9 The African Roots of Community-Oriented Primary Care

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"They were nice. They cared about us."

For the past seventeen years, I have heard this over and over as I talk with elderly people about the work of the Pholela Community Health Centre (PCHC) in the middle of the twentieth century. Located in the rural, mountainous Pholela region of what is today KwaZulu-Natal, South Africa, the PCHC was an experiment in social medicine carried out in the 1940s and 1950s. One of social medicine's most important origin sites, the PCHC married clinical care with an attention to what are today called the social determinants of health at the household and community scales to improve the health of the entire region. In Pholela, doctors, community health workers, and residents worked together developing a brand of social medicine called Community-Oriented Primary Care (COPC). Within ten years, infant and crude mortality had plummeted, malnutrition had all but disappeared, and communicable diseases like syphilis had decreased markedly.[1] The PCHC was a resounding success. It was so successful, in fact, that it has been referred to as a model for the world.[2]

The PCHC and the social medicine pioneered there looms large in the history of social and community health. Not only has it served as a model for the world, taken up in places like Uganda, Israel, Chile, the United States, and Canada, but even to this day it is pointed to as the kind of practice the world needs to alleviate health disparities. Central to the stories and legacies of COPC is Sidney Kark, founder of the PCHC and world-renowned social medicine practitioner. Kark got his start in Pholela and from there went on to found the Institute for Family and Community Medicine at the first Black medical school in South Africa at the University of Natal. Through this work, he brought COPC to urban South Africa, first in Durban and later to cities across the country. As apartheid hardened in

This chapter draws on material from my book, Abigail H. Neely, *Reimagining Social Medicine from the South* (Durham, NC: Duke University Press, 2021), which has a more complete list of references as well.

[1] Mervyn Susser, "Pioneering Community-Oriented Primary Care," *Bull World Health Organization* 77, no. 5 (1999): 436–8.

[2] "Community Health: A Model for the World," *Against the Odds*, accessed October 21, 2016, at: https://apps.nlm.nih.gov/againsttheodds/exhibit/community_health/model_world.cfm.

the 1950s and his work became impossible, Kark left South Africa, taking positions at Harvard University and the University of North Carolina, Chapel Hill (UNC), in the United States, before settling in Jerusalem, where he founded the Department of Community Medicine at the Hebrew University and helped reorient the Israeli health system around community health centers and the practice of COPC. Kark even went on to contribute to the WHO's Alma-Ata Declaration of Primary Health Care for all in 1978. A storied and important career by any measure, Kark had a tremendous impact on social medicine worldwide.

But Kark was not alone in Pholela. The "they" in the quote that opens this chapter tells us as much. Sidney Kark arrived in Pholela with his wife Emily, who was also a medical doctor and who accompanied him in his medical practice and his academic career. Together, they pioneered COPC and co-authored some of the most important texts on social medicine in the twentieth century.[3] But they did not do so alone, Edward and Amelia Jali, a Zulu health aid (one step below a doctor) and nursing sister, and a team of Zulu-speaking community health workers joined them in Pholela where together they worked to develop COPC. While the legacy of Sidney Kark is well documented through his own writings and writings about his work,[4] the legacy of Emily Kark, Edward and Amelia Jali, the community health workers at the PCHC, and Pholela's residents is harder to find. Drawing on over seventeen years of ethnographic research and conversation in Pholela with its residents, this piece offers an alternative history of COPC and by extension social medicine, one which decenters Sidney Kark (though he was very important), and focuses instead on the work and lives of his team, the communities in which they implemented their programs, and the things they used in that implementation. So doing, it shifts understandings of the production of science and social medicine away from (mostly white, mostly male) doctors and offers alternative explanations of how and why with their social medicine practices become important, meaningful, and successful.

Sidney and Emily Kark met at the University of Witwatersrand (Wits) in Johannesburg, where they were medical students. At Wits, they blended a typical biomedical education with classes in the critical social sciences.[5] From

[3] Sidney L. Kark, *Epidemiology and Community Medicine* (New York, NY: Appleton-Century-Crofts, 1974); Sidney L. Kark, *The Practice of Community-Oriented Primary Health Care* (New York, NY: Appleton-Century-Crofts, 1981).

[4] H. Jack Geiger, "Community-Oriented Primary Care: The Legacy of Sidney Kark," *American Journal of Public Health* 83, no. 7 (July 1993): 946–7; Sidney L. Kark and John Cassel, "The Pholela Health Centre: A Progress Report," *South African Medical Journal* 26, no. 6 (1952): 101–4; Sidney L. Kark and Guy W. Steuart, *A Practice of Social Medicine: A South African Team's Experiences in Different African Communities* (Edinburgh: E. & S. Livingstone, 1962).

[5] In addition to their classroom teaching, a number of the faculty from the university's Medical School held important posts in the South African government and the Ministry of Health in particular. It was these men who would champion Sidney's early career.

a number of well-known, progressive faculty members they learned about Marxist interpretations of South Africa's class structure and political-economy, what the Karks later called "socio-economic historical analysis."[6] They learned about the problems created by the country's racial divides and the realities of life for the majority of South Africa's poor Africans. Connecting these lessons with their medical education, they learned that the difficult lives and ill health of many Africans could be attributed to a long history of oppression, disenfranchisement, and race-based economic inequality, or what is today called "racial capitalism."[7] The professors at Wits taught that improving the lives of South Africans living in poverty could only happen by addressing systemic issues: oppression, disenfranchisement, economic inequality, and racism at national and local scales.[8] When applied to health, this approach addressed what we call today the "social determinants of health," recognizing the role of racial capitalism in setting the terms of what is possible. At Wits, the Karks also learned anthropological and historical methods like surveys, participant observation, and analysis trained on structural rather than individual forces. These methods were key to their approach to social medicine and their understanding of Pholela and where the health problems there originated. During their hands-on training, they had opportunities to visit parts of South Africa they had never seen before, witnessing what they had learned in their classes playing out in the lives of the country's majority African population. This experience and education helped lay the foundation for the work Sidney and Emily would do in Pholela and for the relationships that made that work so successful and important.

The professors at Wits also pushed their students to act, insisting that they had a responsibility to do so. Through these professors, the Karks learned about the work of the nascent South African Institute for Race Relations (SAIRR). The SAIRR is an organization dedicated to research and awareness about racial inequality in South Africa and the political struggle to end segregation and oppression.[9] It provided the Karks with a model for a marriage between

[6] Sidney Kark and Emily Kark, *Promoting Community Health: From Polela to Jerusalem* (Johannesburg: University of Witwatersrand Press, 1999), 7.

[7] A term most famously coined by Cedric Robinson, "racial capitalism" recognizes the inextricability of capitalism and racism, with specific attention to anti-Black racism. While Robinson's analysis unpacks the Atlantic slave trade, he also offers a general history of capitalism. Cedric J Robinson, *Black Marxism: The Making of the Black Radical Tradition* (Chapel Hill, NC: University of North Carolina Press, 2000). The relationships around both race and class that make up racial capitalism make particularly strong impressions in settler states. South Africa, especially under apartheid, offers one of the most obvious and striking examples of this. Indeed, the term "racial capitalism" was first coined in South Africa.

[8] Their most influential professors included William Macmillian, R. D. Rheinallt Jones, and Alfred and Winifred Hoernlé.

[9] The South African Institute for Race Relations, established in 1929, was the first national multiracial organization to conduct socioeconomic research about race relations in South Africa. To this day, it is known for its liberal politics and rigorous research.

research and theory on the one hand, and political action on the other.[10] The ideas they encountered in classrooms and from the SAIRR were radical in a country with a long history of racist ideology codified into law (culminating in apartheid, which formally began in 1948). These experiences transformed the Karks from medical students occupied with anatomy, pathology, and other components of a biomedical education, to future physicians dedicated to social change and concerned with the broad social and cultural factors that shape both health and healthcare delivery. Thanks to connections he made as a student, in the years immediately after graduating, Sidney began working at the Ministry of Health and with Edward Jali conducted a large-scale survey of the nutrition of African school children throughout South Africa. This survey offered Kark and Jali hands-on training in the social science methods that would come to underpin COPC as well as an understanding of the depth of malnutrition in South Africa and its links to poverty.

Sixty years after the Karks had left Pholela, in 2008, I sat in a neat, red-brick home at the top of a hillside community I call Enkangala in the catchment of the former Pholela Community Health Centre.[11] In the corner of a spare bedroom lay Gogo Heni (*gogo* is the Zulu word for grandma). In the 1940s and 1950s, she had worked as a community health worker for the PCHC. Community health workers had been the backbone of the PCHC's efforts in Pholela. They worked primarily in communities, gathering data on households to both guide health center programs and evaluate their efficacy. It was through this work that the PCHC measured its remarkable success.[12] They also visited homesteads, helped to build demonstration gardens, met with community groups, and assisted with health education, school lunch, and other programs at area schools. These health assistants were largely from and lived in the communities that surrounded the health center, which meant that educated community members could be employed at home investing the money they earned there. It also meant that the health center would have a workforce that knew the community intimately. It was through people like Gogo Heni and their interactions with community members in Pholela that COPC first took its form.

[10] In addition to their studies, the Karks were heavily involved in student politics and activism, including through the National Union of South African Students (NUSAS), an inclusive, non-racist and non-sexist student organization, with chapters at a number of universities. Kark and Kark, *Promoting Community Health*.

[11] In accordance with the IRB, all names of residents are pseudonyms and all specific community names are pseudonyms. Because the doctors at the PCHC are well known and published extensively on their experiences there, I use their real names.

[12] For a full explanation of this work and a critical take on how the PCHC produced and measured its success, see Neely, "Chapter 1: Seeing Like a Health Center," in *Reimagining Social Medicine*.

By the time I met Gogo Heni she was in the last months of a long life and suffering from dementia. I sat in the dim, cold room on wobbly blue-green plastic chairs with Enkangala's current community health worker, Zanele, a woman who would go on to become a cherished friend. Zanele and I talked about the passage of time and how long it had been since the Karks were at the PCHC. Zanele arrived in Pholela after the Karks had left the country. She came to Enkangala because she married a man from this place. She had heard about the Karks' work and knew that things were different now. There were fewer gardens in homes, more young people migrated for work (which was saying something, since Pholela had the second-highest levels of out-migration in South Africa in the 1940s), and there was much less investment in the community and care from the health center. Though Zanele visited individual households to offer treatment support and health education, the health center's program in the early 2000s was far different than it had been "in the time of the Karks," as residents called the period when "they" (Sidney and Emily Kark) were there caring for them.

As I got to know the community more, I began to see the remnants of the PCHC's work everywhere. On another afternoon, I was wandering with a woman I call Gogo Ngcobo in her garden. I learned that the health assistants had taught her to plant vegetables and staples like maize and sorghum in neat rows and in separate beds so that she could easily spot where beetroot, maize, or peppers would grow. They taught her to fertilize with cow manure and rotate her garden beds periodically so as not to exhaust the soil. She explained that these vegetables were important for her health because of their nutrients and that to preserve those nutrients one needed to boil instead of fry them. As our conversation made clear, she had learned from the health center to sure up her health through nutrition by tending to everything from the soil to food preparation. Gogo Ngcobo's garden and her knowledge were particularly striking because her neighbors had neither gardens as diverse nor such a sophisticated understanding of nutrition and how it affected health. Gogo Ngcobo had grown up in the catchment of the PCHC and had only moved to Entabeni when she was an adult, bringing with her the lessons she learned as a girl. Her neighbors had had none of this experience as children.

In another community I call Ethafeni, which was closer to the PCHC, Mkhulu Vilakazi (*mkhulu* is the Zulu word for grandfather) took me on a tour of the mountains that sat above his home. Long known to the nomadic pastoralist ancestors of today's residents because of the nutritious sourveld that grew there, the mountains of Pholela served as pastureland for the communities' livestock. As Mkhulu and I walked slowly up the mountain, we paused to step over a fallen wire fence and looked at a wooden fence post in the distance weathered by the sun and rain. Mkhulu explained that fencing was crucial for the rotational grazing that agricultural extension workers taught residents they

needed because it allowed large sections of the pasture to rest while livestock grazed in other places. As we continued, he pointed out three subtle indentations in the hillside. These were cattle dams, he explained, or they had been. The government workers had built these dams for the livestock to drink as they grazed in this pasture. As he talked, his expression betrayed a wistfulness for a time when the government cared about Pholela and its residents. These ghosts in the landscape offer reminders of the past, of things that are there but not there, much like Gogo Heni who lay on her deathbed occupying a place between past and present. The landscapes and the people of Pholela offer reminders of the work of the PCHC in the time of the Karks and the lasting power of COPC in this place.

In 1940, when the Karks established the PCHC, Pholela was part of the African Reserve area of KwaZulu in the province of Natal. Nestled in the foothills of the southern Drakensberg Mountains, the district sits in a messy patchwork where communally held African land is mixed in amongst European farms and small European (white)-occupied towns. Though apartheid would not officially begin until 1948, there had long been policies and practices of dispossession of and discrimination against African populations, part of what Patrick Wolfe refers to as the apparatus of settler colonialism.[13] In the nineteenth and early twentieth centuries, economic and minority interests coalesced into policies that forced native Africans onto smaller and smaller pieces of land called "Reserves," forcibly settling nomadic and semi-nomadic peoples like the ancestors of Pholela's residents. The most significant early legislation was the 1913 Natives Land Act, which made it illegal for Africans to own or lease land in white areas. When the PCHC was established, African Reserves comprised 11.7 percent of the land in South Africa and housed the vast majority of Africans, who made up 69 percent of the country's population.[14] This dispossession meant that whites gained access to extensive parcels of land for agricultural production, mining, and other natural resource extraction. The industrial development that followed was key to making South Africa the biggest economy on the continent. It also meant that most rural Africans had only limited space for agriculture and few or no opportunities to expand their production. As a result, African men were compelled into wage labor because they could no longer make a living from the land. And as African men migrated to urban, industrial, mining, and agricultural areas to work, they left their families behind because of laws requiring Africans to carry passes for work in white areas.[15]

[13] Patrick Wolfe, *Settler Colonialism* (London and New York, NY: A&C Black, 1999).

[14] Leonard Monteath Thompson, *A History of South Africa*, 3rd ed., Yale Nota Bene, (New Haven, CT: Yale University Press, 2001), 297.

[15] Dorrit Posel, "How Do Households Work? Migration, the Household and Remittance Behaviour in South Africa," *Social Dynamics* 27, no. 1 (2001): 165–89; Cherryl Walker, *Women and Gender in Southern Africa to 1945* (Cape Town: New Africa Books, 1990).

Stolen land and compulsory labor together enabled huge profits for white people in South Africa. This stratified landscape and stratified wealth is what racial capitalism had wrought.

Pholela exemplified this political reality. Women remained at home growing what little they could on too-small patches of marginal lands while men sent remittances from the meager wages they earned as unskilled laborers in cities and on farms. The combined livelihood approach meant that families barely survived and that their health often suffered. Indeed, malnutrition was one of the most remarkable features of the population when the PCHC began its work in 1940. In addition, when they returned home, the men brought new diseases like syphilis and tuberculosis with them, which took root in their malnourished families and neighbors. It was this political, economic, and health context that would help shape the possibilities and limitations of the social medicine that developed in this place.

Many of the gogos I work with in Pholela had been girls or young women when COPC began. Take one woman who I have spent a lot of time with over the years, Gogo Sithole. Affable and open, Gogo Sithole was an important presence in Pholela in the early 2000s, as well as fun and easy company. She was also energetic and hard-working, well into her nineties, often running around Enkangala, working in her garden, and helping out friends at a pace that tired me out. This plus the little bit of English she had learned made her a perfect candidate to be a domestic servant for the Karks sixty-five years before I met her. After the Karks arrived, Gogo Sithole took care of their house and their children and came to know a bit about social medicine from that experience. She also loved and appreciated the Karks in a way I found common for those who lived in Pholela in the 1940s and 1950s – she even named her first child after theirs, Carol.

In the early 1940s, Gogo Sithole was a young woman. She had grown up in Enkangala and was recently married. She had little formal schooling, but lots of experience caring for children, working in fields and gardens, taking care of livestock, and generally contributing to her household's livelihood. She would go on to have eleven children, the first out of wedlock. Her husband, who also came from Enkangala, migrated for work for most of their life together, sending money home on occasion and keeping the company of "girlfriends" in the city, on the farms, and along the railroad where he found employment. To make ends meet, Gogo Sithole worked as well, first for the Karks and the doctors who followed. Later, she opened up a small stand to sell food and drinks to patients and employees at the health center. She combined this income and the money her husband sent home with what she could grow in her garden and in her fields to provide for her family. By the time I met Gogo Sithole, she was already in her eighties and lived at a ramshackle homestead that was always teeming with several generations. Six of her eleven children

had predeceased her due to accidents and disease, both HIV and untreated chronic conditions like diabetes. While Gogo Sithole was uncommon, her experience was not.

The importance of the work of the PCHC was present in Gogo Sithole's homestead and her long life, as well as in her stories. As I got to know her better and as I got to know the work the PCHC had done in the 1940s and 1950s, I began to notice various elements of her homestead like the vegetable garden, pit latrines, and rubbish pit that I had learned about in the archives. These things had been key to the health center's vision of a healthy homestead and by extension social medicine. One day, soon after I had returned to Pholela from two months in the archives, Gogo and I ambled around her homestead chatting. I looked down and right in front of us was a new water tap. I asked Gogo about it. She told me that the family had collected its money to buy a new tap because their other one had run dry. Access to protected water was important, as Gogo Sithole and her neighbors had explained to me, because it ensured that they would not get sick from bacteria (and other things) in the water they drank. In the years before the PCHC, there were no protected water sources in Pholela, nor were there pit latrines, rubbish pits, compost pits, or diverse gardens. As I walked around Gogo Sithole's homestead that afternoon, it suddenly dawned on me that many of the homestead elements I had taken for granted were actually products of the health center's social medicine program. They remained in Pholela's homesteads thanks to the upkeep and work of area residents.

The importance of the PCHC's work was also evident in the way she participated in my research. Months before, as I conducted my first major interview with her to better understand what life was like in "the time of the Karks," it became clear that Gogo Sithole was an old hand at research. I used a printed questionnaire I had based on Sidney and Emily Karks' publications and the annual reports they and others produced about the PCHC. I was hoping to gather similar data so that I could trace change over time. As we moved through the questions, Gogo Sithole sat straight up and the wrinkles in the space between her eyebrows deepened as she concentrated in order to be sure that she fully understood what I was asking. The answers she gave were both accurate and comprehensible, two good qualities for research it seemed to me.

After a few questions, Gogo Sithole stopped me. She told me she knew exactly what we were doing. She explained that in the "time of the Karks," community health workers and researchers would come around and ask many of the same kinds of questions. And then she pointed out that I was not doing it very well because I did not know the right order of the questions and I did not phrase them correctly. In addition, I fumbled a bit and appeared unprepared (which was true, it being my first interview).

To be the kind of researcher Gogo Sithole was expecting, I needed to ask the right types of questions – about specific illnesses, crop yields, and hygiene

practices in the household – and I needed to do so quickly, efficiently, and confidently, using the correct phrasing, all in the right order. In return, Gogo would answer those questions "correctly," concisely, and efficiently. According to Gogo, those were our roles in the research process.[16]

Like the fruit trees that lined her garden and the waste-disposal pits in her yard, Gogo Sithole's commentary on my research was a reminder of the impact of the PCHC on this place and its people. More importantly, however, it offered a lesson about her role and that of her neighbors in the work that the PCHC did in Pholela. Soon after the Karks and their team had established the PCHC, they set out to get to know the communities that surrounded the health center. In addition to meeting with the *Inkosi* and his *Ndunas* (the local power structure), the PCHC began with a household survey carried out by community health workers to gather information on basic household demographics, garden and field inventories, and health. This allowed them to get to know the conditions of life in the communities and in households, and it provided baseline data against which to measure progress. Focusing on the household had an added benefit of introducing the health center's staff to Pholela's residents, a first step in the relationships that would be so important to the PCHC's success and the development of COPC.

From the information it gathered in those surveys and in discussions with residents, the PCHC developed a social medicine program that was rooted in the homesteads of Pholela, reflecting both the needs of the communities and the possibilities for health and healing in this place. In practice, this meant a major health education and health improvement campaign. To make this happen, health assistants went door to door bringing lessons on hygiene and nutrition as well as plans for how to improve homesteads. To make the homestead a healthy place, the PCHC believed that residents needed to add new elements, rearrange existing components, and keep everything neat and tidy; they needed to reshape the landscape. In practice, successfully remaking the homestead required that health assistants and residents work together and learn from each other. It also required new relationships between people and things, as community health workers, Pholela's residents, and the things of homestead transformation reconfigured homesteads, health, and relationships together.

To promote health, the PCHC focused on the home vegetable garden. The health center saw vegetables packed with vitamins and minerals (micronutrients) as key to improving baseline health. The homestead vegetable garden, like the one Gogo Ngcobo showed me around in her homestead, became an important component of COPC because it provided an easy way to supply

[16] For more on my process of learning to be a researcher and on the role of research participants in the work of the PCHC, see Neely, "Chapter 2: Relationships and Social Medicine," in *Reimagining Social Medicine*.

nutrients to residents' diets, a way that was not deemed communist and therefore illegal as prescriptions of fresh vegetables were. Building gardens and growing new crops required new seeds, new tools and techniques, new knowledge, and labor, especially at first. As a result, health assistants and Pholela's residents built these home vegetable gardens together with seeds and tools provided by the health center and tips and techniques offered by agricultural extension workers in the area, the same agricultural extension workers who built the cattle fences and dams on the mountain top that Mkhulu Vilakazi and I visited.

Once they began growing, residents consumed the vegetables from their gardens. The micronutrients in those vegetables helped to counteract some of the most pernicious aspects of malnutrition and led to significant drops in overall rates. This was a biomedical solution to a health problem. But this biomedical solution was an intervention in the biology of the landscape as well as the body. And just as in the case of the new waste-disposal system, it was an intervention that necessarily involved people. Vegetables, people, nutrients, cells, and science all worked together to improve health. These improvements motivated residents to continue planting vegetables as they felt their positive effects and saw them in their children. Thanks to the impact that increased nutrients in diets had on residents, the non-human components of gardens, like soil, seeds, and shovels, became integral to the relationships between health center staff and area residents that underpinned the COPC developing in Pholela. Through new vegetable gardens (as well as other elements), the homestead landscape and the bodies of Pholela's resident were transformed.

Of course, the Karks and the PCHC understood ill health to be rooted in social structures as well as biology and the environment. For them, South Africa's system of racial capitalism, which kept Africans in the Reserves and ensured that they would remain destitute, was the ultimate social cause of illness. But these broad-scale political-economic processes were harder, if not impossible, to intervene in. As a result, the PCHC saw efforts to remake homesteads as a winnable stopgap measure (an intervention in the biological world) that could improve health, even if they did not reduce poverty (the most important aspect of the social world). This approach of focusing on the biological was quite successful and it was built on a bedrock of relationships among health center staff, residents, and the stuff of homestead transformation.

The transformation of homesteads catalyzed even more new relationships. Soon after they began planting new vegetables in their home gardens, Pholela's women formed seed cooperatives to share seeds and knowledge as they worked to improve their gardens in terms of both taste and nutrition. As women traded seeds, their gardens grew more diverse, and their yields improved. Together, they selected vegetables and seeds for taste and productivity. These seeds, the vegetables they would become, and the nutrients they would supply led to a

new social formation and more influence for the women of Pholela. The seed cooperatives became the basis for a woman's advisory group first at the health center and later for the area chief, giving women a voice in official politics. The new social organization around seeds mattered beyond Pholela, too. As the women who were members of the seed cooperatives interacted with health center staff, the PCHC began to see the positive impact that these cooperatives offered to garden variety and yields. Seeing this as an excellent community solution to a health problem (malnutrition), the Karks and others incorporated cooperatives into COPC. By the 1970s, seed and other cooperatives had become a hallmark of this brand of social medicine as they traveled beyond Pholela to places like Mound Bayou, Mississippi. In Mound Bayou, the site of the first rural health center modeled on Pholela in the US, the farmer's cooperative was one of its most important and distinctive features.[17]

The PCHC staff's ability to recognize the value of seed cooperatives and their subsequent incorporation into COPC was thanks to the staff's relationships with Pholela's women. Relationships that Emily Kark played a central role in creating. It was Emily, not Sidney, who one woman asked about when I had just arrived in Pholela in 2008. She had not heard from her in a while and was worried. Emily sent a Christmas card every year. She loved them and they loved her, the women explained. She had been the one who studied them and their children, who cared about them and their health.[18] After all those years and across thousands of miles, the ties that bound these women together remained strong. But that was not all; the value of the seed cooperatives came in part through the seeds the women shared, the vegetables that grew from them, and the nutrients they contained. After all, it was the improvements in health that the PCHC and the Karks are best known for. The seeds these women shared led to new configurations of human social relationships that would extend beyond Pholela to other sites of COPC and beyond gardens to broader political structures. It would not be a stretch to say that thanks to the flexibility of the seed cooperative model, residents like Gogo Sithole have left a mark on places like Mound Bayou, Mississippi, and Jerusalem.[19] It was the non-humans – the things that could travel and adapt – that made it possible for

[17] "Community Health: A Model for the World."

[18] For example, see: Emily Kark, "Menarehe in South African Bantu Girls," *South African Journal of Medical Sciences* 8, no. 1 (1943): 35–40; Emily Kark, "The Growth and Nutritional State of Bantu Girls in Durban," *South African Journal of Medical Sciences* 18 (1953): 109–24; Emily Kark, "Puberty in South African Girls: I. The Menarche in Indian Girls of Durban," *South African Journal of Clinical Science. Suid-Afrikaanse tydskrif vir kliniese wetenskap* 4, no. 1 (1953): 23–35.

[19] I think with Marianne de Laet and Annemarie Mol's concept of fluidity here to understand seed cooperatives as a fluid technology. Marianne De Laet and Annemarie Mol, "The Zimbabwe Bush Pump: Mechanics of a Fluid Technology," *Social Studies of Science* 30, no. 2 (2000): 225–63.

Pholela's women to leave this mark. And it was in part their relationship with Emily Kark, that amplified their work through COPC.

As the example of vegetable gardens reveals, the relationships between Pholela's residents and health center staff and between people and the environment underlie the dramatic improvements in the health and the groundbreaking innovations the PCHC offered social medicine. These relationships are obscured by the aggregate data that fill annual reports, articles, and books written about the PCHC, rendered invisible in official accounts of COPC and in the publications of the Karks and their colleagues. In their role as research subjects and in their relationships with researchers and the things of social medicine, Pholela's residents and their knowledge, experience, and social world had a tremendous impact on how the PCHC, the government, and the rest of the world would understand Pholela and replicate the social medicine developed there. And it was these relationships – relationships between health center staff and area residents and between people and things – that provide the lasting imprint of COPC in Pholela. "They were nice. They cared about us." This is one of the lasting legacies of the PCHC in this place.

The value of writing from Pholela, from the perspective of this place and its people, is that it centers relationships. It reveals that COPC emerged just as much from the people of Pholela as it did from Sidney and Emily Kark, John Cassel, the second medical director and father of social epidemiology, and the nurses and community health workers they worked with. My experience in Pholela and my relationships with residents taught me this. As Marilyn Strathern writes, "it is through their relations with others that [researchers] understand relationships."[20] And as Gillian Rose writes, one of the consequences of these relationships is that "neither the researcher nor the researched remains unchanged through the research encounter."[21] As the stories of my time with Gogo Sithole makes clear, the woman I met and worked with was forever shaped by her relationships with the people who worked at the PCHC. The PCHC's practice produced research subjects. Its work in communities also produced researchers, as the health center's staff learned how to be social medicine practitioners through their work with Pholela's residents. Just as I learned to be a researcher from Gogo Sithole. In her study of the Rhodes Livingston Institute, Lynn Schumaker asserts that relationships between British researchers and African researchers ensured that anthropology would be "an activity done by and meaningful to Africans."[22] Likewise, thanks to

[20] Marilyn Strathern, "Don't Eat Unwashed Lettuce," *American Ethnologist* 33, no. 4 (2006): 532–4, 523.

[21] Gillian Rose, "Situating Knowledges: Positionality, Reflexivities and Other Tactics," *Progress in Human Geography* 21, no. 3 (1997): 305–20, 315.

[22] Lyn Schumaker, *Africanizing Anthropology: Fieldwork, Networks, and the Making of Cultural Knowledge in Central Africa* (Durham, NC: Duke University Press, 2001), 249.

the long-term relationships developed in Pholela, social medicine was deeply meaningful to communities, to the homestead landscape, and to the individuals whose health improved. But the PCHC's social medicine was not just meaningful to Pholela's residents, it was also the *product* of their relationships with the staff at the PCHC and the things of social medicine. And the impact of those relationships can be seen in the work of many of the social medicine doctors and pioneers highlighted in the other chapters of this book.

Science studies scholars have long sought to uncover the social relationships that underpin science. As Sandra Harding writes, science is "co-constituted with [its] social [order]."[23] Through insights like this one, feminist and postcolonial scholars have challenged often unspoken assumptions that science is a white, male endeavor. In doing so, they question ideas of universality and objectivity – ideas that are entangled with the practices of legibility, standardization, replicability, and consistency that were so important in the PCHC's work in Pholela. These scholars demonstrate that objectivity and universality are partial and particular, and that science is as much about the places in which research is conducted and the people it is conducted by and with as it is about the subjects researched and knowledge produced.[24] In Pholela and in many places in the Global South, the relationships that formed the basis of the practice of science are obscured. The result is that people like Gogo Ngcobo and Gogo Heni are written out of the stories of scientific achievement. Twenty minutes sitting on a bench in Gogo Sithole's yard taught me how important that silence is. But sitting in her yard and standing on the mountain with Mkhulu Vilakazi taught me that things matter too. Donna Haraway and others demonstrate that non-humans play an important role in the practices of science, the production of knowledge, and everyday life more generally. Taken together, these scholars demonstrate that knowledge, practices, landscapes, and people are the products of people, plants, animals, and things.[25]

Centering Pholela's residents and its landscape forces us to rethink what constitutes social medicine. While the doctors who implemented and helped develop COPC are key to its spread – after all, it was Sidney Kark who helped lay the foundation for the Alma-Ata Declaration – they were not the only ones who were important to the development of social medicine in Pholela.

[23] Sandra Harding, "Postcolonial and Feminist Philosophies of Science and Technology: Convergences and Dissonances," *Postcolonial Studies* 12, no. 4 (2009): 401–21, 403.

[24] Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14, no. 3 (1988): 575–99; Sandra G Harding, *The Science Question in Feminism* (Ithaca, NY: Cornell University Press, 1986); Anne Pollock and Banu Subramaniam, "Resisting Power, Retooling Justice: Promises of Feminist Postcolonial Technosciences," *Science, Technology, and Human Values* 41, no. 6 (2016): 951–66.

[25] Karen Barad, *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning* (Durham, NC: Duke University Press, 2007); Donna Haraway, *Simians, Cyborgs, and Women: The Reinvention of Nature*, 1st ed. (New York, NY: Routledge, 1991).

As the unkempt fences, the pit latrines, the vegetable gardens, Gogo Sithole's efforts to teach me how to conduct research, and Gogo Heni's ruminations reveal, Pholela's people and landscapes were integral to the social medicine developed there and exported around the world. And following Schumaker, it was residents' work with internationally recognized doctors like Sidney and Emily Kark and John Cassel that would make what developed in Pholela valuable to the science of social medicine – to the project of universal science. After all, Pholela's residents already knew it was valuable. They could feel it in their bodies and see it in their children. It was the rest of the world that needed to be convinced.

The global importance of Pholela's residents and the things of social medicine came into sharp relief as I sat in the archives at the University of North Carolina, Chapel Hill, in the summer of 2021. A particularly prescient site given that Sidney Kark and John Cassel had founded the Department of Epidemiology there. I was reading through the files of the Delta Health Center in Mound Bayou, Mississippi, as well as the files of H. Jack Geiger, social medicine icon and founder of the Delta Health Center. In the 1950s, Geiger was a medical student at Case Western Reserve University and traveled to South Africa to train with the Karks in Pholela and Durban. There he learned about COPC and social medicine, which became foundational to his life's work. In 1968, after Freedom Summer, he advised Sargent Shriver, the architect of US President Lyndon Johnson's War on Poverty, about how to extend healthcare to end poverty. His model was based directly on what he had learned in South Africa and centered on community health centers. Thanks to Geiger, the first two health centers of the Great Society Program were in Mound Bayou, MS, and Columbia Point, a housing project in Boston, MA, where Geiger lived and worked. As I read through the Delta Health Center's papers and through Geiger's correspondence, the lessons of Gogo Sithole and her neighbors came through. In his papers, the needs and wants of Mound Bayou's residents were front and center, just as they had been in Pholela. The structure of the health center and in the specific programs taken up bore striking resemblance to that of the PCHC where health center staff and residents had worked together to develop COPC. One need look no further than the Bolivar Country Farming Cooperative, so important for nutrition, which was a key component of the health center's efforts. Modeled in part on the seed cooperatives of Pholela's women and in part on the larger practice of collective action and organizing among rural Black people in the US South, the Bolivar County Farming Cooperative, like Pholela's women's seed cooperatives, offers evidence of the centrality of Mound Bayou's residents to the social medicine practiced there. A medicine made visible through the white doctors who practiced it but always meaningful to the African and African American women who were so important to its development.

After a long and storied career, Geiger passed away in December 2020. Obituaries ran in publications from *The New York Times* to the *New England Journal of Medicine*, chronicling a truly remarkable life. Geiger was a decorated professor of social medicine, started two organizations that would go on to win Nobel Peace Prizes, and had a hand in bringing social medicine all over the world. His legacy is everywhere in the US, from Mound Bayou to Boston, from the US–Mexico border to King County, WA. Community health centers that were built thanks to Geiger's efforts serve over 23 million people who have no other access to healthcare. This is Geiger's legacy. But it is also Gogo Sithole's legacy, it is also Gogo Heni's legacy. That we know about Geiger and not about these gogos tells us something profound and important about the stories we tell about social medicine.

Emily Kark shows us this, too. She was Sidney's partner in life and in Pholela but as the memories of Pholela's women attest, she was the one they had such strong bonds with. As they told me, she was also a mother, she understood them and their children. They had something in common. They could work together. And, indeed, Emily produced a number of chapters and articles about women and children and the work she was doing in Pholela, offering evidence of the importance of these bonds (as well as the health impacts of gender).[26] And yet, it is Sidney whom scholars tend to write about when writing about the history of social medicine. And all of this is to say nothing about the non-humans – the vegetables and their nutrients, the household waste, and the germs it allowed to procreate – that made up the landscapes of social medicine in Pholela.

As the archives I visited at UNC made clear, underlying the legacy of COPC and its founders was a profound willingness to learn and to listen, to be in community with the people social medicine is there to serve, to recognize the role of Gogo Sithole, Gogo Heni, Gogo Ngcobo, and Mkhulu Vilakazi in the practice of social medicine. This is the lesson of Emily and Sidney Kark. This is the legacy articulated by Pholela's women: "They were nice. They cared about us." A legacy made plain not only through drops in infant and crude mortality rates and the end of malnutrition, but also in the worried look and desperate request for help to find Emily to be sure she was OK. While none of Pholela's residents were memorialized in print when they died, their work and legacy live on in part through the life's work of people like Sidney and Emily Kark and H. Jack Geiger profoundly shaping both social medicine and the health of the people it serves all over the world.

[26] See n. 19.