Lecture by KZN Health MEC, Dr Sibongiseni Dhlomo: From Jerusalem to Pholela

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Programme Director,

In 1998, I registered with one University in our country to do Masters in Public health.

Two blocks in that MPH were done outside South Africa; the first one in Haddassa University in Jerusalem and the second, in George Washington University in the United States of America.

It was quite ironic and humbling that the first lecture in Jerusalem was on Community Oriented Primary Health Care (COPC) which was about Pholela.

For me, it was ironic in the sense that I grew up at UMbumbulu, an hours' drive to Pholela but had to learn about Pholela in a country over 6000 km away from Pholela.

I found it humbling in the sense that international experts on COPC still have high regard for what was initiated and implemented right here in Pholela.

Among other experts who lectured to us there, was Dr Emily Kark whose husband, Dr Sydney Kark had passed on the very same year of our

arrival, April 1998, both these being pioneers of COPC in my own country.

From Haddassa we came back to South Africa and planned as a class, a visit to Pholela. Again today, colleagues, we are back to trace those good foot prints that were implanted by Drs Sydney and Emily Kark while practising here.

When I am not in Pholela and not around the leadership of Pholela and Umkhohlwa, people who were young girls and boys during the period of the Karks in the 40s; I speak more about this place. Today, it is different as it is more of an opportunity for all of us to learn from these leaders of the revolutionary experiences that were initiated in this area. It is thus for that particular reason that **Mrs Khanyisile Shozi**, one of the living legends of that era will take us around the original site of the old CHC and also narrate to us what used to happen there.

It is also my fervent dream that we could at the certain point in time bring together all the world's international experts with intimate knowledge and experience of Pholela back here to revive that history--hence the title of my lecture: **From Jerusalem back to Pholela.**

It is thus a great honour to finally find space; time and an opportunity to pay tribute to the two pioneers of the Community Oriented Primary Health Care in our country; that is, **Drs Sidney and Emily Kark.**

Their important and memorable story started with their arrival as a couple, who were both doctors, at Pholela in 1940 where they founded the Pholela Health Unit.

The task of the centre was defined as follows: 'It should combine **curative and preventive services**, including the following essential functions:

- Prevention and treatment of diseases;
- Health education, with particular reference to the organisation of maternal and child welfare services; as well as,
- Local co-operation and community responsibility.'

This was to happen at the time that there were no organized preventive and promotive services concerned with maternal and child health; health of the schoolchild; or any other defined groups in the population.

There was also no information available on births and deaths, nor was there any source for data on health state or illnesses. The Birth and Death Registration Act was only promulgated in this country in 1958.

During this period, it should also be emphasised that penicillin and other antibiotics were not yet widely available, while oral rehydration therapy and measles immunisation had also not been discovered yet.

Reporting on the wonders she witnessed when growing up in the area; one eminent person in the name of **Honourable Dr Nkosazane Dlamini Zuma,** the Chairperson of the African Union Commission,

when delivering her keynote address at the World Health Assembly in Geneva on 21st May 2013, said:

"...*As a young girl growing up in Pholela, in rural KwaZulu-Natal, South Africa, I became acutely aware of the close links that exist between health and development. This occurred partly through the work of Dr Sidney and Emily Kark and John Cassel. Departing from a disease-focussed and hospital based approach to health care; they established the Pholela health centre where I grew up.*

Theirs was one of the first attempts to integrate system-wide, structural changes at social, cultural and behavioural levels with biomedical interventions. Recognising the difficulties that patients had, especially pregnant mothers, to reach the medical centres when in labour, they built what they call "waiting houses" for women to come and stay whilst waiting to deliver."

Let me hasten to acknowledge other significant individuals who made their foot prints here, for instance, **Mrs Nhleko**, still alive but now ailing, who worked as a Nurse in this facility as well the former IEC Chairperson, **Dr Brigalia Bam**, who also served as **a Clerk and Assistant Health Educator** at this Health Care Centre from 1954 to 1958.

Programme Director; here the importance of **understanding local concepts of health and disease along with methods of health education was stressed.**

Malnutrition was also recognised as a big problem hence emphasis was put on field experience pertaining to **practical nutrition,** which in a nutshell, entailed:

- Demonstration **vegetable gardens** and the introduction of **school meals**;
- Demography in health, i.e. a **home health census**,
- **Community health education** at homes, in schools, and at village meetings; as well as,
- **Encouragement of self-help** by families and community groups.

As would be expected, lay out for all this necessitated meetings with different stakeholders in the community including chiefs (Amakhosi); elders and the teachers.

As means to address the misgivings of the community leaders who were viewing all this with suspicion and resentment particularly on the approach of visiting homes 'like spies' - people from the local community; both females and males, were appointed as community health workers (CHWs).

At this initial stage, it was thus a blessing that the pioneers of this work were joined by other professionals in the name of Edward Jali, a medical aid graduate from Fort Hare and his wife, Amelia Jali, a graduate nurse of the McCord Zulu Hospital in Durban.

A big bonus also came with the appointment of Mrs Margaret Shembe ('Ma Nzimande'), previously a headmistress of the local school; she is accredited for pioneering a system of **'preschool child centres'.** These centres served as nutrition education and feeding platforms utilizing produce from local vegetable gardens. Indeed, this was of big relevance to an effort **to address malnutrition among children under 5 years of age.** Maybe, as a Province, we should take pride for resuscitating this in the form **Operation Sukuma Sakhe** and Phila Mntwana Centres.

We are happy that in this area we still have **Mrs. Mbelu** who lives in uMkhohlwa village working, in her home and communal gardens to produce the vegetables that she cooks and serves with full understanding of the value of the fresh produce and the nutrients it carries. From her we will learn of the story she has around her lemon trees.

All these combined efforts made it possible for the Pholela Health Unit to begin earnestly attending to problems of infectious disease outbreaks which included smallpox; typhoid and typhus fevers, as well as family diseases such as tuberculosis and leprosy.

One very important feature of their work came with the effort to hold weekly health unit staff meetings which drew together clinical staff and community health workers to review their work. From these engagements; ***clinic-based staff realised that they knew very***

little about the family life and social circumstances of their clients. This, colleagues is the focus of the medical training in Cuba.

In essence, the COPHC approach which was shared with the staff members entailed the following processes:

- Community diagnosis
- Prioritization
- Detailed problem assessment
- Intervention planning
- Implementation
- Evaluation and
- Re-assessment

In short COPC is a **continuous process** by which **primary health care** is provided to a **defined community** on the basis of its assessed health needs, by the **planned integration** of primary care practice and **public health**

Using the example of malnutrition, dietary surveys were carried out by 24-hour recall of foods eaten. This was done daily with each child for over a period of 1 week, and in one school during four seasons of the year. Health education was conducted for both teachers and for children. Sessions of direct relevance to the health of the children were organized for various classes at the schools. These included talks by community health workers, discussions and practical demonstrations using field microscopes and other equipment, as well as illustrations and

observation visits in the area.

A special teaching discussion group, of teachers from various schools and health centre staff, was held periodically at the health centre. Action included planting vegetable gardens at each school, which provided part of a school meal prepared by the children. Pit latrines and pits for making compost from waste were constructed at several of the schools, and where possible, water sources were protected from contamination.

These activities were reinforced by a special weekly nutrition clinic held at the health centre, with group discussions, demonstrations, and participation in vegetable gardening, poultry keeping, and methods of preparing and cooking various dishes. These sessions were for schoolchildren and those not attending school. The end result of all these efforts was a remarkable change in the life of the community with children becoming healthier and free of opportunistic diseases.

As history would dictate, sadly, the Pholela CHC's Community Oriented Primary Care approach was abandoned by South Africa when the Nationalist's Government took over. What then followed is what we have today, our health system being drawn into curative and hospi-centric approach. Almost all Health Workers in this country have been socialized in this approach.

Our very ówn' COPHC approach, ironically, was subsequently adapted and developed by practitioners elsewhere, especially in Israel where the

Karks finally settled and wrote a book entitled: '**Promoting Community Health: From Pholela to Jerusalem.'**

This very Pholela COPC effort had its strengths being recognised to the level that it also contributed significantly to the international body of experience that was formalised in 1978 in the **Alma-Ata Declaration on Primary Health Care**, which amongst other aspects pronounced:

'Primary health care includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries and provision of essential drugs.'

New direction

Working with my team, we thus decided on this lecture because we are convinced that there are valuable lessons that can be learnt from what was initiated and practised in that era.

We are also of the mind that in our capacity as health care professionals; managers and chief operation officers today, if again, we follow the teachings of the KARKS, there is also a lot we can do to

improve the lives of the communities where our health care institutions are based.

Our thinking and resolve is also reinforced by an observation made by Drs Sidney and Emily Kark, in 1989, when they intoned**:**

'*We believe that the approach we and our African colleagues were able to develop has relevance to the present day for such communities.*

Health education and community organization became a foundation for a unified practice of community medicine and primary care, thus developing an integrated promotive, preventive, and curative service. An important focus of the health centre's practice was that of education for healthy living.

As a health project that had an educational orientation, it was concerned with what the people in the community felt, thought, and did about health.'

The significance of this lecture today is thus our announcement that as KwaZulu Natal, we are now reclaiming our rights to the principles of Community Oriented Primary Health Care under the theme: **FROM JERUSALEM BACK TO PHOLELA**

Our approach is based on Primary Health Care Re-engineering (PHC-Re-engineering).

Here we are bolstered by the fact that PHC Re-engineering has been prioritized with the aim to accelerate equity in service delivery towards universal access to health care in line with the National Health Insurance vision. This is a vision that aims at improving access and quality of Health Services that provided to communities and also focuses on keeping people healthy for as long as possible through health Promotion and Disease Prevention.

With that in mind; we have invested resources on prevention; treatment; rehabilitation and support efforts at community level by creating and strengthening Community based outreach teams, properly functioning and supervised clinics, Family Health Teams and School Health Teams.

Our ANC led progressive government has also made clear of its intention to redirect the Health System of this country towards the Primary Health Care approach.

It established collaboration with Cuba, one of the countries that have made great strides in improving the health of its citizens by adhering to the principles of Community Oriented Primary Health Care.

As part of this collaboration, the KwaZulu-Natal Department of Health is currently funding 783 medical students studying in Cuba at an approximate cost of R 143.4 million.

The training of doctors in Cuba is an attractive option for us as the Cuban programme is based on the PHC philosophy. We are already noticing the positive inculcation of this philosophy through the good work being done by the few doctors that have been allocated in areas where they are implementing what they learned; i.e. the late Dr S. Camara at Pholela; Dr. S. Madela in Dundee; Dr. N. Gumede again based at Pholela, and the others.

We are happy that one of the activities for this day is to honour **Dr. S. Camara**, who in 18 months (01 June 2013 to 24 December 2014) worked in this facility. She is credited for being able to influence and motivate the CHC and feeder clinics health workers to start thinking and working on the COPHC approach to service delivery. It is on this basis that one of the staff residences is named after her and we will be unveiling the plaque later today.

We find it very interesting and relevant that the approach of these Cuban trained doctors is **client and wellness oriented** as opposed to the disease oriented approach. Their socialization fits well with our efforts of Operation Sukuma Sakhe (OSS) strategy which requires community diagnosis; feedbacks to communities; development and ownership of community plan, its implementation, monitoring and evaluation of progress.

As a Province, we are working towards utilising these Community Oriented Primary Health Care trained Medical Officers most of whom are the Cuban trained doctors as change agents, by strategically allocating

them in areas where they can be able to teach, demonstrate, mentor and influence the current South African trained workforce.

We envisage a role for them in the sub-districts where they will be responsible for the following:

- Supporting and strengthening Community Based and Outreach teams including Family Health and School Health Teams, in health promotive and preventive activities.
- Conducting regular community visits
- Introducing client support system
- Introducing Youth and Men days in the CHC and feeder clinics
- Strengthening the referral system from community based platforms to the Community Health Centres and from Community Health Centre to the District Hospitals and beyond where necessary
- Facilitating easy referral of special cases directly to Specialists
- Capacity building for all workers in the CHC and catchment area.
- Mentoring; coaching and supporting Community Outreach teams, as well as,
- Identifying community structures to work with, i.e. war rooms, Local Operation Sukuma Sakhe (OSS), Local AIDS Council (LAC), Integrated Development Plan (IDP) and providing feedback to local leadership and committing to interventions plans

We would also like to have some of them in institutions of Higher Education where our current Health Practitioners such as Medical staff,

Nurses and Paramedics are produced in order for them to influence the current curricula.

Colleagues; we thus invited you here at Pholela to the initiation site for the Community Primary Health Care (COPHC) as espoused by Dr Kark then and again as a springboard where our current efforts aimed at revitalization are being initiated.

We intend making this establishment a pilot site that would eventually demonstrate the effectiveness of the COPHC approach in addressing health systems challenges. This is where we will be monitoring; evaluating; and documenting the process of implementation so as to enable replication and sharing of practices to all our Districts.

The Department of Health highly appreciates partners such as the University of KwaZulu Natal (UKZN) KwaZulu Natal Nursing College and the University of Western Cape that have worked with us in starting the process of revitalizing this site.

The UKZN has actually expressed its commitment to this course in a letter dated 09 June 2015. In the letter they indicate that they have identified Pholela Community Health Centre as one of the sites for health science student for both under and Post graduate training. They have actually started sending the first year students to the centre for orientation of on COPC

Another very significant development is that UKZN has also requested that the original Pholela CHC site be registered as a heritage site. This

conforms well to our desires of eventually establishing Pholela CHC as a **Drs Sydney and Emily Kark Museum**. To this end, we are already collecting artefacts that will be housed in such museum, some of them from the late **Dr Mervin Susser and his wife Prof Zena Stein** in New York.

We also hope our visit to this cradle of Community Primary Health Care approach site will assist all of us as health workers to develop a caring ethos and commitment to the improvement of the health status of our communities.

From here, we should therefore learn not only to be responsible for the patients who attend our health facilities, but also have a sense of responsibility towards the majority of the population in our facilities' catchment areas.

In conclusion, let me extend my appreciation to the Provincial task team that is working on this revitalization of COPHC which includes representatives of partners mentioned above.

God bless you and help us all grow in the understanding and implementation of Community Oriented Primary Health Care.

I thank you