> 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.