I don't see where you have a family and community practice. Perhaps it's a pretty good emergency service and polyclinic, cycling your patient or family through all your special clinics [each seen divided as though the dozen segments of a flatworm, I thought]. Perhaps your antenatal clinic is an efficient screen, a preeclamptic exclusion chamber. But how is that better than a decent hospital ambulatory service could do?" Some of us looked crestfallen. Some bridled. Emily Kark said something mollifying.

"That's unfair," Margaret Cormack retorted. "It's very well for your training institute to run a family practice with all your resources; you can give each team its own families to care for. The demands of unfiltered township life, whoever comes, hundreds in a day relentlessly, are what we must face, and we've no choice but to care for them all." The discussion grew intense, but by the time we neared the end of the 8-hour drive back to Johannesburg, we knew how we would create a family practice. Soon after, we had obtained the approval of our board (not without opposition) to put our plan into action.

We divided the township into three areas. Each area was to have a team of doctor, nurses, midwives, and assistants with continuing responsibility for the care of the families and individuals assigned to them. Over a weekend, a task force of friends and students helped us reorganize the many thousands of clinic records into the three defined areas.[10]

Then we set about doing our work in the new context. Our own ideas were elaborated upon and integrated with what we learned and kept on learning from the Karks and their colleagues. Our reach into the community followed from the tireless and imaginative incursions of Helen Navid, a sociologist who had just taken charge of the Entokozweni Community Center. In part her incursions were practical—open-air schooling, health education, vegetable clubs, and social support. In part they were scientific—random sample surveys of health beliefs and morbidity of the township (to our knowledge then unprecedented in such Third World settings), anthropological observations of infant feeding practices, and the like.

In 1955, Navid's work was brought to an abrupt halt. She had been very active and, with Father Trevor Huddleston, uncharacteristically public in opposing the enactment and enforcement of two apartheid laws. One such law undermined Black education; its progenitor, Henrik Verwoerd, declared that the new curriculum would teach the Bantu to be what they were fit to be—namely, "hewers of wood and drawers of water." The other law physically removed Blacks from the one place where they could be resident freeholders in the City of Johannesburg. Forthwith, Navid was banned from all gatherings of more than two persons (counting herself) and from all organiza-

tions, including Entokozweni, for so-called statutory communism under the all-embracing and often baseless provisions of the apartheid government's Suppression of Communism Act.

In Alexandra, a protest meeting was called by the African National Congress. I refused the request of the vice-chairman of the Alexandra Health Center board (a superior court judge) that I not join the platform and speak. In those complicated times, it was in truth a delicate matter for the board chairman (Judge Oliver Schreiner) in that he might be compromised by the act of the superintendent (the position I then held) of an institution for which he had responsibility. On the Supreme Court, he was adjudicating a key constitutional issue on the rights of "coloured" people to retain the vote. Even so, and debatably, I did not accept the option of resigning that I had been warned went with the refusal and chose instead to be dismissed.

Shortly before, Sidney Kark had joined the new Natal University Medical School as the founding head of the Department of Social, Preventive and Family Medicine. He was already engaged in complex negotiations, which for some years saved the Institute of Family and Community Health from a hostile government. He saved us too from immediate unemployment, if only for a short period. The second dean of the medical school, Professor I. Gordon, visited Alexandra to ask Zena Stein and me to move immediately to Durban. Interim arrangements would be made for us until the negotiations were complete and we could be appointed as faculty in the new department. Medical school negotiations with the government for the funding on which our appointments depended proceeded less smoothly than expected, however. For reasons more tangled than I can explain here—or perhaps than I now understand—we used the passports obtained with difficulty some time before and left for a period of postgraduate training in England. We were not to return.

South African politics, more than most, have been charged with paradox and irony and one might even say comedy, were the issues not so grave. Sidney Kark himself had been investigated by the Department of Health, to which he had given devoted service since 1938, for so-called communist activities. He had not the remotest link either with "statutory" or any other kind of communism. This bizarre charge, it turned out, referred to the free distribution of food and the like to rural Blacks by the health centers under his direction. The fact was indisputable and admitted. To prevent and treat malnutrition in children, the standard prescription was dried skimmed milk.

Sidney Kark is among the most single-minded, persistent, and dedicated persons I have known. Ever since he was a medical student, he had been thinking about, developing, elaborating, putting into practice, and enlarging his ideas on social medicine. Yet in 1958, after 20 years of application but scarcely 4 years after starting what I believe was the most far-reaching teaching program in family and community health anywhere then or now, he and Emily felt obliged to give up the task and left the country. The medical school was under threat of losing the autonomy it enjoyed as an affiliate of the "White" University of Natal and of being relegated to the status of a Bantu college. The government minister responsible would thereby gain veto power over faculty appointments and other matters vital to academic freedom.

The Karks moved first to the University of North Carolina, where it was hoped that Sidney Kark would develop the epidemiology program. A year later, however, with the help of the World Health Organization, he was given the chance to continue his lifework in the final phase of his career in Jerusalem. He went to Israel to found a teaching health center and the Department of Social Medicine of the Hebrew University and Hadassah Medical School (later to evolve into the School of Public Health). These institutions followed and applied the principles first tested in South Africa. Several of his South African colleagues joined him there, including the Gampels, who had tutored us as students at Pholela. Joseph Abramson, a distinguished epidemiologist who was one of the students in the course of 1947, succeeded to Kark's Jerusalem chair. What had been learned was disseminated through an international teaching program and published works.[12,13] Indirectly, too, Kark's protégés, students, and followers in several countries shared that task.

Not only Israel but the world at large gained by the relocation of the Karks. Sidney Kark's resulting accessibility to nearly all nations as a teacher and writer has helped him and those influenced by him to purvey the sophisticated central ideas of health based on community-oriented primary care. The ideas have followed the natural epidemic curve, except that, having reached a climactic point at Alma-Ata, they have not as yet shown the expected signs of a downturn. They have instead become part of the everyday discourse of the practitioners as well as the cognoscenti in the field. And, once more, these ideas are beginning to guide thinking about health care in the homeland to which they have returned and which may soon complete its liberation. □

Acknowledgment

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