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The art of medicine

The roots of social medicine: a story of relationships

As the COVID-19 vaccine roll-out began in the USA in December, 2020 and health experts strategised about how to get vaccines to the underserved, H Jack Geiger, a legend in social medicine, died aged 95 years. Geiger was the visionary behind the community health centre programme at the heart of US President Lyndon B Johnson's Great Society programme, which constituted the largest expansion of the social safety net in the USA in the second half of the 20th century. Today, these health centres provide care to more than 30 million medically underserved people in 13 000 communities across the USA. Among his many other accomplishments, Geiger also helped set up two organisations that were awarded Nobel Peace Prizes, Physicians for Social Responsibility and Physicians for Human Rights.

Geiger got his start in social medicine as an American medical student on study leave in South Africa during the 1950s. He went to a rural area then called Pholela in what is today KwaZulu-Natal to train with physicians Sydney and Emily Kark who had pioneered community oriented primary care (COPC) at the Pholela Community Health Centre (PCHC), which the Karks had founded in 1940. COPC decentred the clinic, focusing instead on communities and the homesteads that comprised them. In Pholela, Geiger learned that by concentrating on the community, medicine could attend to both illnesses in individuals and the social structures, including poverty and racism, that make people sick in the first place. The social medicine he learned in Pholela was remarkably successful. In the PCHC's first 10 years, infant and crude mortality rates, infectious diseases, and malnutrition all decreased substantially. It was these results Geiger hoped to replicate when he brought the lessons he learned back to the USA. Unfortunately, soon after Geiger returned to the USA to complete his studies and begin his career, South Africa's apartheid government withdrew funding for the PCHC, closing most of its outreach programme and hastening the departure of its medical director. By 1962, this experiment in social medicine was over.

Abigail H Neely

Women who grew up in the catchment of the PCHC inspecting field notes, KwaZulu-Natal, South Africa

I met Geiger in the summer of 2008 while I was in the middle of my dissertation fieldwork in Pholela, conducting ethnographic research and interviews about health and healing. Learning about the history of social medicine from Pholela's residents shifted the focus of my work from doctors to the people living in this community. By this account, the social medicine that evolved in Pholela, and was a foundation for the community health centre system in the USA, developed out of the relationships between the residents and health centre staff. Although the Karks and their successors influenced the development of the PCHC, COPC, and social medicine more widely, they did not play the most important part in that story. Telling the history of social medicine from the homesteads of Pholela's residents challenges more common histories that begin in Europe and North America and focus on doctors; it also shifts understandings of medicine, public health, and science more generally and whose stories and actions are centred in those accounts.

The PCHC's success was built on a bedrock of relationships that developed through frequent visits by health centre staff to residents' homes. The PCHC started its work in Pholela with a household survey, which helped the health centre get to know the community and was repeated annually. Soon after, PCHC staff began home visits, which would become a hallmark of COPC. Today, many of Pholela's residents remember that when they were children, community health workers came to their homes not only to teach about various things such as parasites, but also to help clean the homestead, to help build rubbish pits, to create vegetable gardens, and to chat with and support their families. Together Pholela's residents and community health workers rebuilt homesteads to be the foundation for health. Through this work, community health workers became trusted confidants and community members. And thanks largely to the relationships residents built with health centre staff, as well as the skills they learned and the new features of their homesteads, many of those changes remained even after the PCHC lost its funding.

Crucially, not all the work of health improvement in Pholela originated at the PCHC. For example, Pholela's women established community cooperatives to trade seeds as they managed their gardens for variety, productivity, taste, and nutrition. The importance of these seed cooperatives should not be underestimated. Although small, residents recall that the cooperatives helped to encourage them to diversify their

gardens as knowledge about cultivation passed informally and yields increased. One woman showed me all the seeds she keeps, explaining that she first learned how to select seeds by watching her mother and the other women in their seed cooperative when she was a girl. Access to more, diverse vegetables was important to health because it meant access to more micronutrients, which were essential for helping prevent the widespread, low-grade malnutrition in Pholela and the infections that pray on malnourished immune systems. The cooperatives petered out some time after the health centre lost its funding, but their legacies remained in the knowledge, memories, and wellbeing of residents who benefited from them. The doctors also recognised the value of these seed cooperatives and incorporated them into COPC as it came to be implemented across the globe. These important seed and later farming cooperatives in places such as Mound Bayou, MS, USA—the first health centre Geiger helped to establish under the Great Society programme—became a hallmark of COPC and stood as a testament to the lasting impact of Pholela's women in its development.

Undergirding these new initiatives and the more basic aspects of COPC were the relationships among Pholela's residents and between residents and the staff of the PCHC. In oral histories about the PCHC and its work developing COPC, residents talked at length about the community health workers who visited their homes and the relationships they built with them. They also talked about the doctors, noting how important it was that the Karks listened to them. Indeed, it was through these relationships that the contours of COPC emerged. In the reorganised homesteads of Pholela's residents and in their improved health and wellbeing, in the seed cooperatives and vegetables they grew, and in the data that made the PCHC's success clear, the impact of these relationships is visible. As COPC was codified, promoted, and exported, the fingerprints of Pholela's residents and the relationships between them and the health centre were everywhere.

The influence of the PCHC on social medicine extends far beyond South Africa and the USA and its 1400 community health centres where COPC is still practised. As apartheid, became even more draconian in the late 1950s, the Karks and many of their colleagues left South Africa. The Karks travelled first to the USA before settling in Jerusalem, Israel, where they would found and run what was at the time called the Department of Public Health and Community Medicine at the Hebrew University and is today the Hebrew University-Hadassah Braun School of Public Health and Community Medicine. John Cassel, the second medical director of the PCHC and a pioneer of social epidemiology, moved to the University of North Carolina, Chapel Hill, NC, USA, where he established and chaired the programme in epidemiology. Others who worked at the PCHC moved on to Canada, east Africa, and the UK, bringing the lessons of COPC around the world. And in 1978, Sidney Kark was among the authors of the Alma Ata Declaration of primary health care for all. The knowledge and experiences of Pholela's residents in the PCHC project had a tremendous impact on this social medicine diaspora. Recognising the role of these residents and the importance of relationships to social medicine is more than just a rhetorical strategy; it is a corrective for a well known story that privileges the lives and experiences of white doctors over those of their patients. In making decisions about how they and their family members would access health care and manage their homesteads, Pholela's residents partly shaped the successes and failures of the PCHC. More than that, as the example of the seed cooperatives shows, Pholela's women were integral to the specifics of the COPC model that was later implemented elsewhere.

Understanding the history of COPC through the connections between Black women in rural Mississippi who helped run the farming cooperative at the Delta Health Center in Mound Bayou, and Black women in rural KwaZulu-Natal, South Africa, where the cooperative idea was born, roots this strand of social medicine in the decisions and actions of the people who lived in the catchments of these social medicine interventions. In the present COVID-19 pandemic, during which the limitations of global health programmes led by actors in high-income countries and the problems of health-care systems organised for profit not people have been made plain, primary care and social medicine are more important than ever. As proponents of social medicine work for its establishment across the globe, local participation remains crucial, just as it does in extending access to vaccines to hard-to-reach populations. The history of COPC and the PCHC highlight that participation in the development and implementation of health-care programmes is not simply something solicited by those with advanced degrees or positions of power. The story of Pholela's residents and their participation in the work of the PCHC reveals that such health-care programmes and the science that underpins them rest on the work of the people who live in the places in which they are implemented. And more, that the health of some 30 million Americans today is partly shaped not only by influential doctors, but also by the South African women with whom those doctors worked. In this telling, the story of COPC and social medicine is a story of relationships, between Pholela's residents and the community health workers and doctors who worked in their communities, and between rural African women and rural African American women. Shifting the spotlight from physicians like Geiger to these women teaches us much about the history of social medicine, lessons which are more important than ever, as we imagine and fight for healthier futures for all.

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