The Return of the Pholela Experiment

Medical History and Primary Health Care in Post-Apartheid South Africa

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I examine why South Africa’s pioneering Pholela model of primary health care, dating from the 1940s, held such appeal for the country’s new policymakers after 1994, and why those policymakers have failed to make it the basis of an effective public health care system since then. In the 1940s, the innovative Pholela experiment had served as such a model, to be replicated gradually throughout the country until a new health care system in its image was finally in place. However, this vision was dashed by the hostility of the mainstream medical profession and, after 1948, even more so by the new apartheid government, causing the idea to wither and become no more than a vanishing memory. In the 1990s, the model resurfaced as part of the country’s transition to democracy, eliciting great enthusiasm among a new generation of health policymakers. I conclude by looking at the fate to date of this second coming of the Pholela experiment. (Am J Public Health. 2014;104:1872–1876. doi:10.2105/AJPH.2014.302136).

IN APRIL 1990, JUST TWO months after the release of Nelson Mandela from an apartheid prison and the unbanning of the African National Congress (ANC), its chief representative in Mozambique told an upbeat international conference on health in southern Africa that the party’s aim was to establish “a national health service in South Africa, based on the principles of primary health care and geared towards a programme of health for all by the year 2000.”

During the next 4 years of South Africa’s transition to a democratic political order, this goal was elaborated on by both the ANC and progressive public health specialists who shared its vision. In giving their enthusiastic support to the idea, several of the latter pointed out that this would not be the first time that the country had sought to mold its health system around primary health care; 50 years earlier, an official attempt to create a national health system based on primary health care–style health centers had briefly flourished.

Between 1945 and 1948, following the innovative model of Sidney and Emily Kark’s Pholela Health Centre in deep rural Natal, 44 such health centers had been set up around the country by the national Department of Public Health as the foundation of a wholly new national health system. In the words of the National Health Services Commission (the Gluckman Commission), whose grand vision this was, such a system would provide the basis for “an organized National Health Service in conformity with the modern conception of ‘Health’ which will ensure adequate medical, dental, nursing and hospital services for all sections of the people of the Union of South Africa.”

That this ambitious scheme to reshape the country’s health system around an entirely novel principle had been cut short by a combination of medical, racial, and state politics in the years after 1948 only boosted the sense of triumph and joy that the ANC’s commitment to primary health care received from progressive health workers in the 1990s. As 2 of them, Steve Tollman and Derek Yach, wrote in the American Journal of Public Health in 1993, “As South Africa undergoes rapid social, economic, and political change, the rich heritage of public health and primary health care is being rediscovered. . . . The work at Pholela is now recognized as a highly effective example of a rural health center applying (indeed initiating) principles that
are today seen as key to primary health care. It seemed that, after 45 years of neglect under apartheid, the time had at last come for their resurrection.

Doctors who had worked at Pholela as students in the 1950s now waxed lyrical about the lessons it held for the new, democratic South Africa. “Good ideas and concepts . . . may be rediscovered or re-invented—and may even flourish—in the face of urgent need, political upheaval, or both,” wrote one in 1993. “In South Africa, as the accession of the ANC approaches, the work of the Karks and their successors is now recalled, and the relevance of community health centers is appreciated as a possible centerpiece of the new national health care system that must soon emerge.” Even more glowing was the tribute of the editor of the American Journal of Public Health, Mervyn Susser, an ex-South African who had spent several months at Pholela in about 1950. In his eyes, the Karks’ innovations at Pholela were even more significant beyond South Africa, for he believed that “Sidney Kark assembled the girders on which, at some remove, the famous declaration of Alma Ata rests.”

Not surprisingly, therefore, when the aged Sidney and Emily Kark visited South Africa in 1992, they were feted by progressive-minded health workers. The ANC’s shadow minister of health, Nkosazana Dlamini-Zuma (who had herself grown up near Pholela, cherishing “the African health workers and medical students” there as role models), held lengthy consultations with them; medical school professors jostled to tell them of their own fledgling community-oriented primary care units, and even that old foe of primary health care, the South African Nursing Council, sought a meeting to discuss the role of community health nurses in a community-oriented primary care–based dispensation. “Wherever we went,” mused Sidney Kark, “there was a major interest in translating the concept of primary health care into practice.” The editor of the South African Medical Journal exuberantly declared in 1994, “The Pholela Health Centre was one of two spectacular attempts at health care innovation that surfaced in the early 1940s, well ahead of their time. The other was the report of the Gluckman Commission . . . Today’s policymakers need look no further for a model on which to base a sensible and effective primary health care network.”

Nor did they. Given its noble pedigree and the urgent need to extend health care equitably to all in the new South Africa, primary health care naturally formed the foundation of the ANC government’s National Health Bill, which aimed to transform the country’s health sector comprehensively. Through its many drafts between 1998 and 2003, when it was finally passed, the bill’s primary health care core remained unchallenged. Primary health care is “the basic ‘plank’ of our [new] health system,” explained James Ngculu, the chair of Parliament’s Portfolio Committee on Health, and the minister of health insisted that the new health system would be “based on primary health care. . . . It is our responsibility, nationally and provincially, to always protect the principle of primary health care in our country.”

“The linear forebear of this primary health care approach, the inspiring Pholela experiment, was a Department of Public Health initiative in 1939, aimed at addressing the escalating burden of infectious and deficiency diseases among increasingly impoverished rural Africans in South Africa without incurring large expenditure. Indeed, in 1939, the country’s Secretary for Public Health had laid down that “All increased demand for treatment of illness among Natives must be met by cheap clinics. Such clinics must be set up in rural areas where the bulk of patients could be treated on out-patient lines.” In the remote district of Pholela in Natal, the newly appointed medical duo of Sidney and Emily Kark interpreted this as a broad mandate to innovate, but inexpensively. Drawing on contemporary ideas of social medicine and its implementation in Europe, China, and Dutch Java and on Sidney Kark’s recent experience in helping to conduct a nutritional survey of African children in rural South Africa, the pair began to develop a health center–based system there that, in contrast to the dominant curative medical model of the day, combined the provision of free curative, preventive, and promotive medicine at one site. Approved by local chiefs and the wider community, it not only treated the sick but also sought to maintain the condition of the well by encouraging all members of the community to

THE PHOLELA EXPERIMENT, 1940–1960

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visit the center periodically and to allow trained, locally recruited health assistants to visit their homes to collect data on the social and economic context of their health. This information was entered onto family health cards, which were closely analyzed by health teams at the center to identify any imminent threats to health and well-being and to nip these in the bud through targeted interventions. An individual’s health, whether bad or good, was thus always seen within the framework of his or her family’s health or even that of the community at large. Sidney Kark called it “the application of epidemiology in clinical practice,” which also served “as an early warning system of epidemics occurring in the community.”15

Given Sidney Kark’s sensitivity to the key role of diet in health, particular attention was paid to the nutritional status of this rural community. Apart from close monitoring of what they consumed at home, community members were given practical advice about the best crops to plant by means of a demonstration vegetable garden in the grounds of the health center, while a close watch was kept on the nutritional status of preschoolers in the child care center nearby—any sign of malnutrition immediately elicited a course of food supplements. Sports and nutrition days for all children every Saturday allowed the health center team to cast an eye over the health of children not attending the child care center and to intervene nutritionally or therapeutically if this was deemed necessary. Older children also came under specific health scrutiny as a comprehensive school health service was instituted in the district’s schools following discussions with staff and parents.

In short, the social medicine system built up around the Pholela Health Centre from 1940 tried to be a holistic, one-stop center devoted to combating disease and preserving good health in one clearly defined community. It sought to marry treatment, prevention, and promotion in a novel combination that made doctors part of a composite health team and the health center part of the community. Although followers of Michel Foucault might perceive panoptic tendencies in the center’s gaze and surveillance and a desire for near-total control in its actions, elderly residents of Pholela do not recall it thus. In their memories, “Kaki” (their nickname for Kark) remains “someone who cared about us and our health.”16

This incipient version of community-oriented primary care developed at Pholela was strongly promoted by the Gluckman Commission and progresses in the national Department of Public Health between 1944 and 1948 as the model for a new health care system in South Africa. “[A]ll extra-institutional medical practice in future should be based upon Health Centres, each serving the population within a clearly defined area,” Henry Gluckman (who was appointed minister of health in 1945) argued,17 and by 1948 the Pholela Health Centre had been joined by 44 other health centers around the country, operating on similar principles but with significant adaptations to local circumstances (both rural and urban) and by an institute in Durban to train health workers for these centers.

Yet, as already hinted at, from the start health centers of this ilk were not popular among the mainstream medical profession; after the accession of the apartheid-minded National Party to government in 1948, the idea enjoyed dwindling support in the topmost echelons of official power. Over the next dozen years, Pholela and its fellow centers were gradually strangled by the state until, by 1960, they had all been turned into curative, outpatient clinics or day hospitals. At Pholela and the 44 other sites, the memory of the holistic service that had once been offered there faded generation by generation—until the impending sea change in South African politics in 1990 promised a return of the Pholela model.

**RETURN OF THE PHOLELA EXPERIMENT SINCE 1994**

But the past often appears more golden than it actually was, especially when it is imported unchanged into a very different present. Since 1994, the much-heralded resurrection in words of the Pholela model of primary health care has not been matched by its resurrection on the ground. As is clear from the outline (presented in the previous section) of what the model entailed in practice, it was very intensive in the skilled labor and commitment it required to func-
tion effectively. In post-1994 South Africa, both of these have been in short supply at all levels because of the skewed nature of education under apartheid, the slow-to-change curative orientation of medical and nursing training, and the attractions of the global employment market and the domestic private health sector to South African health personnel.

Nor was the new, post-1994 district health system, which was meant to provide the framework for the rollout of community-oriented primary care, able to do so effectively. Too often, implementing it was impeded by turf wars, vested curative interests, disputes over demarcation, a poorly functioning referral system, and bureaucratic rigidity and inexperience. Increasingly, proposals for reforms did not leave the page on which they were spelled out at length and so became more and more delinked from the reality on the ground. In the judgment of two health sector analysts, “Preoccupation with organisational structure and authority . . . led to a loss of momentum in systems development and service delivery and ultimately, in the under-performance of PHC [primary health center] services in many parts of the country.”18 One health center doctor observed dejectedly that “Management know the value of community orientation but often seem cautious about wide community involvement as it may ‘create expectations.’”19

Moreover, aggravating these shortcomings year by year have been the addition of chronic diseases to the health burden and the swelling HIV/AIDS epidemic, with its escalating capacity to swamp every health care facility in the country. Health care personnel, confronted by a daily surge of HIV-positive people, were hard put to practice anything but palliative medicine, and that at a time when President Thabo Mbeki’s denial of the connection between HIV and AIDS made it very difficult to do even this as antiretroviral therapy was blocked, or at least frowned upon, by the national Department of Health. “[M]ention of COPC [community-oriented primary care] by doctors is mostly regarded by managers as an indulgence considering the patient queues,” lamented one dispirited practitioner.20

Even as enthusiastic a proponent of Pholela-style community-oriented primary care as Steve Tollman was forced to admit in 2008 that “the promise of PHC in South Africa remains largely unfulfilled.”21 In a second article he regretted that the “translation [of COPC] into practice has been limited and patchy at best. The policy framework created has not, as yet, enabled the emergence of a functioning district health system able to draw effectively on health center practice as pioneered in Pholela.”22 Damningly, one health center doctor reported that, because of the chronic shortage of doctors and the consequent heavy reliance on primary health care nurses to see the bulk of patients, the latter “often bypass the nurses to get to a doctor and hospital.”23 With despair, Tollman admitted that “While the Pholela experience and COPC have played a symbolic and inspirational role, their direct influence on district and sub-district health development is slight at best.”24 No less a person than South Africa’s director-general of health admitted in 2013 that many public health centers were “in a shambles.”25

The clear lesson from this disappointing picture is that adopting a primary health care approach is not a magic bullet that automatically improves the health status of a population. Implementing it requires wide-scale medical, social, financial, and political commitment and sacrifice, a fact that South African authorities must recognize, just as their counterparts in 41 other primary health care–practicing countries around the world do. The latest buzz-phrase in South Africa, “a re-engineered PHC system,”26 suggests that they do, at least on paper. But history should remind them that the flow of a cool river (the meaning of pholela in isiZulu) can all too easily be blocked by human obstacles.

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This article was accepted June 11, 2014.

Acknowledgments

My thanks for the comments and suggestions by the Journal’s three anonymous reviewers and by the participants in a seminar at the Institute of Health and Social Policy at McGill University in April 2013.

Endnotes


12. Debates of the National Assembly (Hansard), 61 (2003), col. 6138.

13. The complex causes of this situation are well examined in recent general histories of South Africa; for example, William Beinart, Twentieth Century South Africa (Oxford: Oxford University Press, 2001), part 1, especially chapters 1 and 5.


16. Comment by anonymous Pholela resident at public meeting at Pholela, August 12, 1998.


