

**Pulmonary Tuberculosis in Cape Town
and the Karoo, 1870-1920: Policy and Attitudes**

by

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STATEMENT
BY
VALERIE ANNE ZANGEL

I declare that

PULMONARY TUBERCULOSIS IN CAPE TOWN AND THE KAROO, 1870-1920: POLICY AND ATTITUDES

is my own work and that all the sources that I have used or quoted here have been indicated and acknowledged by means of complete references.

I further declare that I have not previously submitted this work, or part of it, for examination at the University of South Africa (UNISA) for another qualification or at any other higher education institution.

Signed by
Valerie Anne Zangel
October 2017

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I dedicate this thesis to my sister and her husband, Betty and Michael Carroll, who encouraged me throughout the process.

ABSTRACT

This thesis focuses on the attitudes and policies which shaped the history of pulmonary tuberculosis in the Cape from 1870 to 1920 and culminated in the passing of the *Public Health Act, Act 36 of 1919*. It was this act which formed the basis of public health legislation in South Africa until the 1970s. The thesis is a contribution to the history of medicine and to the history of legislation.

Topics explored include pulmonary tuberculosis and its early global history. When the practice of sufferers visiting places with particular climates became fashionable, towns in the Karoo became a popular destination. Their journey to the colony, together with their experience in Cradock is the subject of a chapter. Once the disease spread to the local population, the focus shifted to the attitudes and policies of the local authorities and their failure to address its spread. In contrast, in Cape Town the city council and its medical officer of health took up the challenge, but with limited success. The fight against tuberculosis was assisted by a number of dedicated individuals such as Dr Neil Macvicar who was the founder of the Native Health Society. The Society for the Prevention of Consumption, which was officially launched in Cape Town in June 1904, also contributed to educating the public about the disease. Once the Cape Colony entered into political Union in 1910 there was the added dimension of tuberculosis on the mines and the reluctance of mine officials to take care of workers suffering from the disease. This became an issue during the proceedings of the Tuberculosis Commission. The attitudes and prejudices towards the local population became formalised in the *Public Health Act, Act 36 of 1919* because the act was drafted with the health of the white population in mind. By providing a skeleton budget for local authorities to deal with tuberculosis, the legislature ensured that the healthcare of the majority of the population, especially those who were most vulnerable to the disease, was not addressed. The legacy of that decision continues to haunt South Africa to the present day.

Keywords: pulmonary tuberculosis; public health; legislation; Cape Town; Cradock; Public Health Act, Act No. 36 of 1919.

PREFACE

This thesis was originally conceived as a study of the social history of tuberculosis in the Cape during the colonial period. It soon became apparent that there was an absence of archival material to give a voice to the stories of those who had been most affected by tuberculosis in the Cape, predominately Coloured and Black people who lived mainly in poverty in the townships close to the urban centres. Instead the decision was made to focus on the administratively-based response to tuberculosis on the part of the government, public health officials, local authorities and the medical profession to the prevalence of the disease. These responses are considered in terms of their attitudes, particularly towards the local population; policy decisions and ultimately the legal framework, which culminated in the passing of the *Immigration Regulation Act, Act 22 of 1913* and the *Public Health Act, Act 36 of 1919*.

The study is based in the Western Cape, particularly Cape Town which was the first port of entry and the seat of government during the colonial period. A chapter is also included on Cradock. Although Cradock is located in the Eastern Cape, its importance lies in its close association with tuberculosis immigrants. Furthermore, the attitudes of the local authority towards both public health in general and tuberculosis in particular, were typical of those in other small towns.

A period of fifty years, from 1870 to 1920, is investigated. It begins at the time when tubercular immigrants first began to arrive in the Cape Colony. It was only after the incorporation of the Cape Colony into the Union of South Africa that the Tuberculosis Commission was appointed, and that legislation was enacted to regulate the entry of tubercular immigrants into the country. Likewise, the *Public Health Act, Act 36 of 1919*, was the first recognition by the legislature that tuberculosis was a disease which displayed unique characteristics which required specific attention in the act. The period was also a time when medical knowledge was going through tremendous changes. Tuberculosis was particularly affected by

the bacteriological era, especially the discovery by Robert Koch in 1882 that the causal agent of tuberculosis was the tubercle bacillus. The era was marked by the identification of pathogens and the recognition that pathogens cause disease. The classic discoveries were rabies, typhoid and diphtheria, all of which could be controlled by therapies before the drug era. However, linked to these discoveries was the realisation that many infectious diseases were diseases of sanitation and clean water supply, especially typhoid and cholera.

Tuberculosis, as a bacterial disease, should have been easily treatable, and yet it was not. This was primarily due to the fact that in the words of Rene and Jean Dubos,

Tuberculosis is a social disease, and presents problems that transcend the conventional medical approach. On the one hand, its understanding demands that the impact of social and economic factors on the individual be considered as much as the mechanisms on which the tubercle bacilli cause damage to the body. On the other hand, the disease modifies in a peculiar manner the emotional and intellectual climate of the societies it attacks. This results in a subtle interplay between the social body and the social disease.¹

This allowed for cultural explanations to flourish. These changed over time, as medical knowledge advanced. Examples of the changing attitudes towards tuberculosis included the romanticism of the disease, where a link was drawn between artists and the disease, as well as the search for what was commonly known as a 'climate cure' where sufferers travelled to destinations believed to have suitable climates for relief from the symptoms of the disease.²

In South Africa the cultural explanations took on distinctly racial overtones, especially once it became apparent that tuberculosis was rapidly spreading among the local Coloured and Black populations. Attitudes were influenced by the shifting state of knowledge about the disease, as well as by improved medical structures,

¹ R. J. Dubos and J. Dubos, *The White Plague: Tuberculosis, Man and Society* (London: Gollancz, 1953), vii.

² See Chapter 1.

and in the century, the move to political union and to broader national initiatives. Financial considerations also played a pivotal role, because much of the energy of officials was directed towards the avoidance of financial responsibilities. Also of importance was the segregation of the different racial groups, a move which ensured that tuberculosis would continue to flourish among people of colour, while becoming less prevalent among whites as a result of the greater emphasis placed on their well-being.

The local considerations discussed in a wider international setting with much emphasis placed on conditions in Britain and to a lesser extent, Australia. As a British colony, with a medical profession largely dominated by doctors from Britain and continental Europe, the influence of Britain cannot be ignored.³ Conditions in Australia, especially with regard to immigration policies and procedures, also provided valuable points of comparison. International conferences on tuberculosis, which were held on an annual basis, were an important method of disseminating information.

The consequence of the choice of subject matter is that this study has an unavoidable Eurocentric orientation. This is compounded by the fact that the official records of the Public Health Department as well as the articles in contemporary medical journals are seen from a predominately male, Western medical viewpoint. However, it was these attitudes, combined with the influence of prevailing trends such as the sanitation movement, Eugenics and Social Darwinism, which shaped attitudes towards tuberculosis. These were ultimately reflected in policy decisions as well as *The Public Health Act, Act 36 of 1919*. It was the first time that policies and procedures regarding tuberculosis from a public health point of view were

³ H. Phillips, 'Home Taught for Abroad: The Training of the Cape Doctor, 1807-1910', in H. Deacon, H. Phillips, and E. Van Heyningen, *The Cape Doctor in the Nineteenth Century. A Social History* (Amsterdam and New York: Rodopi B.V. 2004), 105. South Africa did not have a full medical school until 1920, which accounts for the high prevalence of British and European doctors.

incorporated into legislation. The act itself, although amended on 21 occasions, remained South Africa's basic public health legislation until 1977.⁴ This points to its significance over an extended period of time and underlies the need for a study which investigates the background leading up to and including the passing of this act.

⁴ H. Phillips, 'History of Medicine. The Origin of the Public Health Act of 1919', *SAMJ*, 77, (19 May 1990), 532.

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War on Consumption: Which way are you going?

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Department of Public Health, Union of South Africa

ABBREVIATIONS

BMJ	<i>British Medical Journal</i>
BWEA	The British Women's Emigration Association
FMCES	Female Middle Class Emigration Society
HIV	Human Immunodeficiency Virus
MDR	Multi-drug Resistant
MOH	Medical Officer of Health
NAPT	National Association for the Prevention of Tuberculosis
SAMJ	<i>South African Medical Journal</i>
SAMR	South African Medical Record
TB	Tuberculosis
WNLA	Witwatersrand Native Labour Association

TERMINOLOGY

As an unfortunate consequence of South Africa's political past, any historical account has to take into account the racial classifications that were assigned to all South blacks during the period of white colonisation and settlement.

During the period 1870-1920 the word 'European' referred to whites, whether they were born in Europe or not. The terms 'European' and 'white' have been used variously in this thesis, depending on the context.

The word 'coloured' when used in this thesis as an adjective with a lower case 'c', as in 'coloured people', refers inconsistently to all people of colour, or to people of mixed descent.

I have used the term 'black' to refer to all people of colour, and 'Coloured' to distinguish between the different communities of mixed race, most of whom, in the period of this thesis, were resident in the Cape.

As for pulmonary tuberculosis, it has been referred to by different names over the centuries. During the period of this thesis, three terms were in regular use, namely 'consumption', 'phthisis' and 'tuberculosis'.

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Chapter 1

Pulmonary Tuberculosis: The Disease and Early Global History

If the number of victims a disease claims is the measure of its significance, then all diseases, particularly the most dreaded infectious diseases, such as bubonic plague, Asiatic cholera, etc., must rank far behind tuberculosis.

Robert Koch.¹

The burden of ill-health and death caused by tuberculosis makes it one of the most important diseases in the history of human society. There has been no other single disease which has been prevalent and widespread over such an extensive period of time.²

In the Cape Colony tuberculosis became widespread at the end of the nineteenth century. Two factors contributed to its increase at the time. The first was the rise of popularity of the colony (from about 1860 onwards) among tuberculosis sufferers travelling in search of climatic conditions which they believed would help relieve the symptoms of the disease. The second factor was the spread of the industrial revolution from Europe to Africa under the banner of imperialism.³ This led to the development of industrial centres in countries such as South Africa, where growth was accelerated following the discovery of diamonds in Kimberley in 1868 and gold in the Transvaal in 1886. The rapid increase of the population and urbanisation of the local population resulted in overcrowded living conditions, poverty and poor nutrition, all factors which contributed to the spread of tuberculosis.

While the above statement points to the *circumstances* under which the disease spread, it provides no information about the causes of the disease itself. In the next section, the aetiology of the pulmonary form of tuberculosis is discussed.

¹ T.F.B. Collins, 'History of Medicine. The History of Southern Africa's First Tuberculosis Epidemic', *South African Medical Journal* (hereafter *SAMJ*), 62 (13 November 1982), 780.

² C.A. Metcalf, 'A History of Tuberculosis', in H.M. Coovadia and S.R. Benatar (eds), *A Century of Tuberculosis: South African Perspectives* (Cape Town: Oxford University Press, 1991), 1. C.A. Metcalf MBChB (Cape Town), BScMed (Hons) (Epidemiology) (Stellenbosch). Medical Researcher, Centre for Epidemiological Research in Southern Africa, South African Research Council (at the time of writing this chapter). See 'List of Authors', Coovadia and Benatar *Century of Tuberculosis*, no page number.

³ R.M. Packard, *White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989), 3.

What is Tuberculosis?

Pulmonary tuberculosis is an infectious disease contracted primarily through the inhalation of airborne droplets containing bacteria called the tubercle bacilli. These are emitted in tiny airborne particles by persons with active tuberculosis when they cough, sneeze or even talk.⁴ Infection with the tubercle bacilli may or may not lead to the development of the active disease. In most cases the infection will produce a primary lesion, usually situated in the lungs, within four to twelve weeks after infection. This lesion may heal or, more frequently, become calcified or ossified in a primary complex that contains the active bacilli. This process prevents the dissemination of the bacilli within the body. At this point the host may not experience symptoms but will normally test positive if a tuberculin skin test is carried out.⁵ Such an infected person will retain a latent infection that may reactivate in later life or be triggered if the immune system is compromised by immunosuppressant diseases, malnutrition or stress.⁶

In other cases, the primary lesion is not contained and the infection spreads in the lungs and on some occasions to other organs in the body through the blood or lymph systems. This normally occurs within six to twelve months after infection, although in some cases, disease progression is much more rapid and leads to extensive damage of the affected organs. This results in serious debilitation and if left untreated, death. The rate at which the disease progresses, like the probability of reactivation, is determined by the state of the infected person's immune system. Young children

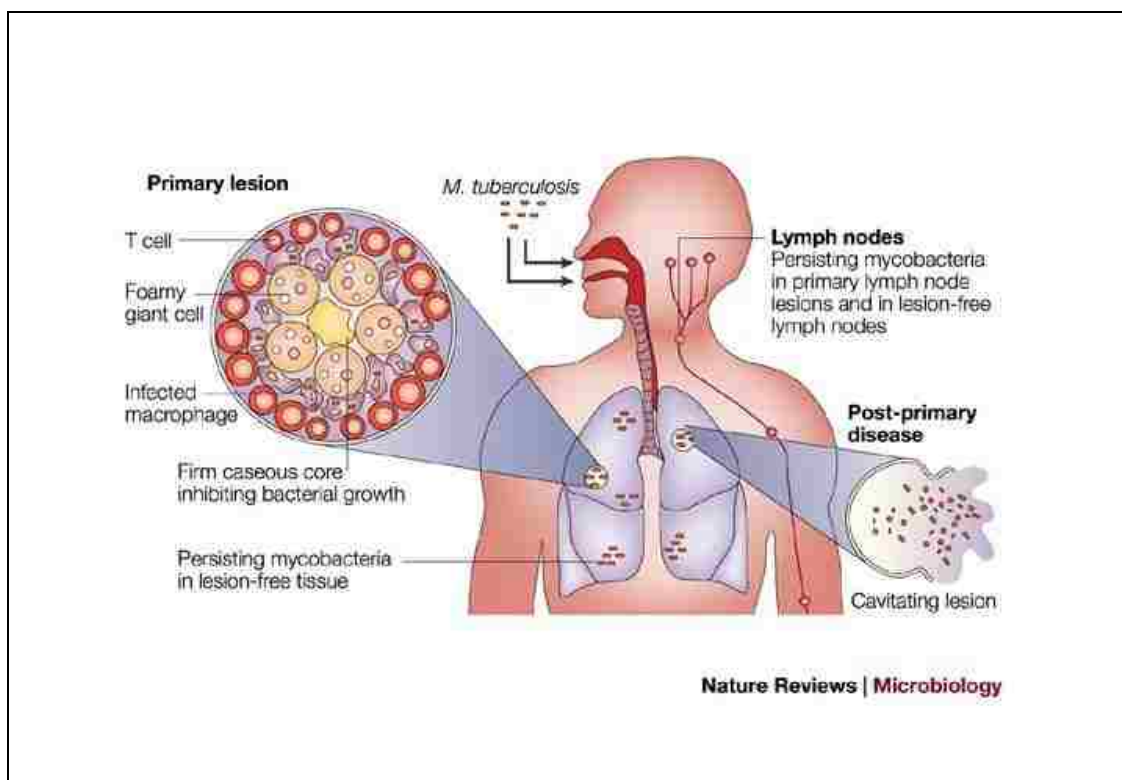
⁴ H. Bynum, *Spitting Blood. The History of Tuberculosis* (Oxford: Oxford University Press, 2012), xvii-xviii.

⁵ See <http://www.webmd.com/a-to-z-guides/tuberculin-skin-tests> Tuberculin Skin Test. Accessed 15 July 2016. The tuberculin skin test (also called a Mantoux tuberculin test) is done to check if a person has ever been exposed to tuberculosis. The test is carried out by putting a small amount of tuberculosis protein (antigens) under the top layer of skin on the inner forearm. If exposure to tuberculosis has occurred, the skin will react to the antigens by developing a firm red bump at the site within two days. See National Library of South Africa (hereafter NLSA), Union of South Africa, Government Reports (hereafter UG), UG34-1914, *Union of South Africa. Report of the Tuberculosis Commission, 1914* (Cape Town: Cape Times, Government Printer, 1914), 11. Tuberculin's value as a diagnostic aid was first recognised as far back as 1891.

⁶ Packard, *White Plague, Black Labor*, xviii-xix.

under three and young adults, as well as women during child-bearing years, appear to be the most susceptible to disease progression, as well as persons suffering from malnutrition, measles, malaria, and most recently AIDS. There is also evidence that other forms of physical stress, exhaustion, and alcoholism contribute to the progression of tuberculosis.⁷

Pulmonary tuberculosis is by far the most common form of the disease. Its onset is generally insidious, and the disease may only be detected when it is in a comparatively advanced stage. Early symptoms usually include fatigue, weight-loss and coughing. In the more advanced stages these symptoms become more severe, with a common feature being the expectoration of blood-stained sputum (referred to as haemoptysis) from bleeding in the lungs.⁸ The illustration below shows the symptoms of tuberculosis in diagrammatic form.⁹



⁷ Ibid., xix.

⁸ *Encyclopaedia Britannica*, Volume 22 (Chicago: William Benton Publishers), 1968, 299.

⁹ See <http://howafrica.com/7-facts-need-know-tuberculosis/> Diagram of symptoms of tuberculosis. Accessed on 24 June 2016.

Global History of Tuberculosis

It is not known when and where humanity first became afflicted with tuberculosis, but it appears from widespread evidence that tuberculosis predates written records.¹⁰ Tuberculosis was, for example, well known in classical Greece.¹¹ Early Greek literature has several references to consumption (tuberculosis), the earliest being in the writings of Homer, dated 800 BC.¹² Hippocrates (460-370 BC) recognised tuberculosis and understood its clinical presentation. He considered it to be ‘the greatest and most terrible disease’.¹³ It is believed that he introduced the word ‘phthisis’, and described it to include the symptoms of a persistent cough, fever, excessive perspiration, wasting and haemoptysis.¹⁴ Although he believed that the disease was due to ‘evil air’ he did not consider it to be contagious. Aristotle (384-322 BC) suggested that it might indeed be contagious and may be due to ‘bad and heavy breath’.¹⁵ He believed that tuberculosis was spread from person to person by some substance breathed into the air from the sufferer’s breath.¹⁶

Even at this early stage there were varying views about whether or not tuberculosis was contagious. This became a key factor in determining attitudes and policies related to the disease. As these debates continued through the centuries, so too the words used to describe the disease changed, emphasising the aspects which were important at that particular time. In early Hindu writings, for example, the disease was referred to by a word meaning ‘a consumption’. Translations of this word, such as the Greek word ‘phthisis’ used by Hippocrates, seem to have been adopted by most ancient and modern languages to designate tuberculosis.¹⁷

¹⁰ Coovadia and Benatar (eds), *A Century of Tuberculosis*, 2.

¹¹ T.M. Daniel, ‘The History of Tuberculosis’, *Respiratory Medicine*, 100 (2006), 1863.

¹² Metcalf, ‘A History of Tuberculosis’, 5.

¹³ M. Gandy and A. Zumla (eds), *The Return of the White Plague: Global Poverty and the ‘New’ Tuberculosis* (London and New York: Verso, 2003), 15.

¹⁴ Metcalf, ‘A History of Tuberculosis’, 8.

¹⁵ I.W. Sherman, *Twelve Diseases that Changed our World* (Washington: ASM Press, 2007), 106.

¹⁶ M.E. Molyneux, ‘Straight and Crooked Thinking about Tuberculosis’, *SAMJ* (17 November 1982), 34.

¹⁷ R.J. and J. Dubos, *The White Plague: Tuberculosis, Man and Society* (London: Gollancz, 1953), 5.

The disease was still prevalent throughout the Middle Ages. From the mid-sixteenth century Europeans in Italy, Spain and the south of France gradually came to regard tuberculosis as contagious, and by the second half of the eighteenth century there was a widespread movement throughout southern Europe to prevent contagion.¹⁸ In Italy this took the form of a legislative enactment, promulgated in 1746, which required that all the belongings of persons suffering from the disease had to be burned and their homes re-plastered and whitewashed after their death. In order to ensure that these regulations were complied with and that their possessions were not sold to dealers of second-hand clothing, the dealers were required to obtain written confirmation from the mayor's office that the deceased had not suffered from tuberculosis. This information was obtained from the death certificate. Any medical practitioner who failed to disclose a death from tuberculosis was subject to a fine for the first offence, and exile from the country for four years for further offences.¹⁹

In 1720, the English physician Benjamin Marten, in his book entitled *A New Theory of Consumptives, More Especially of a Phthisis or Consumption of the Lungs*, proposed that pulmonary tuberculosis was infectious. He also considered that sustained close contact of tuberculosis was necessary for the transmission of a sufficiently infectious dose to cause disease, and that transmission was airborne. However, his views were ignored by his contemporaries.²⁰

In Britain hospital records providing information about the causes of death began to be kept during the seventeenth century. Statistics from 1650 indicate that tuberculosis accounted for approximately 20 per cent of all deaths in England and Wales, with the greatest number occurring in the urban areas. There are indications that tuberculosis mortality slowly decreased during the latter part of the seventeenth century, accounting for only 13 per cent of the deaths in 1715. It began

¹⁸ M. Gandy, 'Life without Germs: Contested Episodes of the History of Tuberculosis', in M. Gandy and A. Zumla (eds), *The Return of the White Plague*, 17.

¹⁹ A. Newsholme, *The Prevention of Tuberculosis* (London: Methuen and Company, 1908), 55-56.

²⁰ Metcalf, 'A History of Tuberculosis', 12.

to increase again in 1730, reaching a peak in England by about 1780.²¹ This was early in the industrial revolution period, and by this stage the death rate had reached an incredible 1 120 per 100 000 living persons each year.²²

The high death rates from tuberculosis resulted in much speculation about the causes of the disease and its spread. In England the medical profession denied that it was contagious. As a result, until the nineteenth century medical opinion regarding the nature of tuberculosis comprised of a number of diverse theories. Some of them were based upon the misinterpretation of correctly observed facts, but most of them were without any foundation whatsoever. Chief among the theories was the view that the disease was entirely hereditary and that 'catching cold' was the main factor in determining its onset.²³ In England and northern France this belief was based on the observation that the disease tended to run in families. The belief that tuberculosis was contagious was generally rejected in these regions and in the European colonies until late in the nineteenth century.²⁴

According to Gandy,

Hereditarian and 'constitutional' conceptions of TB had allowed dual cultures of the disease to emerge: for the poor TB was a disaster, yet for the rich the illness was transformed into an intense personal experience. The nineteenth century internalization of TB as, for wealthy sufferers, a disease of the self rests on an interplay between Romantic anti-urbanism and pre-bacteriological epidemiology. ... The literary Romantic movement, which was especially influential between 1760 and 1830, sought to transform the moral stigma of TB into a profound experience of individual sensitivity 'which dissolved the gross body, etherealized the personality, expanded consciousness'. The disappearance or 'consuming' of the body became a metaphor for spiritual transcendence, in contrast to the widespread revulsion associated with pulmonary tuberculosis by earlier scholars and physicians.²⁵

²¹ Dubos and Dubos, *The White Plague*, 8; Sherman, *Twelve Diseases that Changed our World*, 107.

²² T.M. Daniel, *Captain of Death: The Story of Tuberculosis* (Rochester: University of Rochester Press, 1999), 30.

²³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 5. It is now accepted that genetic factors play a very minor role in determining susceptibility to tuberculosis, and that these are overshadowed by environmental factors. The frequent occurrence of tuberculosis in families can be explained by the transmission of infection within the home, as well as by family members being subjected to the same environmental factors. See Metcalf, 'A History of Tuberculosis', 12.

²⁴ Metcalf, 'A History of Tuberculosis', 11.

²⁵ Gandy, 'Life without Germs', 19-20.

The Romantic period saw an eminent gallery of victims of tuberculosis. These included writers, poets and composers such as Percy Bysshe Shelley (1792-1822), John Keats (1795-1821), Elizabeth Barrett Browning (1806-1861) and Frédéric Chopin (1810-1849).²⁶

One of the more interesting people to suffer from tuberculosis was John Keats, the English poet. He was born in London in October 1795. His mother died of tuberculosis when he was fourteen years old. As a young man Keats was a student at Guy's Medical School in 1815.²⁷ It was while he was there that he decided to become a poet. Three years later his brother Tom contracted tuberculosis. Keats nursed him until his death in December 1818. Two years later, Keats coughed up blood. With his medical training, he was immediately able to make his own diagnosis, recognising that he had tuberculosis. After this, Keats never again regained good health, and appeared to have been defeated in both mind and body from the onset of his illness.²⁸

Death from tuberculosis of leading figures in the Romantic movement such as John Keats and Robert Louis Stevenson intensified the association between artistic genius and consumption, thereby separating the experience of illness (and creativity) from any wider social context. Tuberculosis became associated with a heightened state of creativity in the shortened life of poets and artists (a creativity believed by contemporaries to be caused by the intoxicating effects of the illness) yet widespread opiate addiction among wealthier sufferers is a more plausible explanation for this 'mental effervescence'.²⁹ However, the cliché which connected tuberculosis and creativity was so well established by the end of the century that one critic even suggested that it was the progressive disappearance of tuberculosis

²⁶ Sherman, *Twelve Diseases that Changed our World*, 108-109.

²⁷ S. Sontag, *Illness as Metaphor* (London: Allen Lane, 1979), 30-33.

²⁸ Daniel, *Captain of Death*, 103-105.

²⁹ Gandy, 'Life without Germs', 19-20.

which accounted for the decline in literature and arts at the end of the Romantic period.³⁰

At a later stage tuberculosis came to be associated with urban living conditions, which fed into long-term medical discourses surrounding climate and pulmonary tuberculosis. From Hippocrates onwards many physicians recommended changes in climate to alleviate the symptoms of tuberculosis. Consequently, wealthier sufferers began to leave cities in search of warm and dry climates. Places with high altitudes and sunny dry climates were promoted extensively in both medical and lay publications. This led to large scale migration of people with tuberculosis to favoured locations. Initially most health resorts were in Europe, but with the development of European colonies in North America, Africa and Australia, and with improvements in sea travel, increasing numbers of consumptives travelled to the United States of America and to the colonies in the second half of the nineteenth century.³¹

As the century came to an end, physicians and patients began to lose some of their faith in the power of the sun to cure consumption. It was painfully obvious to everyone that tuberculosis recognised no geographical or climate borders – killing young men and women just as effectively in Rome or Athens as in Paris or London, or in South Africa or Australia.³² At the same time the tide began to turn against the continual arrival of consumptives in the Cape Colony. However, it took a further approximately six years before the practice came to a virtual stop.³³

While the option of travelling to gain the benefits of a ‘health cure’ had been available for wealthy and middle class tuberculosis sufferers, there were a substantial number of less affluent individuals who had no alternative but to remain in the countries of their birth. By the nineteenth century a number of historical

³⁰ Sontag, *Illness as Metaphor*, 33.

³¹ Metcalf, ‘A History of Tuberculosis’, 15.

³² Dubos and Dubos, *The White Plague*, 27.

³³ The *Immigration Regulation Act, Act No. 22 of 1913* contained provisions which regulated the circumstances under which tuberculosis sufferers could enter South Africa. This issue is discussed in detail in Chapter 6.

processes, such as urbanisation, industrialisation, colonisation and war led to changes in risk factor profiles in communities and populations and these in turn led to an increase in the prevalence of tuberculosis. Population movements also affected the occurrence and distribution of the disease. Because tuberculosis was so common and, on the whole, not considered to be infectious, no precautions were taken to avoid transmission and infection spread unchecked. The industrial revolution had a great impact on the spread of the disease. It began in Britain during the eighteenth century and spread to other countries in the nineteenth and twentieth centuries, leading to the rapid growth of towns and often to severe overcrowding. It had the greatest impact on the poorest members of society, who were not only subjected to overcrowding but also to poor diets which lowered resistance to the disease. During this time, developments in the public health movement and the growth of the statistical analysis of mortality also influenced the recognition that tuberculosis was a disease of industrialisation.

As increasing industrialisation took place, perceptions on tuberculosis went through a further change, and it became widely perceived as 'a disease of humid and dank cities'. During this time large numbers of people moved into poorly constructed and makeshift housing in the rapidly growing cities. Those who could find work were widely subjected to dusty, confined or physically exhausting working conditions in the textile, metal working and other industries. These conditions contributed to a greater susceptibility to infection. In the absence of any clear understanding of the epidemiology of tuberculosis there was a generalised indictment of urban life rather than any systematic analysis of the changing living and working conditions that placed many people at a much greater risk of contracting respiratory diseases.³⁴

Colonisation also had a great impact on the spread of tuberculosis, especially for the indigenous population. In the past this was attributed to racial susceptibility because of their being 'virgin' populations (or new to the disease). A more likely explanation was the adverse conditions in demography, lifestyle and environment brought about

³⁴ Gandy, 'Life without Germs', 19. The impact of the arrival of consumptive immigrants in the Cape is discussed in length in the next chapter.

by colonisation. For example, the repeated smallpox epidemics, culminating in the devastating episode of 1755, contributed to the destruction of the Khoi as an independent society.³⁵ The cattle-killing episode amongst the Xhosa, in which thousands starved, partly as a result of messianic prophecies which inculcated the hope of driving out the white settlers, but largely also because of the failure of Sir George Grey and the settlers to provide adequate relief, forced large numbers of Xhosa people into waged labour on settler farms.³⁶

One of the prime motivations for colonisation was the commercial exploitation of the countries by the colonisers. In general this led to the impoverishment of Black people through loss of land (which led to overcrowding and loss of food sources) and a transition to wage labour. The increased susceptibility of newly-colonised people to tuberculosis can thus be attributed to the deterioration in environmental conditions rather than to racial susceptibility.³⁷

In 1882 the history of tuberculosis entered another era – that of the bacteriological period. This was as a result of Robert Koch's discovery of the *Mycobacterium tuberculosis* as the causative agent of tuberculosis.³⁸ Although this meant that public health reformers knew what caused tuberculosis, the debate between those who emphasised the relative importance of the environment and social factors over the influence of hereditary factors continued on a new level.³⁹

In Britain, one of the leading public health experts of the 1880s, Arthur Ransome, linked drainage, ventilation, housing and temperance with the new bacteriological ideas. He advocated a consistent insanitationist position from the 1880s to 1915, and

³⁵ R. Elphick, and H. Giliomee, (eds), *The Shaping of South African Society, 1652-1840* 2nd ed (Cape Town, Maskew Miller Longman, 1989), 22.

³⁶ J.B. Peires, *The Dead Will Arise. Nongqawuse and the Great Xhosa Cattle-Killing Movement of 1856-1857* (Johannesburg: Ravan Press, 1989), 63.

³⁷ Metcalf, 'A History of Tuberculosis', 14-15.

³⁸ Koch was hailed as the founder of modern medicine, with a list of discoveries that included the Koch-Weeks bacillus pertaining to the eye disease, trachoma (1882) and the comma bacillus as the causal agent of cholera (1884). See S. Watts, *Epidemics and History. Disease, Power and Imperialism* (London: Yale University Press, 1997), 145.

³⁹ F. Kilpatrick, 'Consumptive Cape Town: The Chapel Street TB Clinic, 1941-1964', MA dissertation, University of Cape Town, 2002, 6.

enjoyed the support of a group of medical officers of health who emphasised housing and urban conditions as critical factors in reducing the incidence of tuberculosis.⁴⁰

As the realisation that tuberculosis was infectious and was spreading in many countries, it became clear that there was a need for global co-operation and coordination if any real inroads were to be made in bringing the disease under control. It was with this in mind that the National Association for the Prevention of Tuberculosis (NAPT) was launched in 1898.⁴¹ Attitudes towards tuberculosis in Britain began to change once the NAPT was founded. Up until that point in time, the disease had been accepted as part of everyday life.⁴² The acknowledgement by the NAPT that tuberculosis was infectious, together with the absence of effective treatment, led to a situation where the patients often found themselves cut off from the wider community. For those who were admitted into state institutions, evidence showed that finding any sort of employment following treatment was difficult, and that tuberculosis patients were even ostracised by friends and family. A short period in an institution did not ensure that patients were no longer infectious, and so ex-patients were stigmatised for the rest of their lives. Moreover, there was still a persistent belief in some form of hereditary predisposition which led patients to hide their medical histories. For some sufferers from tuberculosis, the social consequences of the disease were far worse than its physical manifestations.⁴³

While belief in the hereditary nature of tuberculosis had caused personal problems, the knowledge of the infectiousness of the disease caused even greater difficulty both socially and professionally. Those suffering from tuberculosis were either likened to lepers or they feared that this might be the case. According to Coltart this

⁴⁰ M. Worboys, 'Before McKeown: Explaining the Decline of Tuberculosis in Britain, 1880-1930', in F. Condrau and M. Worboys (eds), *Tuberculosis then and now. Perspectives on the History of an Infectious Disease* (Montreal: McGill-Queen's University Press, 2010), 152.

⁴¹ The NAPT is discussed in detail in Chapter 6.

⁴² O. Checkland and M. Lamb, *Health Care as Social History: The Glasgow Case* (Aberdeen: Aberdeen University Press, 1982), 88.

⁴³ L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain* (Oxford: Clarendon Press, 1988), 5-6.

was the patient's main fear, and he wrote of the 'leper complex' which sensitive patients often developed when they were informed that they had the disease.⁴⁴

Once the NAPT had been formed in Britain, tuberculosis became a medical specialisation in its own right. Travel to foreign destinations was no longer encouraged. It is possible that the new specialists were reluctant to lose their more affluent patients to foreign institutions.⁴⁵ Reports were now being made that the local climate in Britain was beneficial for the treatment of tuberculosis, and open-air treatment was becoming increasingly popular.⁴⁶ At least part of the reluctance of practitioners to send persons suffering from tuberculosis out of the country was because of the increased number of sanatoria that had become available in Britain.⁴⁷ However, it was still widely recommended that after a stay in a sanatorium, patients should emigrate to the colonies where the climate would be kinder to their health. There are no official statistics on the number of people classed as 'arrested' cases of tuberculosis who emigrated, or to the destinations selected by such individuals. However, the follow-up records of the Brompton Hospital for Diseases of the Chest, London, who opened a sanatorium at Frimley in Surrey in 1904, show that emigration was not uncommon.⁴⁸

By the 1890s, as the number of sanatoria in Britain increased, a group of prominent public health officials, including James Niven, the medical officer of health (MOH) for Manchester and Arthur Newsholme, MOH for Brighton, began to feel that too much emphasis had been placed on the improvement of sanitary conditions. This group became known as the infectionists, and believed that the most important method to prevent the spread of tuberculosis was by the isolation of advanced cases.⁴⁹

⁴⁴ Ibid., 223. K. Coltart was the head of the almoner's department at the Brompton Hospital from 1943. Bryder, *Below the Magic Mountain*, 221.

⁴⁵ L. Bryder, "'A Health Resort for Consumptives': Tuberculosis and Immigration to New Zealand, 1880-1914', *Medical History*, 40 (1996), 459.

⁴⁶ Bryder, *Below the Magic Mountain*, 47.

⁴⁷ Bryder, 'A Health Resort for Consumptives', 459.

⁴⁸ Bryder, *Below the Magic Mountain*, 194-195.

⁴⁹ Worboys, 'Before McKeown', 154.

By the late 1890s and early 1900s yet another approach to tuberculosis emerged in the various national and local anti-tuberculosis campaigns – that of the hygienists. Their view was that, ‘if tuberculosis ... [is] preventable, it ought to be prevented. If it is curable, it ought to be cured’.⁵⁰ By that stage the death rate from tuberculosis in Britain had begun to decline, leaving them to conclude that this resulted not from fewer people being infected, but from an increase in the number of people whose bodies were able to arrest, keep latent, or heal the disease. Yet another group, referred to as the diathesians, as represented by Karl Pearson, believed that tuberculosis struck those who had a specific inherited susceptibility to the disease but did so disproportionately. Pearson also believed that the high population densities in cities had produced almost universal infection, leading to a situation where those with susceptibility died, while the others lived. This, he maintained, resulted in urban populations acquiring greater evolutionary fitness.⁵¹

Although these various groups have been discussed sequentially, in practice they interacted, co-existed and in some cases combined following changes in medical knowledge, medical technologies and social priorities created by new professional roles and opportunities.⁵² The number of theories about the best way to deal with tuberculosis was a clear indication of the increasing importance of the subject, as the treatment of sufferers became a medical specialisation in its own right.

While theories may have waxed and waned in popularity, a stay at a sanatorium remained a standard method of treatment in Britain. Sanatorium treatment was given an additional boost in 1912, when the National Insurance Act came into operation.⁵³ The insurance committees were authorised to spend a considerable portion of their funds on the provision of sanatorium treatment. In terms of the National Insurance Act, the insurance committees were *required* to provide treatment for insured persons suffering from tuberculosis in sanatoria. Where they were not available, a contribution towards their upkeep was payable by the

⁵⁰ Ibid., 155.

⁵¹ Ibid., 155-157.

⁵² Ibid., 163.

⁵³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 15.

insurance committee to the local authority or person providing the required care. The treatment could also be extended to the family of the sufferer, at the discretion of the insurance committee.⁵⁴

A further step taken by the British government was to appoint a British Departmental Commission in February 1912. It was mandated to recommend a general policy to deal with cases of tuberculosis in Britain with regard to its preventative, curative and other aspects. The purpose of the report was to provide guidelines to government and local authorities on how to deal with the disease, either in sanatoria or elsewhere. This commission, which included many leading experts and authorities, issued its report in March 1913. It set out in detail the procedures to be adopted by everyone involved at each stage of the disease. The Tuberculosis Dispensary, by providing medication, played a leading role, especially in the earlier stages of the disease. Treatment in 'sanatoria' was recommended. The definition of the word 'sanatorium' was wide enough to encompass treatment at home where the patient was under the care of a medical practitioner. The cost of treatment in these circumstances was also covered by insurance, with payment being made to the medical practitioner. There was an exception to the general principal that home care was acceptable, which applied in cases where the disease was in a highly infectious stage. In such cases isolation was compulsory.⁵⁵

An important principle established by the British Tuberculosis Commission was that the entire community had to be treated, not just certain sections of it. This was achieved by establishing Tuberculosis Dispensaries in the towns. These dispensaries ensured that the instructions of the NAPT were carried out at a local level. They were also responsible for the diagnosis of patients and the visiting of persons they may have been in contact with in order to examine them. The dispensaries also functioned as information and education centres. The Imperial Treasury was of the view that the financial burden should not be carried by the local authorities on their own, but that half of their costs in connection with the disease would be reimbursed

⁵⁴ Ibid., 15.

⁵⁵ Ibid., 15-16.

from the public purse.⁵⁶ State intervention in cases of tuberculosis was not limited to adults, but also extended to children. Children were subject to medical examination, where careful attention was paid to the physical condition of children with free meals being provided to under-fed children. Children found to be suffering from tuberculosis were transferred to 'open-air' schools. One of the main objects of the medical examinations was to detect cases as early as possible, so as to enhance the chances of recovery.

It was not long after the finalisation of the British Commission report on tuberculosis that the First World War broke out. After the war, Pearson's views were recast in a new racial context on the 'virgin soil theory' which was used by the so-called tubercularisationists. The main proponent of this theory was Louis Corbett, who was a university lecturer in bacteriology at Cambridge from 1907 to 1929. Corbett's views signalled a growing tendency among pathologists from 1910 onwards to reassert the role of inherited racial factors in susceptibility to tuberculosis.⁵⁷

The 'seed and soil' metaphor fell on fertile ground in South Africa. The tuberculosis bacillus represented the 'seed' and the human host the 'soil'.⁵⁸ Western-trained medical authorities who had studied the epidemiology of tuberculosis in South Africa were nearly unanimous in asserting that the black populations of the region were, for all practical purposes, free from the disease prior to their contact with Europeans.⁵⁹ They held the view that blacks in effect represented, like island populations in the Pacific, a 'virgin soil' for tuberculosis.⁶⁰

⁵⁶ Ibid., 16. In South Africa the apportionment of costs between government and local authorities was always a contentious issue. In the Cape Colony no contribution was made to local authorities for the care of tuberculosis sufferers. As is discussed in connection with the 1919 Public Health Act, it remained a subject of hot debate even after Union.

⁵⁷ Worboys, 'Before McKeown', 155-157.

⁵⁸ Packard, *White Plague, Black Labor*, 22.

⁵⁹ All Cape doctors were trained outside the Cape Colony until 1920, when the first full medical school was established in South Africa. The vast majority received their training in Britain and Continental Europe. H. Phillips, 'Home Taught for Abroad: The Training of the Cape Doctor, 1807-1910', in H. Deacon, H. Phillips and E. Van Heyningen, *The Cape Doctor in the Nineteenth Century: A Social History* (Amsterdam and New York, Rodopi BV, 2004), 105.

⁶⁰ Packard, *White Plague, Black Labor*, 22.

This understanding of the disease was compounded by the debates that raged about the role of an inherited susceptibility or vulnerability to tuberculosis (seen in the idea of a 'virgin population' that had not built up immunity to the disease), in contrast to the role that the environment played (socio-economic conditions or the political economy of health). The 'virgin population' theory was also divided in its approach between those who believed in the Lamarckian process where a resistance to tuberculosis was acquired and passed on to future generations, and the Darwinian theory of natural selection, where those susceptible to tuberculosis were 'weeded out' from the population over time.⁶¹

The 'virgin population' theory suited the ideology of European colonisers, who were its main proponents. When confronted by the ravages of tuberculosis among black inhabitants of the colonies, this theory conveniently allowed them to underplay or ignore the role of adverse changes in environmental factors brought about by colonisation.⁶² It came to the fore in South Africa in the period immediately after Union, when it was used to justify the migrant labour policy in the mines.⁶³

The views of the tubercularisationists were of particular significance in the South African context. Pearson's views were embraced in South Africa by Dr G.D. Maynard in 1912 at the time when the Tuberculosis Commission was in the process of completing its report. A more detailed analysis of Maynard's views and their implications for South Africa is incorporated in Chapter 7, The Tuberculosis Commission, 1912-1914.

The Tuberculosis Commission in South Africa was appointed at roughly the same time as a similar commission in Britain. Although each had a strong regional orientation in terms of its findings, they offer interesting points of comparison in

⁶¹ Kilpatrick, 'Consumptive Cape Town', 6.

⁶² Metcalf, 'A History of Tuberculosis', 13.

⁶³ See Chapter 7 on the Tuberculosis Commission for a more detailed analysis of this aspect.

terms of the recommendations made to prevent the spread of the disease.⁶⁴ Britain decided to tackle the problem head-on, and was prepared to spend the necessary funds and put in place legislation (such as the Insurance Act mentioned above). With so much effort and resources being made available in the fight against tuberculosis in Britain, the death rate began to decline. The causes of the decline piqued the interest of historians, and led to a proliferation of studies relating to the subject, as is discussed in the literature review later in this chapter.

Literature Review

Tuberculosis, as a disease which has been a major cause of death for centuries, has attracted the attention of some leading historians. Much work has been produced in Britain, America and Australia. This section will highlight a few of the themes in international historical writing on tuberculosis. The final part of this section will analyse the South African historiography on tuberculosis and medical history in general.

An early publication on the history of tuberculosis was that by S. Lyle Cummins, *Tuberculosis in History: From the Seventeenth Century to our own Times* written in 1949. This work focused primarily on the achievements of European and British medical figures who worked in the field of tuberculosis. It was his view that his reputation as a leading tuberculosis expert in the first half of the twentieth century made his work all 'the more authoritative and valuable'.⁶⁵ This attitude, which exemplifies the then popular view that medical doctors had superior knowledge and therefore possessed the credentials to write about medicine, medical professionals and disease, represents what used to be a popular trend in medical literature. South African writers who fall into this category include E.H. Burrows and E.H. Cluver.⁶⁶

⁶⁴ South Africa's recommendations are discussed in more detail in Chapter 7 on the Tuberculosis Commission and Chapter 8 From the Tuberculosis Commission to the Public Health Act, 1914-1919.

⁶⁵ S.L. Cummins, *Tuberculosis in History: From the Seventeenth Century to our own Times* (London: Balliere, Tindall & Cox, 1949), xi.

⁶⁶ E.H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century* (Cape Town: Balkema, 1958); E.H. Cluver, *Public Health in South Africa* (Johannesburg: Central

Four years later, in 1953, René and Jean Dubos, published their book *The White Plague*.⁶⁷ This publication led the way in approaching tuberculosis from a broader cultural and social perspective. It was their view that the rise in tuberculosis mortality was closely connected with the increase of urbanisation and industrialisation, and that its subsequent decline had little to do with the progress of medical science. Rather, they believed that tuberculosis mortality was ‘the consequence of gross defects in social organisation, and of errors in individual behaviour ... and that it could be eliminated by integrating biological wisdom and social technology into the management of everyday life’.⁶⁸ It is commonly acknowledged as the ‘classic’ book on tuberculosis.⁶⁹

Some time passed before any further major works were written on the topic. What prompted the fresh look at tuberculosis was the decline in the mortality rate from tuberculosis in the late nineteenth and early twentieth centuries. The first historian to investigate the declining death rate was Thomas McKeown, whose book *The Modern Rise of Population* was published in 1976. After evaluating a number of potential reasons for the decline, it was McKeown’s contention that the decline had been brought about by improvements in nutrition.⁷⁰

Although McKeown’s views have been criticised for its narrow focus, his work did open up a much wider debate among historians, largely because it raised the question of priorities in disease control and questioned whether policies should be medically based and aim to control the disease, or socially focused by broad-based efforts to redistribute social, political and economic resources. These debates were used as a mechanism to reflect different political perspectives. Coker, commenting

News Agency, 1939); E.H. Cluver, *Medical and Health Legislation in the Union of South Africa* (Johannesburg: Central News Agency, 1949); E.H. Cluver, *Social Medicine* (Johannesburg: Central News Agency, 1951).

⁶⁷ Dubos and Dubos, *The White Plague*.

⁶⁸ *Ibid.*, viii.

⁶⁹ F. Condrau, ‘Beyond the Total Institution: Towards a Reinterpretation of the Tuberculosis Sanatorium’, in Condrau, and Worboys (eds), *Tuberculosis then and now*, 75-76.

⁷⁰ T. McKeown, *The Modern Rise of Population* (London: Arnold, 1976), 128-129.

on tuberculosis being related to poverty, overcrowding, malnutrition and social inequality, remarked that tuberculosis was ‘a measure of social justice, hence its fascination’.⁷¹

It was the view of Grange, Gandy, Farmer and Zumla that attributing the decline to either socio-economic conditions or natural selection was beset with problems due to the lack of sufficient evidence. They also questioned McKeown’s view that the decline of infectious diseases and associated high mortality rates was due to general improvements in nutrition and welfare associated with economic development. They raised concerns about whether historical analysis can be used to predict future trends, coming to the conclusion that a biosocial view was needed to identify and to give differential weighting to the factors and processes that alter risk of infection with tuberculosis, as well as the development of the active disease, and death.⁷²

Michael Worboys has, in contrast, taken a completely different approach to the McKeown thesis. Worboys has gone back to the grassroots of the debate and has explored the views of the generation of British doctors from the 1880s to the 1930s who first recognised and discussed the long-term fall in tuberculosis mortality. Of interest is that none of them identified the reasons advanced by McKeown as their views for the decline in the disease.⁷³ Worboys identified five groups, each with distinct explanations. These are discussed in detail earlier in this chapter. Worboys’ views provide a theoretical backdrop to the various factors, movements and individuals who influenced attitudes towards tuberculosis in Britain during the period 1880-1930. As a British colony largely dominated by doctors from Britain these movements had a profound impact on South Africa and were largely responsible for attitudes and policies developing in the manner in which they did.

⁷¹ L. Bryder, F. Condrau and M. Worboys, ‘Tuberculosis and its Histories: Then and Now’, in Condrau, and Worboys (eds), *Tuberculosis Then and Now: Perspectives on the History of an Infectious Disease* (Montreal: McGill-Queen’s University Press, 2010),16.

⁷² J.M. Grange, M. Gandy, P. Farmer, and A. Zumla, ‘Historical Declines in Tuberculosis: Nature, Nurture and the Biosocial Model’, *International Journal of Tuberculosis and Lung Disease*, 5, 3 (2001), 208-211.

⁷³ Worboys, ‘Before McKeown’, 148.

Just as McKeown's thesis opened a debate pertaining to the decrease in the tuberculosis mortality rate in Britain in the early twentieth century, the experiences of patients in sanatoria have also attracted attention. The interest in sanatoria lies in the fact that they offered social historians an opportunity to tell the stories of patients through the records of the institutions, as well as letters written by the patients. This is in line with the one of the goals of the new histories of medicine, which is to tell the stories of 'ordinary' sufferers of the disease.

An important author who has used sanatorium records to good advantage is Linda Bryder, whose *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* was published in 1988.⁷⁴ The primary focus of this work is the anti-tuberculosis campaign which was launched in Britain in the early twentieth century. The campaign attracted state support and eventually, after World War One, became part of the public health services offered by local authorities. One of the questions she poses is why there was suddenly such widespread interest in tuberculosis, especially as the disease had already been in decline for several decades. Possible answers lie in the concern for 'national efficiency' which had an important influence on health movements launched at the time, as well as the role played by Robert Koch when he discovered that the *Mycobacterium tuberculosis* was the causative agent of tuberculosis in 1882.⁷⁵ Bryder questions why the anti-tuberculosis campaign took the form it did, as well as the part played by professional interests and current ideologies, in an attempt to place the campaign in its broader social and political context. She admits that 'the historian investigating epidemiology often discovers more about the assumptions and prejudices of the inquirers than about the disease patterns themselves'.⁷⁶ In her quest to find answers she investigated how the NAPT operated within the context of the growing interest in

⁷⁴ Bryder, *Below the Magic Mountain*.

⁷⁵ The concept of 'national efficiency' was raised in connection with the poor physical state of recruits for the South African War (1899-1902). The correlation with tuberculosis was drawn as tuberculosis was found to attack young adults in their most productive years and was seen as detrimental to national efficiency. See Bryder, *Below the Magic Mountain*, 22, 30.

⁷⁶ Bryder, *Below the Magic Mountain*, 4. This statement certainly holds true for the South African situation, where cultural explanations on tuberculosis prevailed, especially after Union.

eugenics, as well as the different methods, such as public health policies and sanatoria, used to curb the incidence of tuberculosis.

Bryder's interest in the personal experiences of tuberculosis sufferers has been shared by Sheila M. Rothman in *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History*.⁷⁷ This book draws upon the diaries and letters of over a hundred sufferers in America to convey their experiences of the illness and the treatment they received. It concludes that sanatoria did not offer much value in terms of therapeutic success.

In South Africa writing about medical history typically falls into two main categories. In line with international trends, there has been a strong interest in the social history of medicine. In addition, from the 1970s onwards a growing literature has emerged which focuses on the political economy of health care, investigating the relationship of political and economic power to disease patterns and the health care system in developed capitalist societies.⁷⁸

It was Randall M. Packard, an American historian, who recognised the unique suitability of a study of tuberculosis within the South African context in his *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa*, published in 1989. This work is the most significant contribution to the history of tuberculosis in South Africa, and encompasses more than a hundred years, ranging from the colonial period to the apartheid era. Using the Transvaal gold mines as the primary backdrop to the study, Packard has been able to focus on the exploitation of the labour force on the mines, and in particular how the mines encouraged migratory labour practices to absolve themselves of the financial responsibility for the medical care of their labour force. He also investigates how the migrant labour policy led to the expansion of tuberculosis in the rural areas. Packard's study is not limited to the mines, but also explores the consequences of

⁷⁷ S.M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994).

⁷⁸ S. Marks and N. Andersson, 'Issues in the Political Economy of Health in Southern Africa', *Journal of Southern African Studies*, 13, 2 (January 1987), 178.

the rapid industrialisation and population movements into the major cities, particularly Johannesburg, after World War One. This led to the development of slums in the cities, and the increase of tuberculosis mortality in urban areas. Ironically, Packard concluded that this increase in mortality during the 1920s and 1930s resulted more from the earlier spread of tuberculosis infection to the rural areas of South Africa and the subsequent movement of infected blacks from these areas into the harsh conditions of urban and industrial life than from the introduction of a new wave of previously unexposed immigrants.⁷⁹

Packard has not only enhanced our understanding of tuberculosis in South Africa, he has made an important contribution to the debate on the origins and maintenance of segregation. This is a central theme in his book. He has also shown that ‘tuberculosis control measures in South Africa have involved the application of exclusionary policies designed to keep the disease out of the social and economic centres of white society’. This has been achieved through legislative enactments, including public health acts, urban areas acts, slum clearance acts, influx control and the establishment of ‘independent national states’ beyond the boundaries of white South Africa, thereby removing so-called ‘black health problems’ from white society.⁸⁰

The extended period of the study has allowed Packard to link the history of tuberculosis to the wider patterns of political and economic change. He evaluates how these links have evolved over longer periods of time and how realignments in specific sets of political and economic interests have shaped the longer history of both health and health care. At the same time, by linking the history of health and disease with the wider study of political and economic development in South Africa, he has thrown a fresh light on the changing contours of this wider history and, more specifically, on the high cost in human lives this history has inflicted upon the black population of South Africa.⁸¹

⁷⁹ Packard, *White Plague, Black Labor*, 130-131.

⁸⁰ *Ibid.*, 299.

⁸¹ *Ibid.*, 20.

There is no doubt that *White Plague, Black Labor* ranks as the most important publication on tuberculosis in South Africa, particularly as it offers so much more than a medical history. It is a meticulously crafted analysis of the way medicine and labour were manipulated to serve the interests of the white minority population and is backed by extensive archival research. Where the book falls short is in its failure to include additional material relating to the prevalence of tuberculosis in the Cape, where its presence was the most significant and of the greatest duration. This is not to say that the Cape was excluded entirely. However, with the main focus of the book on the mining industry, it is understandable why the Cape received less attention because the history of tuberculosis developed very differently in the Cape.⁸²

Packard's contribution to the understanding of tuberculosis in South Africa is not limited to *White Plague, Black Labor*. He has also published an article in a special edition of the *Journal of Southern African Studies* on the political economy of health in southern Africa,⁸³ a chapter in H.M. Coovadia and S.R. Benatar (eds), *A Century of Tuberculosis: South African Perspectives* and another in S. Feierman and J.M. Janzen (eds), *The Social Basis of Health and Healing in Africa*.⁸⁴

The publication by H.M. Coovadia and S.R. Benatar (eds) *A Century of Tuberculosis: South African Perspectives*,⁸⁵ is useful in that it adopts an interdisciplinary approach to tuberculosis and includes sections on the history and epidemiology of tuberculosis, its clinical aspects, occupational tuberculosis and diagnostic, immunologic and therapeutic considerations. The historical section includes a history

⁸² This thesis focuses on the concerns and actions in the Cape with regard to tuberculosis. As tuberculosis did not have a significant economic impact on the labour market, as was the case in the mining industry, other social concerns, such as housing, were of greater importance.

⁸³ R.M. Packard, 'Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, 13, 2 (1987), 187-209.

⁸⁴ R.M. Packard, 'Holding Back the Tide: TB Control Efforts in South Africa', in Coovadia and Benatar (eds), *A Century of Tuberculosis*, 42-57; and R.M. Packard, 'Industrialization, Rural Poverty, and Tuberculosis in South Africa, 1850-1950', in S. Feierman, and J.M. Janzen (eds), *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), 104-130.

⁸⁵ Coovadia, and Benatar (eds), *A Century of Tuberculosis*.

of tuberculosis, written by C. Metcalf, which traces the global history of the disease from ancient times before focusing on its occurrence in South Africa up to the introduction of anti-tuberculosis drugs in the 1950s.⁸⁶ This publication is a valuable addition to the literature on tuberculosis because it combines the historical perspective with an evaluation of the steps that have been taken to address the challenges faced in curbing the disease. It begins with an acknowledgement 'that throughout the ages, the burden of tuberculosis has been borne by the most disadvantaged members of society ... [and] is the pre-eminent social disease and provides a useful barometer of the standard of living and equity in any society'.⁸⁷ The book concludes by acknowledging that the continuing prevalence of the disease is rooted in the socio-economic system and the nature of the health service, and that political change leading to a redistribution of the country's resources and a growth economy are the most important interventions in tuberculosis control.⁸⁸ This is a chilling admission that despite the improvement in knowledge and availability of drugs to control the disease, until such time as poverty is addressed the disease will always be widespread among the most vulnerable members of the population.

There have been several studies on tuberculosis emanating from the University of Cape Town. Elizabeth van Heyningen addressed the incidence of tuberculosis in Cape Town in her doctoral thesis entitled 'Public Health and Society in Cape Town, 1880-1910'.⁸⁹ This was the first historical study to evaluate the impact of tuberculosis against the wider background of public health in Cape Town. Van Heyningen highlights that to an even greater extent than traumatic diseases such as smallpox and plague, 'tuberculosis laid bare the concerns and priorities of the different elements controlling the city'. She adds that 'because it did not seriously impede the economic functioning of the city, it would probably have gone unnoticed had it not

⁸⁶ Metcalf, 'A History of Tuberculosis', in Coovadia and Benatar (eds), *A Century of Tuberculosis*, 1-31.©.

⁸⁷ Coovadia and Benatar, *A Century of Tuberculosis*, Preface.

⁸⁸ T. Lee and E. Buch, 'Tuberculosis Control in South Africa', in Coovadia and Benatar (eds), *A Century of Tuberculosis*, 297.

⁸⁹ E.B. van Heyningen, 'Public Health and Society in Cape Town, 1880-1910', PhD thesis, University of Cape Town, 1989.

been for the improvements in record-keeping'.⁹⁰ Of all the Cape colonial towns, it was Cape Town that responded to the challenges posed by tuberculosis in a meaningful way. By placing this response within a wider framework, which includes reactions to diseases such as smallpox and the plague, as well as the improving knowledge of medicine and the advancement of medical structures, Van Heyningen has provided a valuable overview of the period.

There have also been a number of studies done on tuberculosis by students at the University of Cape Town. These include the work by M. Naude, 'The Role of the Free Dispensary in the Public Health Care in Cape Town, 1860-1910',⁹¹ and that by R.W.V. Rowland, 'Some Aspects of the 1912-1914 Tuberculosis Commission'.⁹² Rowland's thesis has gone beyond the analysis of the findings of the commission. He has investigated the early history of the disease and has in addition evaluated the extent to which the findings of the commission found their way into policy and legislation. Naude has researched the way the Free Dispensary, which played an important role in the care of tuberculosis sufferers in the city of Cape Town, was established as a response to conditions prevailing in the city, and how the role of the dispensary was shaped by changes in the health and social conditions of the town.⁹³

A more recent thesis is that by F. Kilpatrick, 'Consumptive Cape Town: The Chapel Street TB Clinic, 1941-1964',⁹⁴ which stands out as an important contribution to the understanding of measures taken to control the spread of tuberculosis in Cape Town. She demonstrates that even in 1941 the response to the disease in Cape Town was still shaped and informed by medical trends in Britain, specifically Dr R. Philip's 'Edinburgh Plan'. Kilpatrick indicates that even with the availability of drugs such as the Bacille Calmette Guerin (BCG) vaccine, which was developed during the 1920s but was not accepted until much later (from the 1950s onwards) the management

⁹⁰ Ibid., 483.

⁹¹ M. Naude, 'The Role of the Free Dispensary in the Public Health Care in Cape Town, 1860-1910', BA Hons essay, History Department, University of Cape Town, 1987.

⁹² R.W.V. Rowland, 'Some Aspects of the 1912-1914 Tuberculosis Commission', BA Hons essay, History Department, University of Cape Town, 1978.

⁹³ Naude, 'The Role of the Free Dispensary', Preface.

⁹⁴ Kilpatrick, 'Consumptive Cape Town'.

and control of tuberculosis still presented problems. The first active antibiotic treatment, streptomycin, was developed in 1944. Although streptomycin inhibited the development of tuberculosis, it had severe side-effects, such as the loss of hearing and balance.⁹⁵ The drugs themselves were limited in availability and efficacy until well into this century. In addition some patients developed resistance to the medication which was available. In cases where the treatment was successful, resulting in an extended lifespan, the drugs did not prevent the sufferer from being infectious. Ultimately this led to a situation that although Capetonians were no longer dying from TB, they were still spreading the disease.⁹⁶ Kilpatrick's study presents a well-written and analysed contribution to the understanding of why tuberculosis continues to remain a problem in Cape Town to the present day.

These theses have been conducted at Honours and Masters' level, and are therefore limited in scope. Notwithstanding this, each has its own contribution to make as preliminary studies which could form the basis of further, more detailed study.

There are a number of South African researchers who have contributed studies on medicine, disease, health and related issues; their work has been invaluable for placing this thesis within a wider context. First among these is Howard Phillips, who has written extensively on the Spanish flu epidemic. Phillips' *Black October: The Impact of the Spanish Influenza Epidemic of 1918 on South Africa*⁹⁷ is a pioneering study which evaluates the 1918 influenza epidemic in which between 300 000 and 400 000 people lost their lives in South Africa. The impact of the epidemic on Natal, the Transkei, Cape Town, Bloemfontein and Kimberley is examined in meticulous detail making use of archival sources and oral evidence.

The Spanish flu epidemic provides compelling subject matter for research. Its limited duration allows for comparisons to be drawn both before and after the event, not

⁹⁵ Ibid., 7.

⁹⁶ Ibid., Abstract, 141.

⁹⁷ H. Phillips, *'Black October': The Impact of the Spanish Influenza Epidemic of 1918 on South Africa* Archives Year Book for South African History, Vol. 1 (Pretoria: Government Printer, 1990).

only on a regional but also on a national basis. It took place within a decade of the establishment of political Union in South Africa, at a time when public health policies had not yet been formalised on a national basis. By evaluating the impact of the epidemic on a regional basis Phillips was able to demonstrate the priorities and attitudes in each centre, namely the gold mines of the Transvaal; the urban areas of Cape Town, Kimberley and Bloemfontein, and the rural Transkei. The structures of the Union's public health department proved hopelessly inadequate. In Cape Town, it was the mayor's office that took control of the epidemic, with the health department playing only a supporting role rather than taking the lead.⁹⁸

The importance of *Black October* for this study is that it provides valuable contextual background to the period immediately before the passing of the Public Health Act. His account exposes the inadequacies of the public health structures at the time. Although the flu was not instrumental in the passing of the Public Health Act (1919) (the process was already underway when the outbreak occurred), it encouraged parliamentarians to put aside their differences and allow for the passage of the bill with a speed that would not have been possible otherwise. It was also a stark reminder to government officials that they could not delay the implementation of health legislation any longer.

Howard Phillips was also part of a collaborative effort, together with other prominent historians such as Elizabeth van Heyningen, Harriet Deacon and Anne Digby, who contributed to *The Cape Doctor in the Nineteenth Century: A Social History*.⁹⁹ This book traces the challenges and opportunities faced by the medical profession during the period of British dominance in the Cape Colony from 1806 to 1910. Although it does not deal with tuberculosis, it provides context for the wider political, economic and social developments that were taking place at the time.

⁹⁸ Phillips, 'Black October', 14.

⁹⁹ H. Deacon, H. Phillips, and E. van Heyningen, *The Cape Doctor in the Nineteenth Century. A Social History* (Amsterdam and New York: Rodopi, 2004).

In discussing the historical writing available on tuberculosis in South Africa, it is clear that it for the most part it focuses on the mines, migrant labour and Cape Town. Although these studies have contributed significantly to the understanding of the history of the disease, there is room for additional work outside of these specific areas.

It is the aim of this thesis to address some of these gaps. The Cape offers a different vantage point of the South African tuberculosis 'story' as compared to that of the Transvaal and the mining industry, especially during the colonial period.¹⁰⁰ For a start, Cape Town is the oldest city in South Africa and the seat of government during the colonial period. It was the first port of entry to the Cape Colony, until the discovery of minerals and the building of the railway line resulted in ports such as Durban and Port Elizabeth becoming more popular, thus diminishing Cape Town's importance as a harbour town. The Cape Colony had the highest incidence of tuberculosis in South Africa, and the earliest exposure to it.¹⁰¹ The Cape also had the most advanced public health system and the greatest number of medical professionals. It was therefore in the strongest position to do something about the disease. This study seeks to evaluate how the Cape responded to tuberculosis, and how attitudes changed with time and improved knowledge.

Synopsis of Chapters

Chapter 1 looks at the etiology of tuberculosis, as well as the early global history of the disease. This is followed by a literature review which seeks to evaluate the international and local historiography of tuberculosis so that this thesis can be placed within a broader theoretical framework.

Chapter 2, 'The Lungs of the Empire', discusses how the popularity of travel to selected destinations by those suffering from tuberculosis led to their arrival in the

¹⁰⁰ Kimberley, where diamonds were mined, has not been included as the challenges facing the mining industry as far as TB was concerned is the subject of Packard's *White Plague, Black Labor*.

¹⁰¹ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 17.

Cape from 1870 onwards. An overview of some of the literature that promoted the idea of travelling to the colony, the ocean voyage and journey overland until they reached their preferred destinations (often in the Karoo), as well as the conditions they found on their arrival, form part of this chapter. Once it was recognised that the disease was infectious and that it was taking a toll on the local population, the tide turned against these individuals, leading to a situation where they were no longer welcome.

It was Cradock, a town located in the Eastern Cape, which was the favourite destination of the consumptives. Chapter 3, 'The Mecca of Consumptives', Cradock, 1870-1912, investigates how the local authority and community responded to their presence. This is set against the broader backdrop of the wider challenges which faced the town in catering for the public health needs of their residents as increased urbanisation took place. The experiences of small towns has largely escaped the historical record, primarily because of the absence of archival sources and because the focus generally falls on larger towns. The presence of the consumptive immigrants in Cradock led to a situation where their experiences were documented in promotional literature and local newspapers. This, taken in conjunction with the district surgeon reports and minutes of town council meetings, provided the sources for an investigation of 'small town' attitudes towards tuberculosis and public health.¹⁰² It became clear that Cradock's officials had little enthusiasm for public health, and even less for tuberculosis.

Attitudes towards tuberculosis in Cape Town, which is the subject of Chapter 4, were in sharp contrast to those in Cradock. The city council, together with its MOH, took a leadership role in the fight against the disease, not only in the city itself but in the colony. Fortunately, Cape Town was not alone in taking initiatives against the ravages of tuberculosis.

¹⁰² District surgeons were part-time government officials appointed to perform medical tasks like post-mortems and vaccinations in the rural areas. They also had to report on matters such as health and sanitation, and were therefore the 'eyes and ears' of government in the small towns.

In Chapter 5, 'The Dawn of a New Era in the Fight against Tuberculosis, 1896-1910', the contributions made by other dedicated individuals and organisations are acknowledged. These included the Association for the Prevention of Consumption and the role played by Dr Neil Macvicar, who was the founder of the Native Health Society.

Chapter 6 is a transitional chapter which marks the end of the colonial period and the inclusion of the former Cape Colony into the Union of South Africa in 1910. One of the early issues to be dealt with by the new government was the implementation of an immigration policy. The restriction of immigrants suffering from tuberculosis formed part of the *Immigrants Regulation Act, Act No. 22 of 1913*.

The Tuberculosis Commission, 1912-1914, is the subject of Chapter 7. The report itself opened up the debate on whether tuberculosis was a hereditary or an infectious disease. The dominant views of the mining houses, who were able to use the hereditary debate as a justification for their migrant labour policies, is discussed. The report itself was marred by controversy, not only about the conflicting views on tuberculosis, but because of the antagonism between the commissioners, as well as the amount of time and money spent on its completion.

The final chapter, Chapter 8, 'Public Health and Tuberculosis during the period from 1914 to the passing of the *Public Health Act, Act 36 of 1919*' details how World War One led to a delay in dealing with public health legislation. After the war a conference was held in 1918 at which proposals were put forward for incorporation into the Act. Very shortly thereafter the breakout of the Spanish flu epidemic created a sense of urgency for the implementation of a Public Health Act. The Act itself contained a number of positive features pertaining to tuberculosis. It recognised that it was different from other infectious diseases and therefore needed to be treated differently. It also made notifications compulsory. However, a major weakness was its failure to treat tuberculosis as a *national* problem and instead to leave its prevention in the hands of the local authorities. There was also a failure to provide adequate financial resources, compounded by onerous stipulations before

funding could be accessed. The Act itself was drafted with the health of the European residents in mind, and the fact that tuberculosis occurred most frequently among blacks and Coloureds ensured that the prevention of the disease would never be adequately addressed.

Chapter 2

'The Lungs of the Empire',¹ Travel to the Cape for Health Purposes, 1870-1910

In the nineteenth and twentieth centuries there was a popular belief in Britain and Europe that residence in places with dry air and high altitudes (such as those in the Karoo and other parts of the Cape) were beneficial to tuberculosis sufferers.² Because there were no contemporary means of treatment available (and, indeed, the origins of the disease had yet to be 'discovered') this notion brought a flood of desperate victims to the Cape in search of such conditions.³ The Cape gained popularity for its 'healthy climate' as early as 1858, and this trend continued for almost half a century, playing a crucial role in the introduction of the disease to the area. The Tuberculosis Commission of 1914 found, when attempting to trace the origins of the disease, that it had been introduced by European immigrants and that it had spread to the interior from Cape Town.⁴

Promoting the Cape Colony as a Health Destination

In the middle of the nineteenth century, a number of different factors combined to make travel to destinations such as the Cape Colony more attractive. In the first place, ocean travel was becoming safer and more affordable. Secondly, working and living conditions in Britain were deteriorating as more and more people moved into

¹ C. Swaisland, *Servants and Gentlewomen to the Golden Land. The Emigration of Single Women from Britain to Southern Africa, 1820-1939* (Pietermaritzburg: University of Natal Press, 1993), 151.

² J. Nixon, *Among the Boers or Notes of a Trip to South Africa in Search of Health* (London: Remington & Co., 1880), 279.

³ The aetiology of tuberculosis was unknown until Robert Koch demonstrated the causative organism in 1882 and thereby established beyond doubt the contagious nature of the disease. See C. Pennington, 'Tuberculosis', in O. Checkland and M. Lamb (eds), *Health Care as Social History: The Glasgow Case* (Aberdeen: Aberdeen University Press, 1982), 88.

⁴ National Library of South Africa, Cape Town (hereafter NLSA), Union Government (hereafter UG), NLSA, UG34-1914, *Union of South Africa, Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 21-22. Once tuberculosis had established itself in the Cape Colony, it took on a life of its own. As shown in Chapter 1, its spread was facilitated by the living conditions of the most vulnerable members of society, particularly among the Coloured population.

the cities following the industrial revolution. At the same time the colonies, including the Cape Colony, were actively seeking out people who were prepared to immigrate to their territories.

By 1860 global migration was a fact of life.⁵ For those suffering from tuberculosis, emigration held a special appeal. There were three categories of tuberculosis cases in Britain at the time, divided mainly along class lines. These were the upper-middle class or wealthy, the middle classes and the poor. Even at the end of the nineteenth century, upper-middle class patients rarely entered hospitals, especially when suffering from a disease such as tuberculosis. They were either nursed at home or went to more luxurious sanatoria for treatment. For the middle classes and those whose finances did not extend to such steps emigration to the colonies had advantages, not only because of the perceived benefits of life in the climates of the colonies, but because of changed attitudes towards those suffering from tuberculosis in Britain itself. Tuberculosis cases were increasingly being excluded from voluntary hospitals, making it extremely difficult for such patients to get treatment. Doctors wanted to show 'results' and therefore preferred treating patients with 'curable' illnesses. Moreover, chronic 'incurable' cases 'blocked' hospital beds and this meant that tuberculosis cases were often relegated to the Poor Law institutions. By the second half of the nineteenth century, most of these establishments were also closed to tuberculosis sufferers.⁶ With no other options available, even those with very little in the way of financial resources were managing to scrape together just enough to take advantage of the discounted fares offered by the shipping companies, even though it left them with no funds available once they reached their destination.

There is no doubt that the increased visibility of the Cape Colony created by the immigration agents played an important role in encouraging people to immigrate. One of the leading figures in respect of both immigration and the creation of

⁵ H.R. Woolcock, *Rights of Passage: Emigration to Australia in the Nineteenth Century* (London: Tavistock Publications, 1986), 25.

⁶ L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 23.

awareness of the potential of the Cape as a destination for consumptives, was Thomas Fuller (later Sir Thomas Fuller),⁷ who initially travelled to the Cape in 1864. His wife had been diagnosed with tuberculosis and her medical practitioner had advised her to take up residence in a place with a warmer climate for the benefit of her health. Unfortunately the change did not restore her health and she died in 1872.⁸ This did not deter Fuller from continuing to promote the Cape as a destination which would be beneficial for those suffering from tuberculosis.

Fuller was appointed as the Cape Colony's immigration agent in London in 1873. At the time the colony's operations extended from Luxembourg to Aberdeen. However, he concentrated most of his efforts in Cornwall and the west of England, where emigration to the Cape was well-known and popular.⁹ While in London, he was offered the post of general manager of the Union Steamship Company, a position he held from 1875 until his resignation in 1898.¹⁰

There were a number of organisations based in Britain that also promoted the emigration, especially for women. They were assisted in their task by the growing number of publications which praised the virtues of the colony. One of the earliest of these was by W. Irons, *The Settler's Guide to the Cape of Good Hope and the Colony of Natal*, which was published in 1858.¹¹ Although Irons did not refer specifically to

⁷ Thomas Fuller had two sons, both of whom were doctors. (Edward) Barnard Fuller became the MOH in Cape Town and brought increased awareness of tuberculosis. He later became a politician. Alfred Fuller practised medicine in Boshoff, in the Orange River Colony. He was the author of a number of publications promoting the Cape Colony as a health resort for consumptives.

⁸ W.J. de Kock (ed.), *Dictionary of South African Biography. Vol. I* (Pretoria: National Council for Social Research, 1968), 304.

⁹ NLSA, Official Publications (Cape Colony), Govt Reports, (hereafter G), G8-1876, *Cape of Good Hope, Ministerial Department of Crown Lands and Public Works, No. V. Immigration. Report on Immigration and Labour Supply for the Year 1875* (no publ.), 5-7. In the late 19th century Cornish miners formed the majority of the skilled labour force on the Witwatersrand gold mines in the first 20 years of mining. In 1902-3, the Miners' Phthisis Commission of the Transvaal estimated that over 90% of white miners on the Rand were of foreign origin and of these, most were Cornish. See G. Burke and P. Richardson, 'The Profits of Death: A Comparative Study of Miners' Phthisis in Cornwall and the Transvaal, 1876-1918', *Journal of Southern African Studies*, 4, 2 (April 1978), 148.

¹⁰ De Kock, *South African Biography, Vol. I*, 304.

¹¹ W. Irons, *The Settler's Guide to the Cape of Good Hope and Colony of Natal* (London: Edward Stanford, 1858).

tuberculosis, he noted that there was 'no country on the globe so free from those diseases which spring from putrid exhalations' and he went on to assure his readers that contagious complaints were 'few and far between'. A further feature of Irons's work is that he stressed the need for immigrants in specific occupation categories. He highlighted the opportunities in the Cape and encouraged people in professions such as nursing to consider the opportunities so readily available. In reality there were few professional nurses available in this pre-Nightingale era. Nursing help, even in Cape Town, was difficult to find. It was against this background and need, which was all the more acute in South Africa because of the isolation of many families, that the training of nurses began in Britain. The opening of the Nightingale School of Nursing in Britain in 1860 began the process of training that made the calling accessible to women of higher class. Ultimately, nursing became so popular that more were being trained than could find work in Britain. It was, however, only in the 1870s that real progress was made to help nurses to emigrate. The Cape became the destination of choice for many nurses who sought to restore their health, especially for pulmonary conditions. During the 1890s, the Female Middle Class Emigration Society (FMCES) sent out several women who had chest problems, despite the fact that they were all offering their services to take care of children.¹²

The British Women's Emigration Association (BWEA) was another organisation which was responsible for sending out consumptive women in the 1860s, and they were still sending them 30 years later. One of their clients, a Miss Lawton, who arrived in 1899, was reported as being 'very consumptive' but was still sent as a housekeeper to a bachelor establishment at Bloemfontein. Anna Montana, who began as a nurse to the children of Dr Stevenson of Rondebosch, Cape Town, was also sent to Bloemfontein although it was known that 'she would never be any better'.¹³

The medical profession also contributed to the promotion of the Cape as a destination for those with health complaints. One of the main supporters of the Cape as a health resort was Dr E. Symes-Thompson, who was a Fellow of the Royal

¹² Swaisland, *Servants and Gentlewomen*, 147-150.

¹³ *Ibid.*, 150.

College of Physicians and a health advisor to the BWEA.¹⁴ In an address to the Royal Medical and Chirurgical Society on 8 April 1873, he expressed the view that information on health resorts was geared for the wealthy rather than those of moderate means. He felt that there was a need for those suffering from chronic chest disease to have a prolonged stay in a sunny climate under conditions that were 'different'. Both South Africa and Australia were considered ideal destinations for this group of consumptives.¹⁵

Over the next decade the campaign to attract immigrants was intensified. Up until 1880 the emigration agents had relied on newspaper advertisements and editorials. In that year they were able to come to an arrangement with the post offices in England and Scotland whereby they were permitted to display posters about the Cape in every post office in the country. Still more of these posters were displayed at other suitable places (15 000 in all). Weekly advertisements also appeared regularly in about 60 to 70 newspapers. This had the effect of increasing the visibility of the Cape substantially, especially to the British and Scottish population. Every opportunity was used to provide information about the Cape, including the provision of publications to the Free Library and the Working Men's Institutes. Such publications included the *Official Handbook of the Cape Colony; Glanville's Guide to South Africa; and The Emigrant's Guide to South Africa*.¹⁶

The association between climate and disease had received attention in Britain since 1852 when articles began to appear in the *Association Medical Journal* (later known as *the British Medical Journal*). These articles increased in number until they were a regular feature in *the BMJ* from 1876 until at least 1906, at which stage the trend began to lose momentum when the practice waned in popularity. In addition, 'medico-meteorological observations' together with details of diseases and deaths in

¹⁴ Ibid., 150. The advertisement for Thomson's Commercial Hotel contained in 'The Travellers' Guide' featured in the *Midland News*, 3 November 1891, contains a quotation from

¹⁵ C.J.B. Williams, Reports of Societies, Royal Medical and Chirurgical Society, 8 April 1873, Review of E. Symes-Thompson, 'On the Elevated Health Resorts of Southern Hemisphere, with Special Reference to South Africa', *British Medical Journal* (hereafter *BMJ*) (10 May 1873), 545-546.

¹⁶ NLSA, G19-1881, *Cape of Good Hope. Report on Government Emigration for the Year 1880* (no publ.), 5.

British institutions were published in each issue of the *Association Medical Journal* during the same period.

Public gatherings were used to full advantage to promote travel and residence in the colonies. A case in point was the Universal Exhibition held in Paris in 1855, where reference was made to the lack of disease at the Cape. Emigration was encouraged for those who wanted to escape competition for employment, with a promise that they would 'quickly succeed, by their industry and economy, in securing an honest and independent livelihood' in the colony.¹⁷

The Cape also became the destination of choice for British army officers from India who were suffering from consumption. By 1858 Cape Town had become a favourite 'sanatorium' for officers and members of the civil service who were serving in India; they would visit Cape Town while they were on furlough.¹⁸ The Cogill, Drake and Rathfelder Hotels in the southern suburbs of Cape Town were a famous destination for these consumptives.¹⁹ This practice continued for over a decade.²⁰

In 1869 R. Noble's *The Cape and its People, and other Essays by South African Writers* was published.²¹ By this time the association between climate and disease had already received more than a decade's attention in medical journals such as the *Association Medical Journal* and the *BMJ*. Noble drew a direct connection between

¹⁷ E. Blancheton, *Universal Exhibition 1855: Colony of the Cape of Good Hope* (Cape Town: Saul Solomon & Co., 1855), 4.

¹⁸ Nixon, *Among the Boers*, 279.

¹⁹ The hotel later changed its name to Grand Hotel and was still catering for consumptive visitors in 1882 when its advertisement in the *Cape Times* referred to it as 'Late Rathfelders, the great suburban, pleasure-seeking sanatorium hotel of South Africa'. See *Cape Times*, 20 January 1882.

²⁰ R.M. Packard, *White Plague, Black Labor Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989), 39. By 1869 visits to the Cape by these military officers had fallen 'out of fashion'. See R. Noble (ed.), *The Cape and its People, and Other Essays by South African Writers* (Cape Town: Juta, 1869), 38. In 1875, army furlough regulations prohibited officers from visiting the Cape on medical leave, although they were still permitted to travel to Australia. This matter was raised by Colonel Tamplin in the Cape legislature on 25 July 1893. C.J. Rhodes responded that he believed that the opening of the Suez Canal made for easier travel to other destinations. It was decided to take the matter up with the imperial government so that the restriction could be removed. See *House of Assembly Debates*, 25 July 1893. The matter was not raised in the House of Assembly again.

²¹ Noble (ed.), *The Cape and its People*.

the value of climate and the Cape when he stated that ‘in South Africa we can offer a home to the delicate ... for those whose lungs, liver or joints are painfully out of gear’.²² To substantiate his claims about the value of the Cape climate, Noble quoted details of Major Tulloch’s statistics of the incidence of the disease among the European troops stationed in various colonies. The number of deaths of tuberculosis sufferers at the Cape was approximately four per 1 000, compared to 6,5 per 1 000 in Canada and almost nine in Bermuda.²³ Cape Town, and in particular its suburbs such as Wynberg, Rondebosch and Constantia were considered the prime health resorts.²⁴

Seeing the potential of the southern African colonies as health resorts, and aware that no sanatorium facilities were available, Dr J. A. Ross travelled from England in 1872 with the idea of establishing a sanatorium in Bloemfontein to accommodate wealthy consumptives.²⁵ As he travelled around the country, he explored the ‘potential’ of the various country towns for consumptives. His book, published in 1876, and entitled *Consumption: Its Treatment by Climate with reference especially to the Health Resorts of the South African Colonies*, included full-page advertisements for shipping lines such as the Castle Line Royal Main Service and Donald Currie & Company.²⁶ This was possibly the earliest example of collaboration between a medical practitioner and a shipping line, in which consumptives were encouraged to visit the Cape ‘for the benefit of their health’.

Ross had analysed the climates of southern Europe, northern Africa, the mountain plateaus of Peru, Australia and South Africa as suitable climates for consumptives. He selected South Africa for three reasons: the climate was known to be warm yet invigorating and very dry; it was accessible by steamer; and the country was, for the main part (in his view) populated by English-speaking residents. He recommended the Cape Town suburbs in preference to the central city but his main focus was on

²² Ibid., 31.

²³ Ibid. 31.

²⁴ Ibid., 23.

²⁵ *The Cradock Register*, 10 April 1874. Ultimately nothing came of this idea.

²⁶ J. A. Ross, *Consumption: Its Treatment by Climate with Reference especially to the Health Resorts of the South African Colonies* (London: Henry Renshaw, 1876), no page numbers.

the country towns. Aliwal North, in his opinion, had a 'good reputation'. Bloemfontein was the destination of choice for many consumptives and had established a reputation for the 'cure of consumption'. But it was Cradock that he favoured because it had 'many natural advantages' and would become more accessible on completion of the railway line. More than one consumptive invalid, he said, owed their recovery to their residence in Cradock.²⁷

At the very least, consumptives were encouraged to make the journey for the duration of the British winter.²⁸ It was such advice that was followed by J. Nixon, who was advised by his doctor to 'try the elevated plains of South Africa for the winter' after being diagnosed with inflammation of the lungs.²⁹ Unlike many other promoters, Nixon was a consumptive himself and wrote a most readable volume. On his journey to the Cape in October 1877 he enquired how many of his fellow passengers were suffering from consumption, and stated:

The *American* was laden with invalids. Some were bound for Madeira, and some to the Cape. Most had bad lungs. There were a few sound persons on board. I believe that every saloon passenger going out for the first time was an invalid, with the exception of my friend R, who was in what one of the invalids called 'disgusting' health.³⁰

Nixon's travelling companion on his journey into the interior by ox-wagon was Dr Lawton, another medical doctor who was a consumptive and had travelled to the Cape for the benefit of his health. Lawton did not survive the journey. Nonetheless, Nixon recommended the Cape for medical consumptives since he believed that they could earn high incomes. He wrote in glowing terms that 'South Africa offers golden opportunities to steady young men who would be kicking up their heels at home in vain attempts to establish a practice'.³¹

²⁷ Ibid., 7-8, 14-15, 28, 33, 38.

²⁸ This advice was also given in other publications. See, for example, Nixon, *Among the Boers*, 1; A. Fuller, *South Africa as a Health Resort ... Effects of the Climate on Consumptive Invalids, and Full Particulars of the Various Localities most Suitable for their Treatment* (London: W.B. Whittingham & Co, 1886), 16; W.C. Scholtz, *The South African Climate including Climatology and Balneology ... Particularly with Reference to Afflictions of the Chest* (London: Cassell, 1897), 70.

²⁹ Nixon, *Among the Boers*, 1.

³⁰ Ibid., 278-315, 3, 289, 296, 304.

³¹ Ibid., 309-310.

One such medical practitioner who heeded his advice was Dr John MacIver. He qualified in Edinburgh in 1894. In May 1895 he wrote to introduce himself to the colonial administration in Cape Town: 'I am twenty-five years of age, about 5ft 10ins in height, a graduate of Edinburgh University and a Scotchman'. He was appointed as the district surgeon to the district of Sutherland, and was based in Clanwilliam, a remote upland town in the Western Cape. What he was seeking, however, was an elevated, dry situation. After four months of hardship, MacIver requested a move, desperately citing the 'remarkable disadvantages of living here'. He was moved to Willowvale in the Karoo but died within three months, presumably from tuberculosis.³²

There were several other medical practitioners who suffered from consumption who took up residence in the Cape Colony. Dr S. Wolferstan Morgan, a graduate of London University, was running a successful and thriving practice in Fraserburg in 1893, although he never enjoyed good health while in the colony. He did not die of consumption but suffered an attack of typhoid fever on a visit to Cape Town and died at the Somerset Hospital.³³

Another of the better known doctors who was also consumptive and came to South Africa to benefit from the climate, was Dr B. J. Guillemard. He was a district surgeon in Aliwal North in 1896.³⁴ Two years later he moved to Cape Town, where he played an active role in the establishment and running of the South African Association for the Prevention of Consumption.³⁵ Then there was also Dr George Turner, the medical officer of health of the Cape Colony in 1895. He was diagnosed with phthisis while he was at Guys Medical School in Britain. However, by the time he took up his

³² A. Digby, *Diversity and Division in Medicine. Health Care in South Africa from the 1800s* (Oxford: Peter Lang, 2006), 162-163.

³³ 'Obituary, Dr S. Wolferstan Morgan', *South African Medical Journal* (hereafter *SAMJ*) (May 1894), 32.

³⁴ W. Arnison, 'South Africa as a Health Resort', *BMJ* (March 1896), 813.

³⁵ See Chapter 5, 'Dawn of a New Era in the Fight against Tuberculosis' for more information.

appointment in the Cape, he was already showing signs of recovery from the disease.³⁶

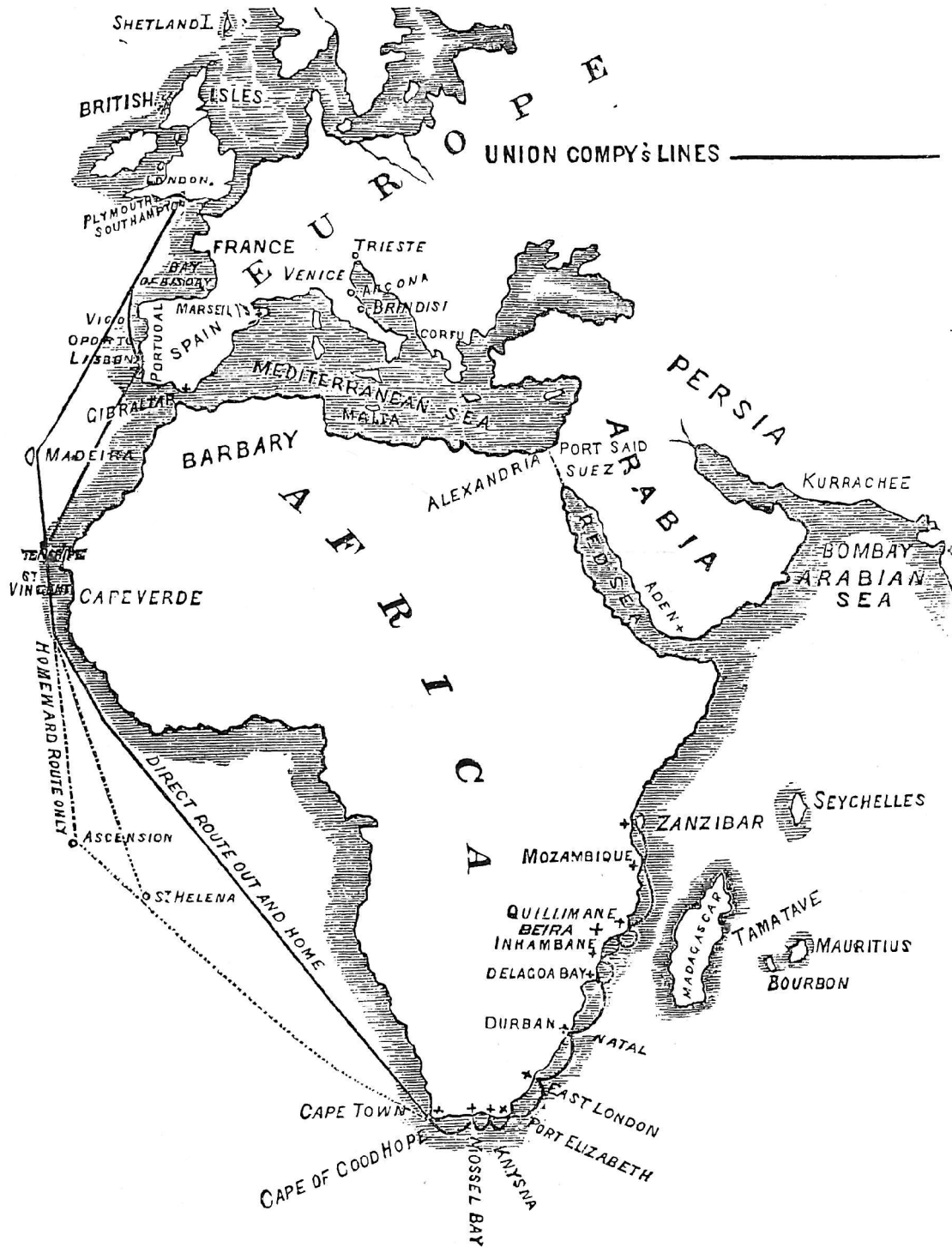
There were several other medical graduates who immigrated to the Cape Colony and set up practices during this period, including Dr John Griffin, who initially practised in Port Elizabeth before settling in Middleburg; and Dr T. L. Parry, who spent some time in the Transkei. Dr A. S. Barrow ran a practice in Indwe and Dr John Kemp Murray spent much of his time in Cape Town.³⁷

³⁶ 'Dr George Turner' (extract from *Guy's Hospital Gazette*), *SAMJ* (September 1895), 135-136. Dr Turner's son contracted the disease while on a voyage to the Cape Colony, during which he shared a cabin with a person suffering from tuberculosis. See Editorial, 'Some Points for Discussion on the Prevention of Tuberculosis', *South African Medical Record* (hereafter *SAMR*) (August 1899), 60.

³⁷ 'Obituary: John Griffin', *SAMR* (August 1895), 149; 'Obituary: T.L. Parry', *SAMR* (March 1903), 15; 'Obituary: A.S. Barrow', *SAMR* (December 1903), 159; 'Obituary: John Kemp Murray' *SAMR* (10 October 1906), 317.

SEA ROUTE TO CAPE COLONY, 1894

THE UNION STEAM SHIP COMPANY'S LINE.



SOUTH AND EAST AFRICA

The Role of the Shipping Companies

The shipping companies played a crucial role in the promotion of the Cape as a destination. During 1880 alone there were 43 shipments of emigrants to the Cape.¹ The Union Steamship Company despatched steamers from Southampton every alternate Thursday and from Plymouth the following day. At the same time the Castle Line, owned by Donald Currie & Co., departed from London via Dartmouth on the other two weeks of the month. The competition between the rival lines was very keen, which reduced the cost of travel between England and the Cape substantially.²

By 1890 the Union Shipping Company, the dominant shipping line to the Cape, was facing stiff competition from the Castle Line. Meanwhile, in the Cape emigration offices and their agencies were set up in most major towns.³ Larger and more frequent ships increased the number of new arrivals with the *Norman* arriving in Table Bay with over 800 passengers. In addition, the value of sea-voyages as a method of treatment for a variety of ailments was receiving a great deal of attention in medical journals.⁴ The steamers of the Castle Line were being spoken of as 'floating hotels' and that 'nothing conducive to the comfort or welfare of the passengers, invalid or otherwise, escapes the attention of the owners and officers of these ships'.⁵ As improvements were made in shipping the duration of the journey decreased. While the standard voyage took approximately 20 days in 1886, eight years later *The Scot* completed the journey in just over fourteen days.⁶

As the shipping lines improved their services so too did the number of publications promoting South Africa as a cure for consumptives increase. In 1886 the Union Shipping Line commissioned Dr Arthur Fuller, the son of Thomas Fuller (who was at

¹ NLSA, G19-1881, *Cape of Good Hope. Report on Government Emigration for the year 1880*, 6.

² Nixon, *Among the Boers*, 3.

³ Agencies included those in London, Southampton, Belfast, Birmingham, Bradford, York, Bristol, Edinburgh, Glasgow, Hull, Leeds, Liverpool, and Manchester. See, Union Steam Ship Company Ltd, *Handbook of Information for Passengers and Shippers. South and East African Mail Service* (London: Union Steam Ship Company, 1894), 51.

⁴ Different aspects of sea-voyages are discussed in greater detail below.

⁵ Scholtz, *The South African Climate*, 15.

⁶ Fuller, *South Africa as a Health Resort* (1886), iii; *Midland News*, 31 May 1892.

this time the general manager of the Union Shipping Lines) to write a book which would promote South Africa as a destination for those suffering from tuberculosis.⁷ Fuller responded with his *South Africa as a Health Resort*.⁸ It was a remarkably successful publication which was revised and reprinted on a regular basis. By 1898 it was in its sixth edition, with 55 000 copies printed.⁹ Other books which were also available from the Union's office were *Emigrant's Guide to South Africa* (Union Steamship Company's edition) and *A Voyage to the Cape* (an extract from W. Clarke Russell's work of that name).¹⁰ Like similar works, Fuller's book commented on the sea voyage, and included case studies of consumptives who had benefited from their stay in the colony. Meteorological particulars were provided and the importance of travelling to the colony while the disease was in an early stage was emphasised. Fuller had no hesitation in claiming that of the many patients who sought relief in the South African climate, very few gained no benefit at all while a good number had their lives prolonged.¹¹

In line with contemporary opinion, Fuller held that the key to a cure was a dry climate. He believed that:

... there are a large number of people who have perhaps a hereditary predisposition to consumption and suffer from chest weakness, manifesting itself principally during the winter in England by prolonged cold sinking to the chest, and being got rid of with difficulty, leaving behind them a cough which lingers perhaps for months. *Such persons are (as we all know) on the verge of consumption, and every winter they spend in the damp, cold climate of England is a danger to them, which all too frequently proves fatal* (my emphasis).¹²

Fuller favoured the interior during Cape Town's wet winter months. Beaufort West, Prince Albert and Graaff Reinet were all recommended but Fuller considered Cradock particularly suitable. He wrote,

⁷ De Kock, *South African Bibliography, Vol. 1*, 304.

⁸ Fuller, *South Africa as a Health Resort* (1886).

⁹ Each edition of this publication contained revisions. It was, however, only in the 1898 edition that Fuller conceded 'that phthisis is infectious is no longer an open question' (page 6).

¹⁰ Union Steam Ship Company, *Emigrant's Guide to South Africa*, xxxi.

¹¹ Fuller, *South Africa as a Health Resort* (1886), 12.

¹² *Ibid.*, 44-45.

Not only is the town healthy, but residence on the farms in the district is equally beneficial and cannot be too strongly recommended. I should therefore advise no invalid to leave South Africa uncured without, if it is in his power, first trying this, one of the best health resorts.¹³

Fuller anticipated that consumptives could find sufficient work in the colony to support a family but felt that the frail individuals should avoid working for the first year or two.¹⁴ His advice was that, if at all possible, consumptives should try living in open-air environments such as on farms as this was one of 'the most certain means of getting rid of their consumption'.¹⁵ Above all, Fuller offered hope: 'cases apparently very hopeless do improve wonderfully with the change, and if they cannot expect to entirely get rid of the disease, they may reasonably look forward to a very vast improvement and a considerable lengthening of life'.¹⁶

Dr Symes-Thomson (referred to earlier in this chapter) also retained his interest in the subject. On 13 November 1888, he addressed a well-attended meeting of the Royal Colonial Institute in London on the subject of 'South Africa as a Health Resort'.¹⁷ The content of the talk was included in later editions of Fuller's *South Africa as a Health Resort* and quotes from the address were incorporated into advertisements for the Commercial Hotel, situated in the Middelburg district of the Karoo.¹⁸ It is clear that promotions such as this reached a wide audience, including medical practitioners and the lay public from both Britain and the Cape.

In his address Symes-Thomson placed emphasis on those patients who required a long-term, or even permanent, separation from the conditions under which their disease had arisen. The colonies, he believed, were less competitive for the frail and sufferers were more likely to flourish under such restful conditions. His view was that:

¹³ Ibid., 22-29.

¹⁴ Ibid., 51.

¹⁵ Ibid., 49. Even after travel 'for health purposes' was no longer popular, farming was recommended for the treatment of tuberculosis.

¹⁶ Ibid., 52.

¹⁷ Dr E. Symes-Thompson, Address to Royal Colonial Institute, 'South Africa as a Health Resort', in *Proceedings of the Royal Colonial Institute, Volume XX. 1888-9* (London: Sampson Low, Marston, Searle and Rivington, 1889).

¹⁸ *Midland News*, 13 February 1894 and subsequent editions.

It is not enough to decide what occupation or profession should be chosen for our youth, we must determine in which part of the Empire it may best be carried out. We must look at life from a larger and broader platform, and regard our colonies with gratitude, as affording health stations for our children and breathing space for our teeming home population.

At home, trained talent and strong health are alike essential ... But there are many whose strength and vitality are not sufficient for success in the high competition of this country [Britain]. These, if transplanted to a Colony where life is more restful, and competition less keen, will rise to eminence ... men of exceptional ability will push their way in every community, and South Africa can boast of many in positions of high trust who could never have attained such eminence in a trying climate.¹⁹

These sentiments were similar to those expressed by Fuller, and also offered hope to ordinary, working-class citizens by stating that the sufferers who regained their health in the colonies were those who were ready to accept any post, or to undertake any work that was available. For professionals, Symes-Thompson had this to say:

As to professional men, whether architects, engineers, lawyers, doctors or clergymen, there is always scope everywhere for really able men. Those who have held their own in the midst of the competition of the old country, are sure to make a position for themselves in a community where the number of really eminent men is necessarily limited'.²⁰

It was this aspect which separated the colony from the European health resorts – the fact that a health seeker who did not have the financial resources to go to a sanatorium in Europe, but who had to continue to work for a living, would be able to do so in an English-speaking environment.

In Symes-Thompson's opinion, 'Aliwal is beyond doubt one of the most valuable health resorts of South Africa for phthisical patients'. Tarkastad, midway between Cradock and Queenstown, was also viewed 'as superior to many other stations'. Cradock was 'regarded in the Colony as one of its principal health resorts'. Other towns receiving praise were Beaufort West, Burghersdorp, Ceres, Hanover,

¹⁹ Symes-Thompson, 'South Africa as a Health Resort', 6.

²⁰ Ibid., 7.

Grahamstown and Graaff Reinet. The towns which were not recommended included Port Elizabeth, the central district of Cape Town and Port Alfred.²¹

In 1893 the Castle Line commissioned A.S. Brown and G.G. Brown to write a book promoting travel on the Castle Line, and as a result *Brown's South Africa: A Practical and Complete Guide for the Use of Tourists, Sportsmen, Invalids and Settlers* was published. These later publications drew little distinction between invalids and healthy immigrants. Several years later, in 1897, W.C. Scholtz's *The South African Climate including Climatology and Balneology and Discussing the Advantage, Peculiarities and Capabilities of the Country as a Health Resort* was published.²² In the chapter on health resorts, Scholtz made the familiar recommendations of Ceres, Beaufort West, Cradock and Aliwal North. Places not previously considered, he remarked, 'are now extolled for their health-giving and curative influences in many cases of the disease, and their reputation has often been fairly deserved'.²³ For dramatic emphasis he added that 'it is no uncommon thing to meet individuals who freely acknowledge that, but for our climate, they would not be alive to tell the tale'.²⁴

Ocean Voyages and the Journey Inland

While the promoters went to great lengths to praise the climate, the one thing they ignored was the very real risk of infection during the voyage, as some people realised. One was an anonymous contributor to the *BMJ*. In an article entitled 'Consumptive Fellow Travellers', he described the position of a healthy person who was forced to share a small cabin with a tuberculosis sufferer:

... the consumptive man will have a considerable dread of ventilation, at least such an amount as a healthy man would desire, and so, at the very outset, the healthy and the

²¹ Ibid., 1-18.

²² Scholtz, *The South African Climate*. There is no indication that this work was sponsored by any organisation.

²³ Ibid., 69.

²⁴ Ibid., 27.

ailing will find their wishes not in accord. What follows? The healthy man, doubtless promoted by those feelings of humanity which generally contemplate suffering of any sort with pity, will probably waive any objections in favour of the invalid, with what danger to his own health?²⁵

Another individual who had strong views about ocean voyages was Dr C.T. Williams, who considered that their value was greatly overestimated and that their serious drawbacks were not fully realised. He believed that many practitioners advised a sea voyage as if it was a universal remedy for consumption – just as ‘open-air treatment’ was prescribed, often with dire consequences. He maintained that any slight advantage there may have been on the purity of the ocean air was far outweighed by the disadvantages of an invalid at sea who was faced with close, badly ventilated cabins, draughty saloons, sea-sickness, damp sea fogs and enforced confinement below the decks during bad weather. In his view, passing through the tropics was particularly challenging for invalids.²⁶

While those promoting emigration naturally emphasised the health benefits of the voyage, the reality was sometimes rather different. Sir William Flower felt that the principal objection to persons in delicate health undertaking a long sea voyage was their lack of ability to control their fate,

... because the invalid could find himself crowded in a dark, close cabin with two or three uncongenial companions, lying on a narrow, hard shelf, portholes rigidly closed, and the atmosphere he breathes poisoned by noisome odours, of which the sickening smell of the oil of the engines is one of the least objectionable; the rain pouring on deck, making escape from his prison, even for a few minutes, impossible; when he feels he would give all his worldly possessions for a breath of pure air, or a few hours’ cessation from the perpetual din of the engines within and the waves throughout. He is perfectly helpless: he must go through it day after day, night after night, until the weather changes or the voyage is ended.²⁷

²⁵ ‘Consumptive Fellow Travellers’ (Reviewed work), *BMJ* 1, 1464 (19 January 1889), 141-142.

²⁶ C.T. Williams, ‘A Discussion on the Treatment of Consumption by Climate. Introductory Address on the Classification of Climates and Comparison of Results’, *BMJ* (27 July 1901), 203. Dr C.T. Williams was a physician at the Brompton Hospital for Diseases of the Chest. Other articles written by him include C.T. Williams, ‘Lettsomian Lectures on the Influence of Climate in the Treatment of Pulmonary Consumption, Lecture III’, *BMJ* (12 February 1876), 186-188; and C.T. Williams, ‘Lettsomian Lectures on the Influence of Climate in the Treatment of Pulmonary Consumption Lecture III (concluded)’, *BMJ* (19 February 1876), 219-222.

²⁷ Williams, ‘A Discussion on the Treatment of Consumption’, 203.

Another passenger, who identified himself only as “W.J.R.” wrote to the *BMJ* about his impression of consumptive sufferers who he encountered on a trip to the Cape Colony. He related how some passengers had no idea what they were going to do once they reached the colony, ‘except perhaps having a hazy notion of ‘taking a situation’ on arrival, even though they could sometimes barely crawl about the deck or sit in a deck-chair’. These passengers frequently landed without a penny unless other sympathetic passengers raised money among themselves to facilitate the costs of their travel “up country”.²⁸

Once consumptives arrived at the Cape, for many their journey was far from over because there was still the long trek to the dry Karoo towns that they favoured. Cradock was particularly popular. It is situated in the Karoo in the centre of an area dominated by cattle, sheep and ostrich farming, and located approximately 180 miles from Port Elizabeth. Travel to Cradock was arduous and time-consuming before the opening of the railway line in 1881.²⁹

There were a few options available to those who wished to travel inland. The traveller could either hire his own cart (at a cost of about 40 shillings a day) or make use of the mail carts, which charged six pennies per mile. The mail carts made no special provision for invalids and the journey was considered to be a ‘rough’ one. Two types of cart were available, the ‘American’ carts or the Cape carts. The Cape carts were high, two wheeled spring carts and were in common use throughout South Africa. In fine weather, when roads were in good condition a journey could be very enjoyable, but in bad weather the carts regularly capsized or were stuck in the mud.³⁰

An alternative method of travel was the use of the ox-wagon, although this was far slower. With average speeds of not more than ten or twelve miles a day, it took

²⁸ W.J.R., ‘Consumptive Patients in South Africa’, Correspondence, *BMJ* (6 May 1899), 1107.

²⁹ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 29. (Evidence of Mr J. Butler).

³⁰ The ‘American coach’ was a coach which was slung on leather straps, and carried 12 inside and 6 or 8 outside, with teams of 10 horses or mules. See A.S. Brown and G.G. Brown, *The Guide to South Africa for the Use of Tourists, Sportsmen, Invalids and Settlers* (London: Sampson Low, Marston & Co., 1896), 31.

approximately three weeks to reach Cradock for passengers who had disembarked in Port Elizabeth.³¹ While some people continued to hold the view that the journey itself was beneficial, camping in the cold and rain, sometimes ‘in a veritable flood’, was ill-suited to consumptives.³²

Travel to Cradock was greatly facilitated by the opening of the railway line in 1881.³³ The Cape Railway authorities were aware of the number of people who were coming to the Cape ‘for health reasons’. Like the steamship companies, they began to promote leisure travel. *The Cape Government Railways: Health Resorts* was published in 1897. In content, too, the *Cape Railways Handbook* emulated those of the steamship companies. It included embellished information about Cape Town and the suburbs. Sea Point was singled out as a ‘health resort [which] cannot be surpassed by any other place of a similar nature’. Other towns which were mentioned with climates likely to benefit those with health problems were Wellington, Ceres and Matjesfontein.³⁴ A number of towns were specifically highlighted as particularly beneficial for those suffering from tuberculosis and rheumatism and included Aliwal North and Kimberley, which had a newly-built sanatorium, as did Beaufort West, where a sanatorium had been built a few miles from the town.³⁵

³¹ H. Weber, ‘The Croonian Lectures on the Hygienic and Climatic Treatment of Chronic Pulmonary Phthisis, Lecture III’, *BMJ* (11 April 1885), 725-727.

³² Brown and Brown, *Guide to South Africa*, 31-32.

³³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 36. The Cape Railways had a network of nearly 2 000 miles by 1896 and the number of passengers using the trains increased by over a million by 1896. Cape Government Railways, *Health Resorts*, (no publ., 1897), unnumbered.

³⁴ Cape Government Railways, *Health Resorts*, (No publ.), 5, 12, 14, 16.

³⁵ *Ibid.*, 33, 17, 26, 19.



South Africa in 1902 showing railway lines.
Cradock is located on the railway line between Port Elizabeth and Middelburg, 180 miles (290 kilometres) from Port Elizabeth.

Source: C.F.J. Muller (ed.), *Five Hundred Years. A History of South Africa* (Pretoria and Cape Town: Academia, 1975), 335.

The sanatoria catered for the needs of wealthy consumptives. This was especially the case with regard to the sanatorium in Kimberley which was financed by the De Beers Mining Company, headed by Cecil John Rhodes. Contemporary sources claim that Rhodes, who later became premier of the Cape Colony, had come to the Cape at the age of fifteen, and at the time he was in 'the last stage of consumption'.³⁶ Although he subsequently recovered, his own poor health may have prompted his interest in the sanatorium. He explained:

The sanatorium is a bit of a hobby of mine. I have always thought that Kimberley would be an admirable place for people with chest complaints from Home, [Britain] if only there were sufficient and proper accommodation. The experience of many has been that this climate has been very successful in such complaints, and doctors all agree that Kimberley is a good place for a sanatorium.³⁷

Rhodes, who was not a philanthropist, and presumably viewed the sanatorium as a paying proposition, made his contribution to the sanatorium subject to the condition that it could only admit those who had 'a reasonable chance of recovery from their ailments'. The comment made in the *Cradock Register* regarding this stipulation was: 'Of course, the proper place is the hospital for very bad cases, but it seems rather cruel that the sanatorium must be restricted to people who might be considered well enough not to need it'.³⁸

The majority of consumptives did not have the financial resources to stay in the limited number of sanatoria which were available. Many of these impoverished sufferers found their way to towns in the Karoo and relied simply upon the climate to help improve their health.

³⁶ M. O'Rell, *John Bull & Co. The Great Colonial Branches of the Firm: Canada, Australia, New Zealand and South Africa* (London: Frederick Warne and Company, 1894), 260.

³⁷ Deacon, H., Van Heyningen, E., Swartz, S. and Swanson, F., 'Mineral Wealth and Medical Opportunity', in Deacon, H., Phillips, H. and Van Heyningen, E., *The Cape Doctor in the Nineteenth Century: A Social History* (Amsterdam and New York: Rodopi BV, 2004), 235.

³⁸ *Cradock Register*, 15 October 1895.

Consumptives in Cradock

When the first trickle of consumptives started to arrive in Cradock in 1871, it was a small town.³⁹ The general health of Cradock residents was reported as being 'exceedingly good' with no epidemics. Reverend T.F. Mtyobo, a black priest of the Church of England, who was a minister in Cradock, reported that there were no cases of tuberculosis among the local people at the time.⁴⁰

A number of case studies suggests a different picture, at least among the new arrivals. One of the earliest consumptives to travel to Cradock was William Clemence, who arrived in 1872. His move from Cape Town was prompted by the hope that 'the air of Cradock would have a beneficial effect upon his constitution'. He took up residence in the Victoria Hotel and while playing billiards with his cousin on the evening of 22 May 1872, his mouth began to bleed.⁴¹ As he went up to his room he requested one of the servants to call the doctor but by the time the doctor arrived he had already passed away.⁴² Clemence's case demonstrated that a person suffering from consumption could display few signs of poor health and yet be at death's door. With few diagnostic tools in the 1870s, the disease was still extremely difficult to detect.

The example of Edwin Bull suggests a slightly different picture. Like Clemence, he arrived in 1872 and lived in Cradock for eighteen months, taking a very active interest in the affairs of the town. At some stages during his stay his condition improved, only to take a turn for the worse at other times. Two weeks before his death, it became clear that he did not have long to live.⁴³ This case, when compared to that of Clemence, recounted earlier, demonstrates that the progress of the

³⁹ *Cradock Register*, 4 January 1871. According to the *Blue Book of 1871*, the population of the town comprised 5 924 Europeans, 1 507 Coloureds, 3 915 Africans. This had remained virtually unchanged for the previous decade. See *Blue Book 1871*, JJ24-25.

⁴⁰ NLSA, UG34-1914, *Tuberculosis Commission Report*, 29.

⁴¹ Bleeding from the mouth is referred to in medical terms as 'haemoptysis' and is often an indication of the final stages of consumption. See Bryder, *Below the Magic Mountain*, 4-5.

⁴² *Cradock Register*, 23 May 1872.

⁴³ *Ibid.*, 19 June 1874.

The Travellers' Guide.

BELVIDERE HOTEL, MORTIMER NEAR CRADOCK.

The undersigned begs to inform those in want of a change in the country that the above Hotel is just the place to go to, being close to the Station and easy distance both by rail or road from Cradock, and as a health resort unsurpassed in the Cradock district.

Horses and Trap kept, Stabling and steady Groom.
Terms very moderate.

W. A. LAVER,
Proprietor.

THOMSON'S Commercial Hotel, MARKET SQUARE, Middelburg, Cape Colony.

T. D. Thomson Proprietor.

THIS HOTEL is well-known throughout the Colony for cleanliness, and the attention and civility shown to all Visitors. A Good Table is kept, and an Excellent Range of Colonial Wines and Spirits always on hand. The Hotel Cart meets all Passenger Trains at MIDDELBURG ROAD STATION. Fare, 2s. 6d.

Referring to THOMSON'S COMMERCIAL HOTEL, in the discussion following the Lecture of Dr. Symes Thompson, in the HOTEL METROPOLE, London, Nov. 13, 1888, Dr. J. A. ROSS said: "I visited and spent a few weeks in the District of Middelburg—right in the heart of the Karroo—and was impressed with its capacity from what I saw and heard. The picturesque little town of Middelburg has an Excellent Up-Country Hotel, celebrated in the Colony for Good Food and Cooking.—VIDE "COLONIES AND INDIA," 21st November, 1888.

disease did not follow any set pattern. For some death came swiftly while others lingered on.

When consumptives first began to arrive in Cradock, the only available accommodation was the Victoria Hotel and one other establishment. The Victoria Hotel was far more popular, both with consumptives and general travellers. Although the accommodation was expensive the demand was so great that the Victoria Hotel was invariably full. On occasions guests were asked to share a room, a request which was not always well received.⁴⁴ By 1880 a further 'first-class hotel and club house' was under construction in Cradock opposite the Victoria Hotel.⁴⁵

By 1878 Cradock residents had begun to recognise the financial value of providing accommodation for consumptives. A Mrs Jackson and her son saw the potential of such a venture and purchased a large house which was used as a boarding establishment for gentlemen. Separate bedrooms and meals were provided, supplying 'a long felt want in Cradock'.⁴⁶ Another facility, run by the partnership of Fitchett and McKenzie, provided boarding facilities for consumptives for 25 years, from 1881 until it finally closed its doors on 26 September 1906.⁴⁷ Private homes also took in boarders.⁴⁸ Despite this, it was very difficult to find accommodation that catered for their specific needs. Although a number of establishments referred to themselves as 'sanatoria', in reality they were nothing more than hotels or guest houses which seldom provided medical attention. For the majority of consumptives, it was the climate that was the important drawcard, and it was probably for this reason that they were prepared to accept living conditions which were less than ideal.

One invalid, finding no hospital or sanatorium in Cradock, addressed an emotional letter to the *Cradock Register* asking:

⁴⁴ Ibid., 20 August 1875.

⁴⁵ Ibid., 27 August 1880.

⁴⁶ Ibid., 30 January 1880.

⁴⁷ Ibid., 26 September 1906.

⁴⁸ Ibid., 11 January 1878.

... in the name of common humanity, where is our hospital? Are invalids to die at our hotels with common hotel attention? Are hotel keepers to be hospital nurses? I understand that the government has generously offered to defray half the expenses of a hospital here, but our authorities preferred to build a new Town Hall, rather than alleviate the suffering of their common brotherhood.⁴⁹

This letter prompted an immediate response from the town officials, in which they expressed their views on the provision of hospital care for visiting consumptives and invalids in general.⁵⁰ They were of the opinion that the cost of building a facility such as the writer had in mind was beyond their financial reach and it would not be fair to burden the local ratepayers with the cost of its upkeep. In short, their view was that:

as regards invalids coming here merely because the climate suits them, the authorities can scarcely be expected to provide a comfortable home for them, especially as the number of arrivals of this sort might, in the course of time, increase to rather an embarrassing degree.⁵¹

The reluctance of local ratepayers to subsidise care for consumptives certainly stood in the way of the development of the colony as a 'health resort'. A month later, the lack of a sanatorium in Cradock was again raised in the *Uitenhage Times*.⁵² It accused the hotel owners and shopkeepers in Cradock of trying 'to grind as much as possible out of visitors with a minimum of outlay and trouble to themselves', and criticised the town councillors for not being prepared to spend money on tarring roads and building a sanatorium. The response from the council showed some degree of irritation that the matter was being raised yet again, accusing the invalids of unrealistic expectations 'in wanting the comforts of an English town, with its low charges' in a South African frontier town, 180 miles from a seaport. It went on to reiterate that the council:

... did not think that municipal commissioners are bound to burden the ratepayers with the costs involved in order to convert Cradock into a sanatorium. Practically, a number of invalids make the act of living in the place, and, making in many cases but a short stay here, are not to be depended on for helping to share in the burden of taxation that may

⁴⁹ Ibid., 27 January 1882.

⁵⁰ Ibid., 27 January 1882.

⁵¹ Ibid., 27 January 1882.

⁵² The original article is not available.

have to be borne. Of course, we exclude from the above category those who buy property, or who make themselves practically one of us.⁵³

Although ultimately a hospital was built in Cradock in 1899, it was constructed mainly for the use of the local community.⁵⁴

The consumptives themselves were seldom in a financial position to contribute towards the establishment of such facilities. Few of the new arrivals were financially independent and most were soon looking for work.

The railways provided employment opportunities for consumptives, since they had a preference for English officials.⁵⁵ In at least one case, an agreement was entered into for a consumptive employee who had previously worked for the British railway system to be employed in the Cape for two years while he recovered from the disease.⁵⁶ Other consumptive employees were the station master at Cradock; a coffee stall attendant in Beaufort West; and three European male consumptives in the refreshment department at Matjesfontein.⁵⁷ They were not the only staff members employed by the railways.⁵⁸ In Cradock the railways employed their own medical officer of health for the district, a Dr Ireland, who also suffered from tuberculosis. Ultimately his health was restored.⁵⁹

⁵³ This was possibly the last occasion on which the town council voiced its views in the press on the consumptives in Cradock. It appears that the subject was not raised at any of the town council meetings.

⁵⁴ *Cradock Register*, 26 May 1899.

⁵⁵ In the *Cradock Register* of 4 October 1878 a comment was made that the 'railway lines are swarming with porters and officials of all kinds from England, for the Government never dreams of appointing colonial men to such offices'.

⁵⁶ The Cradock station master, Jerome McCarthy, who suffered from tuberculosis, had been granted two years sick leave from the Great Western Railways, Pontypool Road, in Britain and was then employed by the railways in Cradock. See *Cradock Register*, 22 January 1886.

⁵⁷ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 36.

⁵⁸ The Tuberculosis Commission found that the number of consumptives employed by the railways were: Kimberley, 5 European males; East London, 39 employees 36 of whom were Europeans; Cradock, 3 European males; Graaff Reinet, 2 European males; Naauwpoort, 10 European males; Laingsburg, 4 European males; Grootfontein, 1 European male; Matjesfontein, 3 European males in the refreshment department and one Coloured female; Prince Albert Road, 6 Europeans; Fraserburg Road, 5 Europeans; Beaufort West, 10 Europeans, one of whom was a coffee stall attendant. See NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 36.

⁵⁹ *Ibid.*, 28.

For consumptives who did not find employment with the railways, the local newspaper, *The Cradock Register*, was their primary outlet to place advertisements in their search for employment.⁶⁰ They offered a variety of skills, ranging from music teachers, clerks and bookkeepers, to doctors (although they seldom stayed for any length of time), salesmen and managers. As for nurses, they were prepared to offer their services either in the town itself or on the farms in the area.⁶¹

From 1882 onwards the advertisements in the *Cradock Register* showed that consumptives were increasingly seeking employment on the outlying farms or as teachers or tutors in private families. In 1876 Ross mentioned that Cape physicians placed their faith in two remedial measures – the one, living and working in the open-air; the other, taking up residence on high elevations. Following both these measures, it was claimed, was bound to produce excellent results.⁶² These comments may have motivated the increased popularity of taking up residence on farms.

The majority of ‘health’ visitors to Cradock at this point in time were young men. Some who sought employment as tutors on farms had absolutely no experience and could only offer credentials such as ‘character and ability’, while others had formal training as teachers and were in possession of excellent testimonials.⁶³ The post of tutor was so highly sought after that even a qualified solicitor offered his services as a tutor on a farm.⁶⁴ On occasion, services were offered at very small salaries, or even for the cost of board and lodging, with the focus being on accommodation rather than income.⁶⁵

⁶⁰ *The Cradock Register* first appeared in 1858 as *The Cradock News and Mercantile Advertiser*. It changed its name slightly over the years, and ceased publication in 1899.

⁶¹ *Cradock Register*, 31 January 1879; 21 February 1879; 31 October 1879; 5 December 1879 and 22 August 1879.

⁶² Ross, *Consumption: Its Treatment by Climate*, 20.

⁶³ *Cradock Register*, 20 January 1882; 24 January 1882.

⁶⁴ *Ibid.*, 2 May 1882.

⁶⁵ *Ibid.*, 20 January 1882.

The accommodation offered on some of the farms was primitive. Ross described the farmhouse in which he stayed as having two rooms, with no windows or chimneys. As a substitute for doors, reeds were tied together and propped up against the openings, mainly as a protective barrier against snakes. The bed was made up on boxes and skins, and although not 'elegant', was clean.⁶⁶

In 1875 Olive Schreiner, then a governess, took up employment for a Boer family on a farm some 25 miles from Cradock. Her room was described as a flat-roofed 'lean-to' set up against the northern wall of the house beside to the kitchen and under the same roof. We are told that it was mud-floored and the roof leaked, so that when heavy rain fell she had to sit under an umbrella. Until she secured a basin she washed in the little stream in the *kloof*, a ravine which ran down from the mountain-top almost to her door. In her next position, again employed as a governess, on a farm between Cradock and Tarkastad, she had far more comfortable accommodation because that particular farmer was more affluent.⁶⁷

Another well-known individual who came to live in Cradock in 1876 was 22-year-old James Butler, who travelled to South Africa in 'search of health'. Before moving to Cradock he spent time in the farming districts near Albany.⁶⁸ His decision to go to Cradock was because the town had been 'so highly spoken of by so many as possessing such a health-restoring climate'.⁶⁹ He recounted in his journal that the journey, made by ox-wagon, was 'hard on near invalids'. He described the grinding monotony and the great discomfort endured during the trip. He also added that most European travellers experienced something of a shock on their first exposure to the 'dwarfing scale of the Karoo; and the inability of the thin vegetation to disguise the elemental rock; the severity, the silence, and, depending on the season,

⁶⁶ Ross, *Consumption: Its Treatment by Climate*, 30-31.

⁶⁷ O. Schreiner, *The Story of an African Farm* (London: T. Fisher Unwin, 1924), 13. The description is included as an example of the type of accommodation available to consumptives employed as governesses on farms. Olive Schreiner suffered from asthma. See H.P. Lewis, *Olive Schreiner: The Other Side of the Moon*. (Fish Hoek: Ihilihili Press, 2010), 70.

⁶⁸ G. Butler, *Karoo Morning. An Autobiography, 1918-35* (Cape Town: David Philip, 1977), 16.

⁶⁹ E. Garner (ed.), *'Jim's Journal', The Diary of James Butler* (Johannesburg: Witwatersrand University Press, 1996); Butler, *Karoo Morning*, 15-16.

the heat, or the cold'.⁷⁰ Butler remained in Cradock for over two years. His health improved so much that he returned to England where his doctors recommended that he should go back to the little Karoo town.⁷¹ Following this advice, he set up permanent residence in the town. Clearly an ambitious man, he established the *Midland News*, a local newspaper; he served on the library commission and on the school board; was elected as a member of the town council; and was appointed as the secretary of the Cradock Farmers' Association. He was also at the forefront of the campaign for the establishment of the Queen's Central Hospital in Cradock.⁷²

Butler was one of several key figures who had travelled to Cradock 'in search of health' and played an important role as a community leader. Others included Dr John Ireland, the medical officer of health for the railways in Cradock. Ireland was also active on the hospital board, became a town councillor and ultimately held the position of mayor.⁷³ J. Patterson, also a consumptive, was appointed as town clerk.⁷⁴ Another prominent individual in the town was the Rev. Hurter, a missionary of the Wesleyan Church. While he did not become a permanent resident, he spent several months in the town in the hope that his health would be restored. During his stay he was extremely active in his field, coming into contact with many of the local people. Ultimately, however, seeing no improvement in his health, he returned to England.⁷⁵

As the number of consumptives in Cradock increased, the residents in surrounding towns seized the opportunity to benefit financially by catering for their needs. N.C. Wolter, a resident of Middelburg, opened a boarding house in the town, and two enterprising nurses set up private nursing homes for consumptive immigrants.⁷⁶ The Royal Hotel in Cookhouse also opened its doors and was particularly enterprising by taking the step of meeting potential residents at the Cookhouse railway station. It

⁷⁰ Butler, *Karoo Morning*, 17.

⁷¹ Garner, *Jim's Journal*, 1.

⁷² Butler, *Karoo Morning*, 24.

⁷³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 28.

⁷⁴ *Ibid.* His full name is not provided.

⁷⁵ *Cradock Register*, 6 January 1880.

⁷⁶ E. Lecky, 'A South African Health Resort', *BMJ* (22 February 1896), 502.

advertised itself as being a ‘first-class well-appointed hotel’ and was obviously geared to attract the more affluent clientele.⁷⁷

As the demand for accommodation on farms grew, at least eight farmers responded by applying for licences to open ‘hotels’ on their farms.⁷⁸ Each of these applications included permission to sell liquor on the premises, and all were granted.⁷⁹ The increased popularity of the area was only partly due to the influx of consumptives. Cradock was conveniently located on the road from Port Elizabeth to the Kimberley diamond fields and became a popular transport hub, initially for ox-wagons and carts and then later, for the railways. Once the railway network was in operation, many of the towns, such as Graaff Reinet and Middelburg, which were located along the routes, became more accessible to consumptives. It was these towns in the Karoo that formed the focal points from which the disease spread into the surrounding areas. This led the Tuberculosis Commission to conclude that it was ‘particularly in those towns which were the first to be opened up by the railway, and which for some time remained termini, that the disease has prevailed longest and to the greatest extent’.⁸⁰

Tide Turning against Consumptive Immigrants

The arrival of consumptives probably peaked in about 1892. In that year Dr J.M. Fehrsen, the district surgeon of Cradock, reported that a large number of invalids had arrived, and that it was unfortunate that most had come when they were in the last stages of the disease. He added that if individuals had temperatures of over 101 degrees they were doomed; he had not seen a single such case recover from the

⁷⁷ *Cradock Register*, 19 March 1880.

⁷⁸ See, for example, *Cradock Register*, 20 January 1882 and 24 January 1882.

⁷⁹ In order to qualify as a ‘country hotel’ it was necessary to have a minimum of four furnished bedrooms, together with stables for ten horses. No system was in place to check if the premises complied with these requirements. See *Cradock Register*, 17 March 1882.

⁸⁰ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 36. The railway line reached Grahamstown in 1879; Graaff Reinet in 1880; Beaufort West in 1880; Cradock in 1881; Kimberley in 1885; Bloemfontein in 1890; and Ladysmith (Natal) in 1886. See NLSA, UG34-1914 *Tuberculosis Commission Report, 1914*, 36.

disease.⁸¹ Two years later, the then district surgeon Dr P.C. de Wet, raised the alarm bells again, adding that the ‘death-rate [of Cradock] is materially increased, and might give the wrong impression as to health and climate’.⁸² He felt so strongly that he voiced his frustration in a letter addressed to *the BMJ* in which he did not mince his words:

These advanced cases not only do not benefit but undoubtedly are a menace to the health of the town. Scarcely any precaution whatever is taken as to when or where expectoration is disposed of, and all this sputum is loaded with tubercle bacilli. At Davos, San Remo and some other health resorts, proper establishments are kept especially for chest cases, and every patient is compelled by those in authority to carry a specially constructed spittoon containing a disinfectant. It would be well for us to recognise that phthisis is an infectious disease.⁸³

By 1899, despite large-scale unemployment in the Cape Colony, hundreds of passengers, finding that the struggle for existence in Europe was too severe, continued to arrive on incoming ships. Many of the new arrivals were obliged to travel third-class, having barely scraped and saved enough money to pay for the sea voyage.⁸⁴ *The SAMJ* reported:

The alarming increase in the number of consumptives settling in the town [Cape Town], many of them in destitute circumstances and with advanced disease, has been anxiously discussed in lay as well as medical circles and it is widely felt some steps to stem the tide of consumptive immigration are urgently needed.⁸⁵

Dr J.K. Murray spoke out against British doctors for indiscriminately sending consumptives ‘out to die in South Africa’. However, he acknowledged that it was often difficult to select cases which would benefit from the change of climate.⁸⁶ In 1896 Murray reiterated that ‘every effort should be made by those in authority in this country, and by the profession as a whole, to deter people in Europe from

⁸¹ NLSA, G14-1893, *Cape of Good Hope, Reports on Public Health for 1892* (Cape Town: Government Printer, 1893), 36.

⁸² NLSA, G55-1896, *Cape of Good Hope. Reports on the Public Health for the Year 1895, including Reports of District Surgeons, Local Authorities and Medical Inspectors* (Cape Town: Government Printer, 1896), 62.

⁸³ *The BMJ* (9 June 1894), as quoted in NLSA, G55-1896, *Health Report for 1895*, 62. De Wet’s attempt to get a by-law passed prohibiting expectoration in public places in Cradock – and the town’s reaction – are discussed in Chapter 3, ‘The Mecca of Consumptives’.

⁸⁴ *Cradock Register*, 27 June 1899.

⁸⁵ Editorial: ‘The Importation of Destitute Consumptives’, *SAMJ* (March 1899), 230.

⁸⁶ J.K. Murray, ‘Notes on Health Resorts. South Africa as a Health Resort’, *BMJ* (25 May 1895), 1158.

making South Africa a dumping ground for the hopelessly diseased'.⁸⁷ He again expressed this view in 1899 saying that while the arrival of the consumptives did not benefit the country, it was difficult to know how the authorities could limit the importation. After all, 'if people got the idea that a certain climate was good for them, they would come, no matter what sort of dissuasion was used'. He suggested that an appeal should be made to fellow practitioners in Europe not to send cases if there was no hope of benefit for the consumptives. 'These enfeebled patients', he added,

had to come amongst strangers, and to put up with great discomfort, and, in his opinion, the best advice to them was to return home with all possible speed. It was better for them to return to their friends and die in such surroundings as their own home would give them, if die they must, than in a strange country among strangers.⁸⁸

As the era of 'travel for health purposes' drew to a close, it presented an ideal opportunity to evaluate the lasting legacy of the period. There is no doubt that many of the early arrivals saw a restoration of their health and went on to become active participants or leaders in their communities.⁸⁹ Others did not share the same happy outcome and died among strangers in a foreign land. However, they brought with them an infectious disease and did not live in isolation. It was therefore inevitable that their presence in communities where little regard was taken to prevent the spread of infection would leave a legacy far beyond their own individual life histories.

The medical profession in the Cape Colony expressed the view that the state should take steps to restrict the entry of tubercular immigrants from 1898 onwards.⁹⁰ The subject was raised in debates leading to the passing of *The Immigration Act, Act No. 47 of 1902* and the amended *Immigration Act, Act No. 30 of 1906*, but apart from imposing a 'means' test in 1902, this legislation did not address the situation fully.⁹¹

⁸⁷ C.F.K. Murray, 'Harrismith, Orange Free State, and its Neighbourhood as a Health Resort for Phthisical Patients', *SAMJ* (November 1896), 166.

⁸⁸ E.F.B. Wilson, 'The Treatment of Pulmonary Tuberculosis', *SAMJ* (March 1899), 241-252.

⁸⁹ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 35.

⁹⁰ G.J. McCartney Melle, 'Consumption in South Africa from a Public Health Point of View', *SAMJ* (October 1898), 138-139.

⁹¹ NLSA, *Cape of Good Hope, Debates of the Legislative Assembly*, 12 November 1902, 666.

This was only done in 1913 in terms of Section 18 of the Regulations of *The Immigrant's Regulation Act, Act No. 22 of 1913* which restricted entry to all but the wealthy, and imposed conditions on measures they should take to prevent the spread of infection to others.⁹²

While the part played by consumptive immigrants in spreading tuberculosis cannot be denied, it is also true to say that by the turn of the century they were not solely responsible for the tuberculosis problem. Internal conditions in South Africa such as the discovery of diamonds and gold, had led to rapid industrial development and urban growth in the late nineteenth and early twentieth centuries. Housing shortages, overcrowded and insanitary living conditions, recession, poverty and droughts all contributed to the creation of conditions in which tuberculosis flourished. The black and Coloured population were particularly hard-hit.

The need to take action to protect the local population from the disease was highlighted by the medical profession from 1898 onwards.⁹³ What was clearly needed was a concerted effort to prevent the spread of the disease and this would require the cooperation of individual sufferers, medical practitioners, local authorities and the state. In the next two chapters the way these challenges were addressed will be discussed.

⁹² Consumptive immigration restriction is discussed in Chapter 6.

⁹³ See, for example, McCartney Melle, 'Consumption in South Africa', 136-141; and W.J. Dodds, 'The Presidential Address to the Cape of Good Hope Branch of the British Medical Association', *SAMJ* (December 1899), 167-175.

Chapter 3

'The Mecca of Consumptives',¹ Cradock, 1872-1910

In many ways Cradock was a typical town in the Karoo region of the Eastern Cape in 1872. It had a small permanent population of approximately 9 000 people.² It was at the centre of an area dominated by cattle, sheep and ostrich farming, with some fruit farming, located approximately 180 miles from Port Elizabeth on the route to Kimberley. The administration of the town was in the hands of a town council and a mayor. This structure was classified as a local authority and was responsible for the provision of public services and facilities in the area. It had the ability to create by-laws for the regulation of its responsibilities and was represented in the Cape legislature by a member of parliament.

A government Public Health Department was established in 1893. The leading official in the department was Dr (Alfred) John Gregory, who was the assistant medical officer of health from 1896 and took over the reins as MOH from 1901.³ In recognition of the fact that most local authorities lacked the expertise to deal with public health issues, district surgeons were appointed to provide the necessary guidance. The district surgeons reported to both the local authorities and the Public Health Department.

As discussed in the previous chapter, one of the aspects which set Cradock apart from other small towns at the time was its popularity as destination for tuberculosis sufferers from abroad who were seeking relief from the symptoms of their disease by benefiting from the climate. As an infectious disease, it was only a matter of time

¹ National Library of South Africa, Cape Town (hereafter NLSA), Union Government (hereafter UG), UG34-1914, *Union of South Africa, Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 29. Evidence of Mr James Butler.

² This total population in 1903 comprised 3 087 'Europeans' and 4 760 Coloureds. See NLSA, Official Publications (Cape Colony), Govt. Reports, (hereafter G), G39-1906, *Cape of Good Hope. Report of the Medical Officer of Health for the Colony on the Public Health and on the Government and State Aided Hospitals of the Colony together with the Reports of District Surgeons and Local Authorities for the Two Calendar Years 1904 and 1905* (Cape Town: Government Printer, 1906), lxxv.

³ The Public Health Department, as well as Gregory's role as MOH, is discussed in detail in Chapter 5.

before tuberculosis spread to the local residents. By 1892 medical professionals came to realise that tuberculosis had established itself firmly among the local population. In Cradock, as was the situation throughout the Cape Colony, it was the Coloured population which was particularly hard hit. In this chapter the focus shifts to the impact of the disease on the local residents.

In view of Cradock's experience with tuberculosis sufferers it provides the ideal case study for a review of an otherwise typical local authority in a fairly remote location when faced with the challenges of providing health care for its residents. In many respects the steps taken (or not taken) were dictated by the parameters of the existing public health legislation and by current trends and ways of thinking. A further aspect was that Cradock, in common with many other towns in the Cape Colony, were reluctant to spend money on health care.

Before examining the action taken, it should be borne in mind that these were informed by the larger picture of other events which were taking place in the colony at the time. It was a time of rapid change, which permeated the lives of all the people living in the Cape. These external factors provide the wider context against which developments in local administration and health care took place.

The Transformation of the Colony

In the four decades after 1868 changes took place in the Cape Colony on an unprecedented scale. It was in that year that diamonds were discovered in Kimberley and this was followed by the discovery of gold on the Witwatersrand in 1886, heralding the beginning of what was later referred to as the mineral revolution. The drive to encourage immigrants to settle in the Cape had already begun prior to the discovery of diamonds – indeed, the marketing of the colony as a destination which was suitable for consumptive immigrants had been part of that larger initiative. Mainly as a result of both these factors, the population of the Cape grew exponentially. In 1875 the population was predominately rural and comprised

of 720 000 people.⁴ In 1891 this number had reached 1.5 million. By 1904 it had again shot up, this time to 2.4 million.⁵ Rapid urbanisation meant that the demand for housing outstripped the supply leading to overcrowding in the urban areas. Changes were also taking place in the rural areas. Among the more notable were various droughts, locust infestations and the dreaded rinderpest epidemic of 1896 that wiped out thousands of head of livestock and necessitated the fencing off of large tracts of land in the rural areas. Small-scale livestock farmers could no longer move about in search of grazing for their depleted herds.⁶ The shift to a 'money economy' made subsistence farming increasingly difficult. As the 'old way of life' changed, the demand for labour saw increasing numbers of people gravitate to the urban areas and to the mines, placing even more pressure on already strained towns as they struggled to provide essential services such as water and sanitation to the increasing number of residents.

The discovery of minerals eventually led to the building of an extensive railway network as the Cape sought to share in the economic benefits of providing goods and services to the rapidly expanding mining industry. The opening up of the country by the railways had great ramifications for the spread of tuberculosis.⁷ This, together with the promotion of more towns as being suitable destinations for consumptives, encouraged the invalids to move into a greater number of the small towns of the Karoo. The scenario which developed in Cradock was replicating itself in other Cape towns, with Graaff Reinet, Oudtshoorn and Beaufort West among the more notable. Coincidentally these were the same towns favoured by consumptives and it was not

⁴ V. Bickford-Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town* (Johannesburg: University of the Witwatersrand Press, 1995), 10.

⁵ E. van Heyningen, 'Regularly Licensed and Properly Educated Practitioners', in H. Deacon, H. Phillips and E. van Heyningen, *The Cape Doctor in the Nineteenth Century. A Social History* (Amsterdam and New York, Rodopi, 2004), 205.

⁶ *Cradock Register*, 29 September 1896.

⁷ For an account of the impact of the railway line on the spread of tuberculosis between the labour centres and Johannesburg, see R.M. Packard, *White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989). The railway line to Johannesburg was only opened in 1892. See NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 37.

surprising that the Tuberculosis Commission found that they were focal points from which the disease spread.⁸

The changing circumstances and increased urbanisation brought many challenges which the Cradock local authority was forced to confront. The most immediate was the provision of water in an area where rainfall was limited. There was also a pressing need for housing and for setting up the necessary infrastructure to meet the needs of both the permanent residents and those who were passing through the town. In addition to these basic requirements, the city officials also had to ensure that public health care was addressed, especially for the residents who were not in a financial position to cater for their own needs. Faced with these competing priorities, attention to public health was not seen as a priority.

While the local authority was faced with its own set of challenges, this was also the case for the residents. In a very short space of time, their lives were changed by circumstances beyond their control as a result of urbanisation. Added to this, the presence of persons suffering from tuberculosis in their midst at a time when ignorance of its infectious nature prevailed, contributed to the spread of the disease. Within a period of less than three decades, tuberculosis was no longer associated primarily with consumptive invalids from Britain, but was firmly established in the local community, especially among the Coloured residents. Once it had penetrated into these communities its spread was accelerated, largely because of the poor conditions under which they lived.

The link between the living conditions and tuberculosis was a crucial one. As expressed by Packard,

The association of TB transmission with overcrowding and of TB morbidity and mortality with malnutrition, immunosuppressant infections, and physical stresses, all often associated with poverty, has made TB a classic social disease, and its incidence is thus linked to changing social and economic conditions within society.⁹

⁸ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 36.

⁹ Packard, *White Plague, Black Labor*, xix.

It is for this reason that taking steps to curb the spread of tuberculosis was as much the responsibility of the Cradock local authority as the medical profession, especially at a time when knowledge of the cause of the disease was still the subject of speculation. Without the requisite understanding of the disease, local officials were also acting 'in the dark'. By the time it dawned on the Public Health Department that there might be a link between poor living conditions and the spread of tuberculosis, people suffering from the disease had already been coming into the town to benefit from its climate for almost three decades.

Tuberculosis in Cradock

Cradock had always been a small town. In common with other towns in the Cape Colony in the nineteenth century, the residents of Cradock lived in different areas according to their race. These boundaries were often fluid, but broadly speaking, white people lived in the town centre and the black population lived in what were referred to as 'locations' or townships outside the urban area. Some of the Coloured residents lived in the town while others found shelter in the townships in often appalling conditions.¹⁰

The standard of living enjoyed by white people was far superior to that in the townships. This was an important underlying reason for the variance in death rates between the different population groups, a fact recognised by Dr Neill Macvicar who concluded that the disease was not, in the main, 'a White man's problem and it was this happy experience which explained, in great measure, the apathy with which most White people regard the tuberculosis problem'.¹¹

The situation was different for the Coloured residents of the town. There were many opportunities for them to come into contact with the immigrant consumptives, particularly as servants working at the local hotels or in the boarding houses where

¹⁰ See later in this chapter for more information about the living conditions in the townships.

¹¹ N. Macvicar, 'Tuberculosis amongst the Coloured Population of South Africa', *South African Medical Record* (hereafter *SAMR*)(26 February 1910), 39-40. Macvicar played an important role in the fight against tuberculosis. His contribution is discussed in Chapter 5.

consumptives resided. Because there were no hospitals or sanatorium facilities in Cradock prior to 1899, the responsibility for the care of consumptives in boarding houses and hotels fell on the shoulders of domestic servants who were predominately Coloured women living in the nearby township. It was these women who attended to the needs of the invalids, taking them their meals when they were too ill to move from their beds.¹² When these consumptives died no disinfection took place and everything they owned, including clothing, was sold to the impoverished black and Coloured residents.¹³

In addition to those employed as servants in the town, there were quite a number of Coloured people living in the town itself. For the most part they lived in outside rooms in the grounds of absent homeowners. The majority of these houses belonged to farmers who came into Cradock periodically to attend *Nachtmaal* services and sell their produce at the farmers' markets.¹⁴ The 'caretaker' tenants lived under conditions that were far from ideal. According to the *Midland News* there was at least one case of two families occupying one room, with no sanitary arrangements available to them.¹⁵ Others lived in stables or outbuildings,¹⁶ and more often than not there was overcrowding.¹⁷ By September 1894 there were 575 Coloured 'caretaker' tenants, including 241 children living in the town itself.¹⁸ When smallpox broke out in October 1894 the town council used the opportunity to call a public meeting; it used the outbreak as a pretext to remove all blacks and Coloured persons from town precincts.¹⁹ Ultimately this was extended to a resolution to move the

¹² Unfortunately, due to lack of statistics, it is not possible to know whether these female domestic servants suffered from a higher death rate from tuberculosis as a result of these practices.

¹³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 28. Evidence of Mr B. Patterson, Town Clerk, Cradock.

¹⁴ 'Nachtmaal' was the Holy Communion service in the Dutch Reformed Church.

¹⁵ *Midland News*, 24 August 1893.

¹⁶ *Cradock Register*, 28 September 1894.

¹⁷ NLSA, G24-1895, *Cape of Good Hope. Reports on the Public Health for the Year 1894, Including the Report of the Acting Medical Officer of Health for the Colony together with Reports of District Surgeons, Medical Officers, Medical Inspector and Local Authorities* (Cape Town: Government Printer, 1895), 48.

¹⁸ *Cradock Register*, 28 September 1894.

¹⁹ *Ibid.*, 23 October 1894.

entire township.²⁰ However, the smallpox outbreak was over by the time the resolution was taken and when it could no longer be used as a viable reason the idea was dropped.²¹ The importance of this incident is that it illustrates the way health issues were used to further other unrelated agendas such as ridding the town of its Coloured residents.²²

Overcrowding was common in the Cradock township on the outskirts of the town. In fact there were two townships, one occupied by blacks and the other by Coloureds. These townships not only housed the town's workforce but seasonal labourers lived there at times when no work was available on the outlying farms. A third township sprung up while the railway line was being constructed in the area. Housing in the townships was far from satisfactory; most of the dwellings were erected without foundations and made of whatever materials could be found.²³

Township residents, especially those who were unemployed or working in the town itself, could not have failed to be impacted by the growth of the town. This was especially the case when the number of hotels and boarding houses grew substantially to take advantage of Cradock's position as a transport hub on the way to the Kimberley diamond mines. As the number of hotels and bottle stores grew, so too did the availability of liquor. Much of the poor quality wine and brandy was sent to the inland towns. This was sold at very low prices, for example a bottle of brandy could be bought for 6d, and a bottle of wine for 2d. In other words, a loaf of bread weighing two pounds and a bottle of spirits cost much the same.²⁴

²⁰ *Public Health Act, No. 4 of 1883, as amended by the Public Health Act, No. 23 of 1897.* Section 15 reads that 'In cases of urgent necessity arising from the prevalence or threatened outbreak of infectious disease ... it shall be lawful for the Minister to make and proclaim such regulations to be in force within such districts as may be required to prevent the outbreak, or check the progress of, or eradicate such disease'. The original act was inspired by a devastating smallpox epidemic at Cape Town between May 1882 and March 1883, when more than 4 000 people died in ten months. See M.W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1901', *Journal of African History*, 8, 3 (1977), 393.

²¹ *Midland News*, 27 October 1894.

²² See Swanson, 'The Sanitation Syndrome', 387-410 for a discussion of how this policy was applied in Cape Town and Port Elizabeth following the outbreak of Bubonic Plague.

²³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 126.

²⁴ J. Hamilton, Surgeon-Colonel, 'Notes on Health Resorts: South Africa as a Health Resort', *British Medical Journal* (hereafter *BMJ*) (26 January 1895), 207.

Workers often went into the town to spend the bulk of their earnings on alcohol, leaving little money available for the purchase of food.²⁵ The reaction of the residents, town council and ultimately the government to the 'liquor problem' was based on the nuisance caused by drunk and disorderly behaviour. Yet the abuse of alcohol was far more nuanced and had grave implications for the individual's health and wellbeing. As far back as 1889, alcoholism was identified as a medical problem which had to be addressed and the government was severely criticised for its role in facilitating its spread by allowing alcohol to escape excise duty while heavy rates were imposed on articles such as bread and coffee.²⁶ Furthermore, the abuse of alcohol predisposes individuals to tuberculosis. Poor nutrition is a further aggravating factor. Studies indicate that individuals who are ten per cent underweight are more than three times as likely to develop tuberculosis as those who are similarly overweight.²⁷

Poor nutrition is often the result of poverty, which in turn is linked to unemployment. In the late nineteenth century in small Cape towns such as Cradock, this was certainly the case, especially for Coloureds and blacks. And yet it was extremely rare for accounts of their plight to appear in the local press. For the most part their harsh living conditions went largely unnoticed. Poverty, malnutrition and alcoholism were commonplace and these issues, coupled with overcrowding, created conditions which were ideal for the spread of tuberculosis.

Explanations for the Disease

Although the link between poverty and tuberculosis was recognised by the Public Health Department in 1896, there were few attempts to uplift the standard of living

²⁵ *Midland News*, 11 October 1892.

²⁶ C.F.K. Murray, 'Some Forms of Endemic and Epidemic Diseases of the Cape Colony and the Urgent Need for a Department of Public Health', in British Medical Association, *Presidential Addresses Delivered before C.G.H. (Western Province) Branch of British Medical Association for the Years 1888 to 1908* (Cape Town: Townshend, Taylor & Snashall, 1908), 25-26.

²⁷ T.M. Daniel, *Captain of Death: The Story of Tuberculosis* (Rochester: University of Rochester Press, 1999), 38.

of the poor and underprivileged members of society. Instead, the tendency was to blame the victims for the disease.²⁸ A.H. Reid, the chairperson of the South African Board of Examiners of the Sanitary Institute, attributed the problem to overcrowding, high rentals and 'ignorance of the merest rudiments of domestic hygiene', while failing to recognise that basic services were not provided in the townships.²⁹

A further approach adopted by medical authorities was to attribute the high incidence of tuberculosis among blacks and Coloureds to their lack of experience in coping with the disease or to the changing conditions of industrial life. It was alleged they were an immunologically 'virgin' population and therefore more susceptible to tuberculosis.³⁰ This argument was presented in a number of different forms over the years, in line with the changing political and economic interests of white South African society.³¹ In contrast, Macvicar was of the opinion that race was not the main issue in the spread of tuberculosis; he found that 'where African and Coloured people are living for a length of time under the same conditions, they suffer equally'.³²

While the medical profession grappled with various explanations for the spread of the disease, the local authority in Cradock held firmly to the idea that the climate would provide relief for the sufferers. In towns such as Cradock and Aliwal North, the 'recovery' of individuals in high-ranking positions added credence to their belief.³³ This strong conviction on the therapeutic value of the climate became a barrier against the acceptance of the need for health legislation, with the argument frequently advanced that 'we have such a magnificent climate out here that it is

²⁸ NLSA, G5-1897, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony for the Year 1896* (Cape Town: Government Printer, 1897), NLSA, G5-1897, *Health Report for 1896*, 19.

²⁹ E.B. van Heyningen, 'Public Health and Society in Cape Town, 1880-1910', PhD thesis, University of Cape Town, 1989, 472.

³⁰ U.G. Lallo and J.T. Mets, 'Tuberculosis, Workers and Occupations in South Africa', in H.M. Coovadia, S.R. Benatar (eds), *A Century of Tuberculosis: South African Perspectives* (Cape Town: Oxford University Press, 1991), 181.

³¹ Packard, *White Plague, Black Labor*, 4. This argument is discussed in Chapter 7. It took an ominous turn and was used to justify the repatriation policy of the gold mining industry.

³² Macvicar, 'Tuberculosis amongst the Coloured Population', 39-40.

³³ It is likely that the disease was in remission in these individuals.

quite unnecessary for us to adopt all those elaborate sanitary precautions that are necessary in less favoured regions, such as England'.³⁴

The Relationship between Public Health, District Surgeons and the Local Authorities

In 1893 the Cradock Town Council appointed Dr Peter Christian De Wet as the health officer for the town.³⁵ In January the following year he presented a report to the council in which he drew attention to the inadequacies of the health care system in the townships and made proposals for improvements. After a short discussion the matter was referred to a committee dealing with the drafting of bye-laws.³⁶ An inspection of the township followed and although some cases of overcrowding were reported, no further action was taken and the matter was dropped.³⁷ Further reports from De Wet detailing the necessary steps to be taken to improve the sanitary conditions and suggesting that the administration of such matters should be under his direct control in his capacity as Cradock's MOH did not meet with approval.³⁸ Other suggestions made by De Wet were also ignored until ultimately, considering the futility of the exercise, they ceased altogether.

Under these circumstances, De Wet continued with his work and only communicated with the council when obliged to do so, for example when outbreaks of infectious diseases occurred.³⁹ De Wet's duties included attending to consultations of the ill in the township, the examination of water, attendances at the prison, the conducting of post-mortem examinations and regular inspections of the township.⁴⁰ It therefore came as a shock to him when, on the 23 November 1905, a

³⁴ A.J. Gregory, 'Health Legislation in Relation to the Requirements of this Colony', *South African Medical Journal* (hereafter *SAMJ*) (April 1894), 228.

³⁵ De Wet (MRCS, England; LSA, London), registered as a medical practitioner in the Cape Colony in 1892 and de-registered in 1911. Information supplied by Dr E.B. van Heyningen.

³⁶ *Midland News*, 11 January 1894.

³⁷ *Ibid.*, 30 August 1894.

³⁸ NLSA, G42-1897, *Cape of Good Hope. Report by the District Surgeons, Additional District Surgeons and Local Authorities on the Health of the Districts under their Charge during the Year 1896; and Reports of the Medical Inspectors under the Contagious Diseases Prevention Act, 1885* (Cape Town, Government Printer, 1897), 56.

³⁹ *Ibid.*, 56.

⁴⁰ *Midland News*, 24 February 1906.

report in the local newspaper revealed that the town council had decided to do away with his position altogether, or allow him to continue at the rate of £25 per annum.⁴¹ This was a substantial reduction because his salary had been fixed at £75 following a consultation with Dr Mitchell who was the assistant MOH for the Cape Colony in June 1902.⁴² It was only after De Wet provided the council with a detailed account of his duties that the mayor was obliged to admit that he was under the impression that the position was a nominal one and had no idea of the scope of his responsibilities. Nevertheless, De Wet's salary was reduced to £60 per annum.⁴³

Although health matters were seldom discussed in town council meetings, this did not mean that proposed or existing public health legislation was ignored. In fact, it was robustly debated because it controlled many of the key issues facing local authorities such as housing, water and sanitation. It was often an area of contestation between the local authority and the government, especially as town councillors resented any measures which challenged their authority or required financial obligations from the town treasury. It was Colonel Schermbrucker, the member of the Legislative Assembly for King William's Town, who expressed the commonly held views of the local authorities during the debates relating to the Public Health Act in 1894, when he said

The result ... will be that you will have a general health officer and a general engineer, thirty-six district medical officers and thirty-six engineers, and every one of these seventy-two will make it their business to worry you day after day. He will detect nuisances here and nuisances there, and naturally so, because a professional man has no regard for the circumstances of cases, but will proceed on his peculiar scientific opinion in a way he thinks right. You would have these thirty-six doctors and thirty-six engineers worrying every municipal council and divisional council of the country, day after day, and in the end such will be their united power presided over by the chief medical officer, that the Government would be obliged at the expense of the taxpayer to make works of sewerage and waterworks, which are actually unnecessary, and will necessitate a great deal of taxing beyond what properties can stand.⁴⁴

⁴¹ Ibid., 23 November 1905.

⁴² Ibid., 24 February 1906.

⁴³ Ibid.

⁴⁴ Van Heyningen, 'Regularly Licensed and Properly Educated Practitioners', 210. Schermbrucker refers to thirty-six district medical officers and engineers as this corresponds with the number of 'main towns' in the colony at the time.

The possibility of having to incur expenditure was a sore point for local authorities, and was one of the chief reasons for their apathy in getting things done in their respective towns.⁴⁵ Councillors would often use the promise to keep rates down as a means to secure election to their posts. The income available to local authorities was therefore decidedly paltry and had to be stretched to cover the whole cost of administration, sanitary services and police, as well as supplying water to the residents.⁴⁶ After the deduction of these expenses there was very little money left to deal with public health.⁴⁷

The powers and responsibilities of the local authorities were governed by the *Municipal Act, Act No. 45 of 1882*. This was extended in 1895 to enable local authorities to take certain steps to prevent overcrowding and to require adequate sanitary accommodation to be provided to all dwelling places in the district.⁴⁸ In the same year the *Births and Deaths Registration Act, Act No. 7 of 1894*, came into effect. Although it had some teething problems in that it took some time before full compliance was carried out, it did ultimately provide for the compilation of statistics showing details of the spread of tuberculosis (and other diseases) throughout the colony. In this particular regard, Cradock had already applied successfully for a by-law to implement a system of birth and death registration in 1890, five years before the 'official' legislation came into force. The intention was to keep records of the births and deaths of all residents, with the township inspector assuming responsibility for maintaining the register for the township residents while all other records were kept at the town hall.⁴⁹

Once official statistics became available as a result of the *Births and Deaths Registration Act* it was no longer possible to ignore the high death rates. By way of

⁴⁵ NLSA, G19-1894, *Cape of Good Hope, Reports on the Public Health for the year 1893 Including Reports of the District Surgeons and Local Authorities* (Cape Town: Government Printer, 1894), iv.

⁴⁶ Ibid. iv.

⁴⁷ The town council's main objection to supporting initiatives to build sanatoria in the area was to minimise expenditure by local rate payers. See previous chapter for additional information.

⁴⁸ Section 4 of the *Local Authorities' Increased Powers Act, Act No. 30 of 1895*.

⁴⁹ *Cradock Register*, 10 January 1890.

example, in 1895 Cradock's annual death rate was 38,20 per 1 000 residents (whites: 21,07 and Coloureds: 48,61).⁵⁰ These statistics pointed to the need for a practical solution to prevent the spread of disease, including tuberculosis.

In 1897 the *Public Health Amendment Act, Act No. 23 of 1897*, came into operation. It included certain stipulations which could have been used advantageously to curb the spread of tuberculosis. These included (in terms of Section 9) the ability to pass bye-laws or regulations controlling the erection of new buildings; the prevention of overcrowding; and the unhealthy use of dwellings and public buildings in the town itself. It also provided for improvements such as the maintenance of good order, cleanliness and sanitation in the townships; the prevention of overcrowding and the erection of unhealthy or unsuitable shacks and dwellings.

Part IV of the Act dealt with the prevention of infectious diseases such as smallpox and gave the Cape governor the power to add additional diseases by way of proclamation. The failure to add tuberculosis to this list until 1903 had important consequences for the spread of the disease. This was because it provided the local authority with a legitimate excuse for its lack of action and allowed it to ignore diseases (such as tuberculosis) if it was not obliged, in terms of the law, to take steps for prevention. When any such diseases were brought to its attention, the standard reply was that it was unable to do anything because there was 'no law on the subject'.⁵¹ Even bye-laws that did exist were seldom enforced.

Several years later, when looking back at the way town councils conducted themselves, Dr George Turner, who was then the MOH for the Transvaal, 'delivered a sledge-hammer indictment of local authorities' refusal to pass efficient sanitary

⁵⁰ G.E.O. Turner, 'Public Health Report of the Medical Officer of Health for the Cape Colony for the Year 1895', *SAMJ* (October 1896), 136-137. The death rate for Coloured residents in Cradock was even higher than those in Cape Town, where the rate stood at 45,70 in the same year. This was the overall death rate, and included deaths from tuberculosis.

⁵¹ *Midland News*, 11 July 1893.

laws and their lack of backbone in enforcing what little law they had.⁵² Gregory held a similar point of view. In a memorandum to the colonial secretary he made the point that much could be done to prevent the spread of tuberculosis by means of prohibiting overcrowding; ensuring that property was properly ventilated; and that dwellings were dry and had proper floors. However, he believed that the government was working faster than the 'backward and unenlightened condition of the people and Local Authorities of this Colony regarding the principles of Public Health, will admit'.⁵³

While the highest echelons of the government and the Public Health Department viewed the municipalities with contempt, the same could be said of the attitude of the local authorities towards the medical profession. At least part of the problem probably stemmed from the fact that district surgeons, as part of their duties, were required to report sanitary defects and health issues to the government and that this information was made public through the distribution of their reports throughout the colony. Therefore, although district surgeons were also residents in local communities they were seen as having an allegiance to the government rather than to the town fathers.

District surgeons, for their part, could only *report* insanitary and health issues. They did not have the authority *to do* anything about addressing such issues. Furthermore they did not have the right to inspect properties.⁵⁴ It was clear that while the strained relationships between the local authorities, the medical profession and the Public Health Department continued, the status quo would continue and little would be achieved in the fight against infectious diseases in general, and tuberculosis in particular. It was the medical profession who rose to the challenge.

⁵² 'Cape of Good Hope. The South African Medical Congress', *BMJ* (30 January 1904), 277. This article was written by a correspondent for publication in the *BMJ*. The name of the author is not disclosed.

⁵³ Cape Archives (hereafter CA), Colonial Office (hereafter CO), CA, CO 7507-963, Memorandum from John Gregory, Assistant Medical of Health, to the Colonial Secretary, undated, but probably written in 1899.

⁵⁴ NLSA, G24-1895, *Health Report for 1894*, 119.

Changes in the Medical Profession

The medical profession was not immune to the changes which were taking place in the colony as they, too, faced challenges of their own. The number of medical practitioners had more than doubled between 1865 and 1891.⁵⁵ This had a two-fold effect of creating additional competition as well as promoting the organisation of the profession. At the same time additional demands were being made on doctors following the increase in mortality rates from infectious diseases such as typhoid and diphtheria.⁵⁶ The colony went through a financial depression during the 1860s and the 1870s. It attained responsible government in 1872, which gave the Cape far greater financial control over its own affairs as well as the ability to introduce independent public health measures.⁵⁷ With the medical profession becoming more organised, government public health was placed on a sounder footing and began to gain greater prestige and credibility in the eyes of the public and the town councils. However, a number of years were still to pass before this translated into cooperation between the smaller local authorities such as Cradock, and their respective health officers.⁵⁸

By the late nineteenth century a paradoxical situation had arisen in which medical science appeared to give doctors revolutionary new tools for the control of disease while in fact, except in occasional instances, the methods of sanitary reform that were introduced in the first half of the nineteenth century remained the most effective way of limiting mortality.⁵⁹ It was against this background that district surgeons began to raise alarm bells regarding the spread of tuberculosis.

⁵⁵ H. Deacon, 'Introduction: The Cape Doctor in the Nineteenth Century', in Deacon, Phillips and Van Heyningen, *The Cape Doctor in the Nineteenth Century*, 30. The numbers had grown from 143 in 1865 to 336 in 1891. By 1904 this number had increased to 629.

⁵⁶ The belief in the therapeutic value of the climate still prevailed at this point in time.

⁵⁷ Van Heyningen, 'Regularly Licensed and Properly Educated Practitioners', 195.

⁵⁸ The situation was different in Cape Town. The reasons for this are discussed in Chapter 4.

⁵⁹ Van Heyningen, 'Public Health and Society', 63.

Growing Awareness of the Spread of Tuberculosis

In 1895 Dr de Wet reported that there was a large influx of invalids who coming into to the town that year and that many of them were in the last stages of tuberculosis. He drew attention to the fact that scarcely any precautions were taken on how and where expectoration was disposed of, adding that this sputum was loaded with tubercle bacilli. He pointed out that in health resorts such as Davos (Switzerland), patients were compelled to carry specially designed spittoons containing disinfectant, adding that 'it would be well for us to recognise that phthisis is an infectious disease'.⁶⁰ De Wet's comments came at a time when there was a greater awareness of the impact of spitting in the transmission of infectious diseases. At the same time manners had changed in the nineteenth century with the habit being associated with the behaviour of 'the lower classes'.⁶¹ However, De Wet's comments fell on deaf ears and nothing was done about the matter.

A year later De Wet reported that the inevitable had happened. The constant stream of consumptive invalids into the town had resulted in its spread to the local population.⁶² In the same year Dr John Gregory also drew attention to the high mortality rate of tuberculosis sufferers in the main towns. Although statistics were only just becoming available following the implementation of the *Births and Deaths Registration Act* they already revealed that the Coloured death rate stood at 5,58 per thousand (compared with 1,98 for whites) across the colony.⁶³ This demonstrated that regardless of how beneficial the 'climate' might be in the treatment of tuberculosis, it offered no bar to its spread, which in the absence of proper precautions, was sure and rapid.⁶⁴

⁶⁰ NLSA, G55-1896, *Cape of Good Hope, Reports on the Public Health for the Year 1895, Including Reports of District Surgeons, Local Authorities and Medical Inspectors* (Cape Town: Government Printer, 1896), 62.

⁶¹ <http://blog.wellcomelibrary.org/2014/03/an-anti-social-habit-in-the-war-on-tuberculosis/>

L. Kaplish, 'An Anti-social Habit and the War on Tuberculosis', Wellcome Library. Accessed 8 October 2016.

⁶² NLSA, G42-1897, *Health Report for the Year 1896*, 57.

⁶³ NLSA, G5-1897, *Health Report for the Year 1896*, 19.

⁶⁴ NLSA, G39-1906, *Public Health Report ... for the Two Calendar Years 1904 and 1905*, lxxxi.

One of the factors which added immensely to the danger of infection from the consumptives was the common practice of expectorating in public and private places by all members of society, a practice which was widespread throughout the colony. This posed an enormous problem in so far as the spread of tuberculosis was concerned because tuberculosis sputum is the main agent for the transmission of tuberculosis from person to person.⁶⁵ There was a commonly held perception in the colony that the sunshine would kill the tubercle bacillus instantly. Dr G.W. Robertson, the government bacteriologist, proved that this view was 'nonsense'. He established in his laboratory that the bacillus survived for eight or nine days when exposed to sunshine, but lived for months in dark, dank rooms.⁶⁶ In the meantime it remained as a persistent and daily threat to infection to everyone, especially those whose resistance to disease was compromised in any way.

The matter was raised in 1896 and again in 1906, when De Wet proposed that the town council consider introducing a law to prevent expectoration in the streets and pathways of the town.⁶⁷ In this he was supported by Dr Dick, who was a member of the council and who had attended the mayor's conference in 1903 when the matter had been discussed. He recommended that a bye-law be implemented and that the council should follow the lead set by Cape Town in this respect.⁶⁸ Notice of the

⁶⁵ CA, Medical Officer of Health Archives (hereafter MOH), CA, MOH 61-82, British Congress on Tuberculosis for the Prevention of Consumption, Resolution of General Congress, London, 27 July 1901.

⁶⁶ *SAMR*, 13 April 1912, 124.

⁶⁷ NLSA, G55-1896, *Health Report for 1895*, 62.

⁶⁸ *Midland News*, 19 July 1906.

MUNICIPALITY of CRADOCK.

MUNICIPAL NOTICE.

**Additional Regulations framed
under Act 45 of 1882.**

NOTICE is hereby given in terms of Section 110 of Act 45 of 1882, that the Municipal Council did at a meeting held on Tuesday, the 17th July, 1906, agree to the passing of the following additional regulation, viz. :—

“It shall be unlawful for any
“person, being a male adult, to
“expectorate (1) on any floor,
“wall, or article, other than any
“article provided or carried for
“the purpose, in any Public
“Building or any Public Bar,
“Restaurant, or Eating House,
“or (2) on any Pavement of any
“street, road or square, or any
“Unpaved Foot or Pathway to
“which the public have the
“right of user, or (3) on the
“Floor of any part of a Cab,
“Omnibus or Public Vehicle.”

And any such person on conviction for contravening this regulation shall be liable to a fine not exceeding Five Shillings, and on a second conviction, to a fine not exceeding Forty Shillings.

A copy of the above regulation is open for inspection of ratepayers between the hours of 9 a.m. and 4 p.m., for a period of 10 days, reckoned from the 7th August, 1906.

By order,

B. A. PATERSON,
Town Clerk.

Town Office, Cradock,
7th August, 1906. 1028

Publication of bye-law prohibiting expectoration in Cradock, 1906

proposal was duly given to the public.⁶⁹ The result was a public outcry. In a letter published in the *Midland News* 'Sceptic' reacted to the bye-law by stating:

Our learned and progressive city fathers appear to have allowed themselves to be persuaded into adopting a suggestion, which has caused a ripple of merriment to pass over the town ... This mirth may or may not be associated with a little amused resentment at such apparently grand-motherly regulations, and a quiet intension to go on expectorating. It is interfering with the rights and privileges of the public, established by custom, from all time.⁷⁰

'Sceptic' went on to state that he believed that the sun was quite capable of destroying any germs.⁷¹ The management of the local sports grounds responded by making their grounds available for those who wished to continue spitting, but limited this concession to Wednesdays. This concession was made known to residents by placards pasted in the town square. 'Perplexed' responded, also in a letter addressed to the *Midland News*,

Barely has the decree gone forth and the new commandment, which expressly states in the words of our modern *wise men*, "thou shall not expectorate" been issued, when lo and behold in direct opposition to the Council's fiat, we are invited by large placards and in large type, "to go to the Sports Ground to clear our throats." ... is it a partial climb down on the part of our local Solomon's to meet public opinion, in a kind of revised version, viz. six days shalt thou *not* expectorate, and on Wednesday, go to the Sports Ground, and do so at your heart's content?⁷²

The objections raised had little to do with the control of the spread of tuberculosis but were instead directed at what was perceived to be an unwarranted attempt to change a common-place practice.⁷³ A couple of weeks later a new town council was elected. Within days it received a petition from the public against the bye-law.⁷⁴ Before long before the council bowed to pressure, indicating that it would wait until the bye-law, as formulated by the Public Health Department, was implemented throughout the colony.⁷⁵

⁶⁹ Ibid., 7 August 1906.

⁷⁰ *Midland News*, 27 July 1906.

⁷¹ Ibid., 27 July 1906.

⁷² Ibid., 1 August 1906.

⁷³ See Chapter 4 for information on the origins of the practice of expectoration.

⁷⁴ *Midland News*, 24 August 1906.

⁷⁵ *Midland News*, 24 November 1906. Although bye-laws against expectoration were instituted in Cape Town in 1904, it was only in 1917 that the prohibition was gazetted. See CA, Archives of

Although the Cradock Town Council did not pay much attention to public health, it seems they did indeed listen when ratepayers made certain demands. Such was the case with regard to the provision of a hospital for local residents.

Building of a Hospital

The idea of building a hospital in the town was initially proposed by ratepayers in 1892. The council approached the government with a view to obtaining funding for the venture, but was informed that unless it was prepared to contribute funds on the 'pound for pound' principle, the project would not be supported.⁷⁶ The idea of building a general hospital was resurrected in 1895 when some residents, including De Wet, embarked on a fund raising endeavour.⁷⁷ It was only in the following year that the council came on board and supported the venture. Its change of heart was prompted by discussions in parliament on the need for a hospital in the area. It was eventually decided that a hospital was needed to cater for persons who were injured in railway accidents.⁷⁸ Once the commitment was made by the railways that they would contribute 'handsomely' to the hospital, building started. In May 1897, at a meeting of the residents of Cradock it was decided that £1,000 of the town's reserves would be allocated towards the building of the hospital and the council confirmed that the funds had been set aside for this purpose.⁷⁹ The hospital had four wards. Three of them catered for ten individuals, with one being reserved for white males, the second for white females and the third for blacks or Coloureds. The fourth ward was smaller and had five beds for blacks or Coloured patients. All medical practitioners gave of their time and expertise on a *pro bona* and voluntary basis. In

the City of Cape Town (hereafter CT), 3/CT 1/7/1/12, Minute of His Worship the Mayor [Lieberman] for the Mayoral Year ending 14 September 1905, 79-80. See also CA, 3/CT 1/1/1/59, Council Minutes, 13 April 1905, 181. Expectoration was prohibited in terms of Government Gazette Notice No. 294 of 1917.

⁷⁶ *Midland News*, 16 April 1892.

⁷⁷ *Midland News*, 11 October 1894.

⁷⁸ NLSA, *Cape of Good Hope, Debates in the House of Assembly, 1896, Third Session of the Ninth Parliament, 1 May-29 June 1896* (Cape Town: Cape Times, 1896), 286.

⁷⁹ *Cradock Register*, 14 May 1897, 18 May 1897.

addition there were six attendants.⁸⁰ The nursing staff consisted of five nurses and a matron.⁸¹

The original plan was that the hospital would be run for the benefit of the railways and for the local population. It was not long before there was an outcry against the idea of admitting consumptives; the feeling was that a separate 'home' should be built for their needs.⁸² This was moot point because soon after the hospital was opened (in May 1899) it was commandeered by the military when the South African War broke out in October 1899.⁸³ Once the war was over, the hospital found difficulty in paying its way. The town council refused to make further contributions as they had issues with the management of the hospital, and it was left to a band of volunteers to raise the necessary funds to run the hospital.⁸⁴ There was a strong reliance on the government grant, which invariably arrived late, if at all.⁸⁵ By 1903 the hospital was insolvent, and the board was pleading for additional government assistance.⁸⁶ Dr Mitchell, the assistant MOH for the Cape, was sent to inspect the hospital,⁸⁷ and the government grant was subsequently increased to £1,250. However, the hospital still struggled to make ends meet.⁸⁸ Ultimately the hospital did in fact cater for consumptives. The hospital board acknowledged that a large number of people came to Cradock in the last stages of tuberculosis and from a humanitarian point of view they could not be turned away. These were expensive cases to treat and often the patients were destitute.⁸⁹

Financing the hospital always remained a challenge. The council remained unsympathetic, even going so far as to refuse to grant a concession for sanitary

⁸⁰ *Cradock Register*, 5 January 1897.

⁸¹ *Midland News*, 25 February 1905.

⁸² *Midland News*, 18 January 1899; *Cradock Register*, 20 January 1899; *Cradock Register*, 23 January 1899; *Cradock Register*, 24 January 1899.

⁸³ *Cradock Register*, 26 May 1899; NLSA, G41-1901, *Cape of Good Hope, Colonial Secretary's Ministerial Division. Reports on the Government and Aided Hospitals and Asylums and Report of the Inspector of Asylums for 1900* (Cape Town: Government Printer, 1901), 24-25.

⁸⁴ *Midland News*, 2 August 1902.

⁸⁵ *Ibid.*, 13 April 1901.

⁸⁶ *SAMR* (March 1903), 13.

⁸⁷ *Midland News*, 31 August 1903.

⁸⁸ *Ibid.*, 25 February 1905.

⁸⁹ *Ibid.*

services at a reduced rate.⁹⁰ That the hospital continued to operate was chiefly due to the efforts of the staff, the majority of whom volunteered their time and did not receive any compensation for their efforts.⁹¹ In addition to serving the needs of Cradock residents, patients came from the surrounding districts of Somerset East, Hanover, Middleburg and Colesberg.⁹²

Living Conditions in the Townships prior to the South African War

Building a hospital was one of the signs of increased awareness that the community needed medical care. In a curious turn of events, the local authority in Cradock did not acknowledge that years of sanitary neglect and apathy had contributed to the spread of disease. They chose instead to do very little to remedy it, and placed the responsibility on ‘gentlemen of colour’ who were ‘promptly selected as the whipping boy for the lash of the sanitary official’.⁹³ In a hard-hitting editorial which appeared in the April 1904 edition of the *SAMR*, the author described how attention was only paid to the needs of Coloured and black residents if there was a raging epidemic. Other than that, they were herded together in townships amid ‘masses of indescribable filth in a way which was a flagrant defiance of every law of hygiene’. For years, medical and lay people had preached about the necessity of providing well-managed townships, all to no purpose. Now that the local authority had the ‘Black man as a conscience salve and a whipping boy’ he could be blamed for the spread of disease, and provide an excuse for continued apathy.⁹⁴

Ultimately, the local authority could not continue to ignore the insanitary conditions in the townships indefinitely. The Public Health Department was increasingly calling upon it to improve standards and curb overcrowding. It was also necessary to

⁹⁰ *Midland News*, 2 November 1902; ‘Passing Events’, *SAMR* (April 1903), 30-31.

⁹¹ NLSA, G41-1901, *Health Report for 1900*, 24.

⁹² NLSA, G60-1903, *Cape of Good Hope Colonial Secretary’s Ministerial Division. Reports on the Government and Aided Hospitals and Asylums for 1902* (Cape Town: Government Printer, 1903), 54-55.

⁹³ Editorial, ‘The Sanitary Whipping Boy’, *SAMR* (April 1904), 70.

⁹⁴ *Ibid.*, 71.

improve housing conditions in the townships because it was feared that illness in the township was a source of danger to the general health of the white residents.⁹⁵

Although concern for the health of the white residents in Cradock was indeed a factor, the urgent need for acceptable housing in the township would probably not have received much attention had it not been for the opportunity to make a profit presented by Section 68 of the *Public Health Act of 1897*. In terms of this clause, local authorities were entitled to levy a hut tax (proportionate to the amount of the general rate levied by it) on all huts and dwellings erected in black townships in their municipal area.⁹⁶ This provided the financial incentive for them to embark on a programme of building accommodation for township residents. There was also the added benefit of silencing their critics regarding the living conditions, while at the same time making a decent profit for the town council. Under these circumstances it made sense to proceed with the project.

Building operations commenced in 1900 with a row of rooms on the south of the town for Coloured persons 'of the better class'. All were let as soon as they were completed. In De Wet's opinion the 'idea was an extremely good one, and profitable as well'.⁹⁷ In the same year the building programme was extended to include the township, where the council erected a row of 32 back-to-back rooms. These rooms were available for rental, and produced an excellent profit for the council. In 1910, for example, the revenue generated was £1,399 against an expenditure of £270, leaving a surplus of over £1,000. The profit from the township project covered a proportion of the ordinary municipal expenditure, roughly 12 per cent.⁹⁸ In other words, profit from income which was generated in the township was simply diverted for use in the town to benefit the white community.

⁹⁵ NLSA, G55-1896, *Health Report for 1895*, 61.

⁹⁶ NLSA, G5-1897, *Health Report for 1896*, 14.

⁹⁷ NLSA, G4-1902, *Cape of Good Hope Reports of the District Surgeons, Additional District Surgeons and Local Authorities on the Health of the Districts under their Charge during the Year 1900; and the Reports of the Medical Inspectors under 'The Contagious Diseases Prevention Act, 1885'* (Cape Town: Government Printer, 1902), 42.

⁹⁸ NLSA, UG34-1914, *Tuberculosis Commission Report 1914*, 131. The Tuberculosis Commission states that the building in the township began in 1903. However, according to NLSA, G4-1902, *Health Report for 1900*, 43, the building commenced in 1900.

In the townships themselves, despite the rentals charged, services were not provided to the residents. In 1903, three years after the buildings had been completed, residents were still calling for water to be supplied.⁹⁹ Although the building of houses and rooms no doubt benefited the occupants by providing them with better accommodation, this project was never conceived as a means of improving public health; this objective did not feature in any of the discussions although it was a step in the right direction.

The apathy towards public health in the ranks of the town council would no doubt have continued had it not been for the outbreak of the South African War in 1899. After the war it was no longer possible to continue with patterns which had become entrenched over the previous decades. For a start, the town was compelled to cater for the influx of a large number of people who sought refuge from the war. In addition, the availability of hospital facilities in Cradock meant that there was a strong military presence in the area. However the impact of the war was not restricted to the use of hospital facilities by the military.

The South African War, 1899-1902: A Turning Point

In addition to making use of hospital facilities in Cradock, the military also brought with them a culture of discipline and the imposition of martial law. One of the first things that the military did when entering into a town, was to assess the level of cleanliness. If it was found wanting, the troops immediately embarked on a 'clean-up' operation often removing years of accumulated rubbish. They also insisted on improved sanitary compliance. This, coupled with the fear of plague, which had broken out in Cape Town in 1900, meant that many of the small towns in the Cape Colony were given their first 'spring-clean' in decades.¹⁰⁰

⁹⁹ *Midland News*, 19 February 1903.

¹⁰⁰ Some of the towns affected were Riversdale, Calitzdorp, Fraserburg, Caledon, Bredasdorp, Swellendam and Prince Albert – for a full list, see NLSA, G66-1902, *Cape of Good Hope Reports on the Public Health for the Year 1901, Including Reports of the District Surgeons, Local Authorities and Medical Inspectors* (Cape Town: Government Printer, 1902).

Although Cradock was not one of these towns it did start paying some attention to its inadequate sanitary conditions, especially those in the township. The old railway township had gradually become more decrepit and had been reduced to a number of dirty and insanitary hovels. This was removed. The main township was severely overcrowded. The outbreak of the war was not the sole cause of the overcrowding, but it was certainly an exacerbating factor. Not only were people forced to move into the town during the war but Cradock was used as a military remount camp. This meant an increase of between four to five thousand people in the township,¹⁰¹ making it impossibly overcrowded, creating ideal conditions for the spread of tuberculosis.

By the end of the war there was a new awareness of sanitary principles which had not existed to the same extent prior to the hostilities. Because controlling the spread of tuberculosis was still seen as closely aligned to the maintenance of hygienic living conditions, the time was ideal for the Public Health Department to take advantage of the break with old traditions and the introduction of new habits that had been inculcated during the war. The time was ripe for tuberculosis to be tackled with new insights and vigour. It was the Public Health Department that was positioned to take advantage of the changes and to take a leadership role in the fight against tuberculosis.

The Role of the Public Health Department

The South African War came to an end in 1902. In the same year tuberculosis was declared to be a notifiable disease, which brought the provisions of Section 29 of *the Public Health Amendment Act, 1897* into operation. The decision to add tuberculosis to the list of notifiable diseases was the result of the alarming increase in its prevalence, which had been witnessed over several years prior to the war. Once the disease became notifiable, Section 29 placed a duty on any person in charge of someone suffering from the disease, or any householder, hotel or lodging

¹⁰¹ NLSA, G66-1902, *Health Report for 1901*, 33.

housekeeper, or school keeper, to give notice of the presence of someone who had tuberculosis to the relevant local authority. It also created an obligation on the medical practitioner who was treating the person to inform those caring for the patient of this fact. The notification took the form of a written certificate which specified the name of the patient, together with his/her age, sex and address. This certificate had to be handed to the relevant local authority, which then had to pay the sum of two shillings and sixpence (2/6d) for each notification made by someone other than the resident health officer. The local authority was, in turn, obliged to provide notification of the disease to the health officer and to the Public Health Department.

De Wet clearly understood what his responsibilities were and viewed the initial report of a disease as merely the first step towards systematic investigation. Every case had to be examined by him and it was his responsibility to ascertain the possible source of origin of the disease and to advise the council on the steps it should take for the protection of the public. De Wet lamented that despite this procedure being in place, the council took no further interest in such notifications.¹⁰² The council did not pass these notifications on to him, and because he lacked the authority to act on his own initiative the end result was that nothing was done.

In the Health Report for the year 1903 Gregory warned that tuberculosis was likely to become 'the scourge of the Coloured and Native races'. He went on to admit that he did not know how the rapid spread of the disease could be prevented under the existing standard of domestic hygiene which prevailed among them, and with 'their herding together as they do in small, ill-ventilated huts and dwellings, with promiscuous spitting over the floor.' Gregory believed that the mere fact that in terms of the recent legislation patients were required to notify the authorities of their health status would impress upon them and their friends that tuberculosis was infectious and presented a considerable danger to those associating with them. He

¹⁰² NLSA, G37-1899, *Cape of Good Hope, Reports of the Public Health for the Year 1898, Including Reports of District Surgeons, Local Authorities and Medical Inspectors* (Cape Town: Government Printer, 1899), 44.

also added that notification would enable the local authority to insist that certain simple precautions had to be taken to prevent the spread of the disease. By way of example he said that they could warn hotel keepers not to allow tuberculosis sufferers to sleep in the same rooms as those occupied by healthy people and that hotel owners should disinfect the premises previously occupied by sufferers when they died or vacated the premises. Other suggestions included the use of sputum cups and the destruction of sputum.¹⁰³

While it cannot be denied that the addition of tuberculosis to the list of infectious diseases was a step in the right direction, this fact was not widely circulated. The notification appeared in the *Government Gazette*.¹⁰⁴ It was not advertised in the local press or any other publications where it would have attracted the attention of residents. The proclamation itself was problematic in that it merely stated that 'tuberculosis' was notifiable, and did not specify that the new legislation pertained only to pulmonary tuberculosis.

Furthermore, there was no publicity attached to the announcement of the new measures. As a point of comparison, the outbreak of rinderpest in 1896 was accompanied by large (full-page) advertisements in the local newspapers.¹⁰⁵ These advertisements detailed the symptoms and the procedures to be followed. A similar approach was taken with regard to smallpox and outbreaks of plague. Despite the acknowledged prevalence of tuberculosis throughout the Cape Colony, no such publicity measures were taken. In Cradock, for example, there was nothing in the press, not even a passing reference, to the fact that the disease was notifiable.

From a practical standpoint, this had important ramifications. The majority of consumptive invalids lived in boarding houses and hotels in the town itself and in

¹⁰³ NLSA, G35-1905, *Cape of Good Hope, Report of the Medical Officer of Health and on the Government and State-Aided Hospitals of the Colony, together with Annual Reports of the District Surgeons and Local Authorities for the Year 1903* (Cape Town: Government Printer, 1904), lxii.

¹⁰⁴ NLSA, Proclamation No. 144 of 1904, *Government Gazette*, 17 May 1904, 'Tuberculosis and Erysipelas declared Notifiable Diseases in terms of Public Health Act, 1883'.

¹⁰⁵ *Cradock Register*, 5 January 1897.

hotels and farms in the surrounding areas. The onus of reporting incidents of the disease fell upon the 'person in charge' of such establishments. It is unlikely that they were even aware of their responsibilities. Under these circumstances, together with the fact that the town council was lax in acting on notifications, the system was destined to fail.

A further shortcoming was the lack of direction provided to local authorities about the steps which should, ideally, be taken upon receipt of a notification. If used correctly, these notifications could have provided local authorities and health officers with valuable information to help prevent the spread of the disease. Cape Town health officers, for example, were able to capitalise on the information received from this source and used it as an important stepping-stone in the education of sufferers and their immediate circle of family and friends.¹⁰⁶

Local authorities in outlying areas did not have sufficient knowledge about the disease and the measures that were necessary to prevent its spread. Gregory acknowledged the need to educate sufferers on this issue, yet he did not provide any leadership in that direction. Just as there was no publicity surrounding the need to notify occurrences of the disease, so too, was there no instructions circulated to the local authorities about what should be done on receipt of the notification. Mention was made of some beneficial steps that could be taken in the 1903 Health Report,¹⁰⁷ but this was hardly a document that would have come into the hands of those who were most impacted by the suggestions. In 1906 Gregory did however acknowledge that the Health Department was 'preparing a circular for the guidance of local authorities in dealing with the disease'.¹⁰⁸

The only direct communication between Gregory and the Cradock town council regarding tuberculosis was a letter from Gregory in 1905. In it he emphasised the

¹⁰⁶ This is discussed in the following chapter.

¹⁰⁷ NLSA, G35-1904, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health and on the Government and State aided Hospitals of the Colony, together with the Annual Health Reports of District Surgeons and Local Authorities for the year 1903* (Cape Town: Government Printer, 1904), lxii.

¹⁰⁸ NLSA, G39-1906, *Public Health Report ... for the Two Calendar Years 1904 and 1905*, lxxxiii.

need for the council to keep a record of the number of cases of tuberculosis in the town, especially in the light of the influx of people settling in Cradock for the benefit of the climate. He added that the council should be kept aware of their addresses, and that reasonable means should be adopted for preventing the spread of infection. Again, he did not elaborate on what these measures should be. For its part, the council simply ignored the letter, not even taking the trouble to discuss it or to bring it to the attention of De Wet.¹⁰⁹ Similarly, a letter addressed to the town council from the Association for the Prevention of Consumption requesting it to call a meeting to discuss the need for a local Society for the Prevention of Consumption in Cradock was acknowledged but never discussed in a council meeting.¹¹⁰

It was only in 1909 that Gregory sent a circular to all the local authorities in the Cape Colony about the steps that should be taken to prevent the spread of tuberculosis. The directions offered by Gregory included that consumptives 'should not kiss others, more especially on the lips, nor should they use anyone else's pipes' and that consumptives should sleep alone with their windows open.¹¹¹ By addressing it to the local authorities and not providing an additional document which could be circulated to the local hotels and boarding houses, a valuable opportunity was lost to educate the general public about the precautions that could be taken to limit the spread of the disease.

What is interesting is that this circular provides, as a guideline to the local authorities, details of the steps which had been implemented in Cape Town in 1903. By that time six years had elapsed since the disease had become notifiable. A delay of this magnitude cannot be justified, especially when Gregory believed that the

¹⁰⁹ *Midland News*, 17 May 1905.

¹¹⁰ *Ibid.*, 22 October 1904.

¹¹¹ CA, Archives of the Town Council of King William's Town (hereafter KWT), 3/KWT, 4/1/99, Memorandum on the Prevention of the Spread of Tuberculosis or Consumption and accompanying Circular Letter No. 12 of 9 June 1909 to all Local Authorities in the Colony. See Addendum No. 1 for a copy of this memorandum.

responsibility for the prevention of the spread of the disease lay with the people themselves, together with the relevant local authorities.¹¹²

One of the other shortcomings of the attempts to curb the spread of tuberculosis was the Health Department's failure to draw attention to the link between the disease itself and the predisposing causes – such as overcrowding and poor ventilation. Over the years, Gregory had repeatedly drawn the attention of local authorities to the urgent need to prevent overcrowding. Apart from his comment in the 1896 Health Report that he saw a definite link between overcrowding and the high incidence of tuberculosis in some towns and adding that this 'needed to be investigated before conclusions could be drawn', he did not reiterate this as a predisposing cause for the spread of tuberculosis.¹¹³ It is extremely unlikely that the local authorities would have 'connected the dots' on their own. It was therefore hardly surprising that on the occasions that local officials did indeed enforce regulations to prevent overcrowding, it was with completely different objectives in mind.¹¹⁴

With no direction from the Public Health Department, and no consequences for the failure to enforce the measures that should have been carried out upon the receipt of the notification, the outlook for the prevention of the spread of tuberculosis in the majority of the smaller Cape towns was bleak, especially in the period prior to Union in 1910. This situation would have prevailed had it not been for the attention drawn to the disease at the various mayor's conferences, the medical practitioners in their annual medical congresses, and articles in the *South African Medical Journal*.

It was the city of Cape Town that took the lead in the fight against tuberculosis. The steps its officials took are the subject of the next chapter. The message that was made loud and clear was that tuberculosis was a national problem which needed

¹¹² NLSA, UG1-1911, *Cape of Good Hope. Report of the Medical Officer of Health for the Colony on the Public Health and Cognate Matters Including the Registration of Births, Deaths and Marriages for the Calendar Year 1909* (Cape Town: Government Printer, 1911), 62.

¹¹³ NLSA, G5-1897, *Health Report for 1896*, 19.

¹¹⁴ The removal of Coloured tenants from rooms in the back-yards of the houses belonging to absentee farmers was a case in point.

immediate attention on the part of all local authorities and the medical profession throughout the Cape Colony. The Cape Town city council was assisted in this initiative by the Association for the Prevention of Consumption. Their combined efforts ultimately culminated in the appointment of the Tuberculosis Commission in 1912, as discussed in Chapter 7.

Chapter 4

Cape Town takes the Lead in the Fight against Tuberculosis, 1870-1910

The city of Cape Town was the capital of the British Cape Colony. It is located at the tip of Africa and was the first port of call for ships travelling to the colony from countries such as Britain. It was also the seat of government and had the largest population of any town in the colony. On similar lines to other towns in the Cape, it was structured as a local authority and had the ability to pass and enforce bye-laws.

Cape Town has the longest history of tuberculosis in the country. The disease may have been present in the town from its foundation, although the first recorded reference to it was in about 1780.³⁵¹

Cape Town had several challenges which made it particularly vulnerable to diseases such as tuberculosis. As a port town it had a large transitory population, a situation which was exacerbated following the discovery of minerals and the opening up of the interior. Accommodation was always in short supply. This was capitalised upon by profiteering landlords who sought to take advantage of the circumstances. This in turn led to slum conditions and severe overcrowding, creating an environment in which tuberculosis thrived. Added to this, there was a high degree of urban poverty and unemployment. Conditions could not have been more conducive for the spread of the disease, as is demonstrated in Table 4.1 below.

In 1875 the municipal authority of Cape Town was paying very little attention to health issues. The town itself was experiencing rapid population growth. During the period 1875 to 1891, the white population in the urban areas increased at the rate of

³⁵¹ National Library of South Africa, Cape Town (hereafter NLSA), Union of South Africa, Govt. Reports (hereafter UG), UG34-1914, *Union of South Africa, Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 25.

51,5 per cent, and the Coloured population at the rate of 68,6 per cent.³⁵² Overcrowding became common, and the condition of the town deteriorated to such an extent that in 1881 a number of professional men and merchants petitioned the House of Assembly in the Cape legislature in protest against the neglected state of the town. Their agitation culminated in the election of the 'Clean Party' to the town council in 1882, eventually inaugurating an era of greater municipal expenditure and a degree of sanitary reform.³⁵³

Table 4.1: Number of deaths in Cape Town, and the percentage proportion of deaths from pulmonary tuberculosis to all deaths for the years 1871-1875³⁵⁴

No of deaths in year	1871	1872	1873	1874	1875
All causes	1 129	988	633	731	655
Tuberculosis	186	150	135	129	102
% proportion of deaths from tuberculosis to deaths from all causes	16,47	15,18	21,33	17,65	15,57

Shortly after coming into office, the new council identified a number of issues which required their attention. These included the provision of a reliable water supply; the improvement of the dwellings of the poor; the taking of steps to prevent overcrowding; and the need to appoint a health officer.³⁵⁵ However, the proposal to appoint a health officer was rejected at the time.³⁵⁶

³⁵² NLSA, Official Publications (Cape Colony), Govt. Reports, (hereafter G), NLSA, G5-1897, *Cape of Good Hope Report of the Medical Officer of Health for the Colony for the Year 1896* (Cape Town: Government Printer, 1897), 5.

³⁵³ E.B. van Heyningen, 'Public Health and Society in Cape Town, 1880-1910', PhD thesis, University of Cape Town, 1989), 122.

³⁵⁴ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 24.

⁴ Cape Archives (hereafter CA), Archive of the Municipality of Cape Town (hereafter CT), 3/CT 1/1/5/182, Minutes of Cape Town Council Meeting, 24 June 1882, 2-4.

³⁵⁶ *Cape Times*, 1 July 1882.

Attitudes towards health matters changed following the outbreak of smallpox in 1882, which caused the death of approximately 1 146 people (in a population of between 40 000 to 45 000).³⁵⁷ The details of the epidemic itself have been discussed in detail by both Van Heyningen and Bickford-Smith and fall outside the scope of this chapter.³⁵⁸ However, the smallpox epidemic was important in several ways because it set the course for the approach to public health for the next two decades and impacted on the way in which tuberculosis was treated.

The changes in legislation and policy following the smallpox epidemic took place within a particular social context. It had already been recognised that there was overcrowding and to deal with the smallpox epidemic and the high levels of filth, the city council appointed an additional thirteen 'overseers' to supplement the number of existing sanitary inspectors. It was their task to report on the sanitary conditions of the 'lower classes'.³⁵⁹ Within days, reports of severe overcrowding were received by the council. For example in Strand Street the inspectors found a dwelling in which nineteen occupants were living in six rooms; and another where there were 26 occupants in eight rooms.³⁶⁰ With such reports appearing regularly in the press, it was no longer possible for the city officials to ignore the living conditions of the poor. These concerns were not necessarily altruistic in nature; they were motivated primarily by the perceived threat of these conditions to the health of the bourgeoisie.³⁶¹

The discussions about overcrowding and poverty in the town were extended to include a redefinition of who, among the impoverished residents of Cape Town, deserved assistance. Instead of showing empathy, the popular view was that they had brought their misfortune upon themselves and were inherently responsible for their dreadful living conditions – and therefore were not deserving of assistance. This line of thinking was developed further during the 1880s when Cape Town was

³⁵⁷ Van Heyningen, 'Public Health and Society', 135.

³⁵⁸ Ibid., 104-166, V. Bickford-Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town* (Johannesburg: University of the Witwatersrand Press, 1995).

³⁵⁹ Van Heyningen, 'Public Health and Society', 136.

³⁶⁰ *The Cape Times*, 3 July 1882.

³⁶¹ Bickford-Smith, *Ethnic Pride*, 98.

going through a major financial depression. By this time the new ideology of Social Darwinism had captured the imagination of the bourgeois in both Britain and the Cape Colony. In Britain, London's dominant class explained the existence of the undeserving poor by means of the theory of urban degeneracy which they believed had resulted from exposure, over generations, to the debilitating urban environment. Within the colonial context this took on a distinctly racial interpretation, with the view among the wealthy and upper middle-class white residents of Cape Town that people of 'mixed race' were particularly likely to succumb to degeneration.³⁶² Segregation was seen as the way to 'protect' whites from 'contamination by 'dirty' blacks'. Nothing came of the matter at the time, primarily due to lack of consensus about who would pay if segregation were to be implemented.³⁶³

The smallpox epidemic also exposed the legislative nakedness of the colony because there were no policies in place which provided guidance on how to deal with the threat. In principle, health care was the responsibility of the Cape colonial office, but the control which the Cape government was able to exercise was very limited. It employed no health officer and the only medical advice to which it had formal access was that of the colonial medical committee. At the time no town in the colony had a health officer and municipal health regulations, where they existed at all, were rudimentary in the extreme.³⁶⁴

It was against this background that the *Public Health Act, Act No. 4 of 1883* was passed. Despite its name, it was not a general Public Health Act but rather dealt with the control of infectious diseases. It was this act which was eventually extended to include tuberculosis in 1903.³⁶⁵ One of the major deficiencies of this legislation was that local authorities were expected to pay half the costs of combating an epidemic. This set the precedent in respect of financial contributions for the control of

³⁶² Ibid., 91.

³⁶³ Ibid., 102-103. This came to a head after the outbreak of the bubonic plague epidemic in 1903.

³⁶⁴ Van Heyningen, 'Public Health and Society', 131.

³⁶⁵ NLSA, *Government Gazette*, Proclamation No. 144 of 1904, 17 May 1904. Tuberculosis was declared a notifiable disease in terms of the *Public Health Act*, 1883.

diseases. The result was that this clause guaranteed that the act would never be enforced wholeheartedly.³⁶⁶ Once this precedent had been set it was almost impossible to get the government to deviate from it and this practice continued up to and including the passing of the *Public Health Act, Act No. 36 of 1919*, proving a major stumbling block in the control of tuberculosis. One of the more positive outcomes of the smallpox epidemic was that it led to the practice of compilation and publication of annual reports on the state of health in the Cape Colony. It also led to Cape Town appointing a municipal medical officer of health and a sanitary engineer (both 'firsts' in southern Africa).

The medical officer appointed by the Cape Town authorities was Dr George Henry Bradwell Fisk (MRCS, London), LRCP (Edin.) (1852-1893). He occupied the post of police surgeon and physician to the Free Dispensary prior to his appointment. Fisk was appointed on a part-time basis in May 1883.³⁶⁷ Within days of his assumption of office he issued a report on the sanitary condition of the town.³⁶⁸ In his second report he drew attention to the large number of people who had died of phthisis and other diseases of the lungs. His view was that prevalence of tuberculosis was greatly aggravated by the overcrowded and badly ventilated houses which were so numerous in Cape Town.³⁶⁹ He recognised that the underlying cause of overcrowding was poverty and that the poorer people became, the more they were compelled to subdivide and sublet their apartments to make enough money to pay the rent.³⁷⁰

Fisk mentioned the high levels of tuberculosis again in 1887, when the problem was escalating and had accounted for 176 of 1 317 deaths.³⁷¹ In 1889, tuberculosis claimed the lives of 139 people, and was second only to 'convulsions' as the leading

³⁶⁶ Van Heyningen, 'Public Health and Society', 145.

³⁶⁷ Ibid., 137.

³⁶⁸ CA, 3/CT 1/1/5/195-487b, Memorandum from Dr Fisk to the Mayor, 15 May 1883.

³⁶⁹ CA, 3/CT 1/1/5/198, Health Report by Dr Fisk presented to town council, 1 January 1884. Fisk was well in advance of contemporary thinking in linking the prevalence of tuberculosis to poor housing conditions. Gregory, the MOH for the colony, only came to the same tentative conclusion in 1896. See NLSA, G5-1897, *Health Report for the Year 1896*, 19.

³⁷⁰ CA, 3/CT 1/1/5/215, Health Report by Dr Fisk to town council, 1 January 1886.

³⁷¹ NLSA, G13-1888, *Cape of Good Hope, Reports of the District Surgeons for 1887* (Cape Town: Government Printer, 1888), 13.

cause of death.³⁷² This number climbed to 188 out of 1 557 deaths in 1892.³⁷³ Despite the high death toll due to tuberculosis, these deaths did not attract the same attention as other diseases. Van Heyningen attributes this to the fact that the disease did not impede the economic functioning of the city and so did not demand immediate and drastic action on the part of the authorities.³⁷⁴ Fisk was also at a disadvantage because although death certificates were issued, they did not call for a medical certificate on the cause of death, thereby losing much of their value as they could not be used for the production of reliable statistics.³⁷⁵ Fisk died suddenly in December 1893.³⁷⁶

Dr Barnard Fuller Takes over as Part-time Health Officer, 1894

Fisk was replaced by Dr (Edward) Barnard Fuller, the son of Rev. T.E. Fuller, a Cape Town councillor at the time.³⁷⁷ Rev. Fuller was formerly a Baptist minister in London, and had focused on the needs of the poor. When he moved to the Cape and took up the role of editor of the *Argus* newspaper, he used this as a platform to highlight the needs of the poor in Cape Town. He was also the author of a pamphlet on the fever epidemic in 1867-1868, in which he drew a connection between the prevalence of poverty and overcrowding and the outbreak of disease.³⁷⁸ He played a pivotal role in the establishment of the Free Dispensary, which later formed an important role in the lives of those suffering from tuberculosis.³⁷⁹ Unlike many of Cape Town's middle classes, the Fuller family came from a philanthropic tradition, giving them an awareness of the plight of the poor. This stood Barnard Fuller in good stead in

³⁷² CA, 3/CT 1/1/5/278, Health Report, 1889, 203. This was out of 1 104 deaths for that year.

³⁷³ CA, 3/CT 1/7/1/3, Corporation of Cape Town, D.P. de Villiers Graaff (MLC and Mayor). Mayor's Minute, with Departmental Reports, Appendices, etc. for the Mayoral Year ending 4 August 1892 (Cape Town: Murray & St. Leger, 1892), 47.

³⁷⁴ Van Heyningen, 'Public Health and Society', 483.

³⁷⁵ CA, 3/CT 1/1/5/210, Dr Fisk's report to city council for 1885, appended to the Council Minutes, January 1885, no page number.

³⁷⁶ 'Obituary, Dr Fisk', *South African Medical Journal* (hereafter *SAMJ*) (December 1893), 156.

³⁷⁷ Revd Fuller was the immigration agent for the Cape Colony in London. See Chapter 2 for details.

³⁷⁸ R. Thornton and T.E. Fuller, *Epidemic in Cape Town, 1867-1868* (Cape Town: Juta, 1868), 12-13.

³⁷⁹ M. Naude, 'The Role of the Free Dispensary in Public Health Care in Cape Town, 1860-1910', B.A. Hons. essay, University of Cape Town, 1987, 42-44.

dealing with tuberculosis.³⁸⁰ Barnard Fuller was educated at the South African College, and went on to qualify as a doctor at Edinburgh University, graduating with first class honours in 1891. He returned to Cape Town in 1892³⁸¹ and was appointed as health officer in 1894. Although his appointment was on a part-time basis, he was able to make a significant impact on the council. He wasted no time after his appointment in bringing the attention of the town council to the high number of deaths from tuberculosis, especially among the Coloured population.

In 1894 Fuller reported that there had been 1 520 deaths that year, of whom 922 were Coloured residents; of these, 202 deaths were from phthisis and other diseases of the respiratory system. By comparison, there were only 136 deaths from this cause among white residents. The Coloured deaths from tuberculosis pointed to overcrowding, dampness, and the general insanitary state of the homes of the majority of the Coloured population.³⁸² In the following year the death rate in Cape Town was 36,21 per 1 000 of population, split between 26,83 for whites and 45,70 for Coloureds.³⁸³

Consumptives from Abroad

Fuller felt that the majority of the tuberculosis deaths among white people were consumptives who had come to the Cape from abroad 'for the benefit of their health'. Most of them were in the final stages of pulmonary tuberculosis on their arrival. Fuller felt strongly that advanced cases should never be sent away from their homes because in his view this inevitably led to an early death without comfort and care to ease their last moments. He believed that all medical practitioners should

³⁸⁰ W.J. de Kock (ed.), *Dictionary of South African Biography, Vol I* (Pretoria: National Council for Social Research, 1968), 304.

³⁸¹ D.M. Dent and G. Perez, 'History, the Place and the Person: Named Buildings on the Campus of the Faculty of Health Sciences, University of Cape Town. *SAMJ*, 102, 6 (June 2012), 396.

³⁸² CA, 3/CT 1/7/1/3, Corporation of Cape Town, Minute by Mayor Woodhead for Mayoral Year ending 27 September 1894 (Cape Town: Townshend, Taylor & Snashall, 1894), 74-76.

³⁸³ By way of comparison, the death rate in Cradock for the same year was whites at 21,07 and Coloureds at 38,20 per 1 000 of population. The higher death rate among those of European descent is attributed to the popularity of the town as a health resort for consumptives. See 'Public Health Report of the MOH for the Cape Colony (Dr G.E.O. Turner) for the Year 1895', *South African Medical Journal* (hereafter *SAMJ*), (October 1896), 137.

warn their colleagues and the public in Britain and elsewhere of the futility and cruelty of sending those who were showing symptoms of advanced phthisis on long, arduous voyages to other countries. At the same time he realised that it was impossible, nor did he recommend, the complete ban of entry of early cases that could possibly benefit from the climate.³⁸⁴

Consumptives from abroad presented several challenges for Cape Town health officials. As the first port of call for the majority of ships from Britain, it was crucial that a plan be put in place. Those in an advanced stage of the disease were invariably taken directly from the ship to the Somerset Hospital.³⁸⁵ There were others who were suffering from active disease and whose sputum posed the threat of infection to the local population. Because such cases generally sought accommodation in the local hotels and boarding houses, Fuller felt it was vitally important that the proprietors should be educated about the disease, particularly that it was highly infectious. A circular was drawn up in English and Dutch in 1899 setting out the precautions that consumptives should take to protect themselves and others. It also offered precautionary advice to hotel keepers and others about how to clean the rooms which were or had been occupied by consumptives. The hotel keepers were also encouraged to report deaths of consumptives to health officers so that an inspector could be sent out to disinfect the premises. This service was offered free of charge by the council.³⁸⁶

It was Fuller's intention to educate the public about tuberculosis at every opportunity. The distribution of the circular was a major step in the right direction in educating ordinary Cape Town residents. By wording the circular in such a way as to offer constructive advice, rather than blame, Fuller did his best to ensure that the consumptives themselves were not stigmatised. In addition, by enlisting the cooperation of the hotel and boarding house proprietors Fuller's staff were able to ensure that the premises were disinfected and made safe for future occupants. By

³⁸⁴ E.B. Fuller, 'Public Health', *SAMJ* (September 1897), 127.

³⁸⁵ CA, Archives of Cape Colony Colonial Office (hereafter CO), CO 7597-963, Correspondence between Board of the Somerset Hospital and the Colonial Secretary, 7 February 1899.

³⁸⁶ Editorial: 'Some Points for Discussion on Prevention of Tuberculosis', *SAMJ* (August 1899), 88.

taking this approach, Fuller was able to report that he had never heard of a case where the distribution of the circular had prevented anyone from getting a night's lodging.³⁸⁷

The constant arrival of consumptives from abroad not only proved a challenge for the city's health department, it also placed severe strain on the Somerset Hospital. The board of managers reported that consumptives were arriving on virtually every incoming steamer in a hopeless condition, with very little chance of recovery, and often they had no funds to provide for their expenses. The hospital board felt that it was:

... positively criminal and inhuman to send out cases practically in the last stages without fair and reasonable hope of recovery, and thus to expose them to a cruel exile among strangers, culminating in their early death far from friends and home.

It cited an example of a young boy aged 14, who had been sent to the Cape by a philanthropic institution, who had landed in Cape Town in the last stages of the disease with ten shillings in his pocket and without knowing a single person in the country. He had been taken directly to the hospital, which did not generally admit such cases, only to die within a few weeks of his arrival. The hospital board went on to stress that for consumptives to benefit from the climate they had to be in the early stages of the disease upon their arrival, and should have sufficient funds to sustain themselves for at least twelve months. It also added that the seaports were extremely prejudicial to the patients and that they needed to proceed inland as soon as possible. It concluded by stating that the labour market in Cape Town was overcrowded, making it difficult, even for those in the best of health, to find employment. This letter from the Somerset Hospital Board was sent to the Cape colonial secretary, with an appeal for him to bring the matter to the attention of the London immigration agent.³⁸⁸ It was also published in the *Cape Times* newspaper,

³⁸⁷ Ibid.

³⁸⁸ CA, CO 7597-963, Correspondence between the Board of Managers of the Somerset Hospital and the Colonial Secretary, 7 February 1899.

the *South African Medical Journal (SAMJ)*, the *Lancet* and the *British Medical Journal (BMJ)*.³⁸⁹

Fortunately, it was at about the same time that the popularity of the Cape as a health resort started to decline in Britain and Europe. This was largely because of the lack of suitable accommodation and the unsatisfactory sanitary state in most of the towns in the colony, including Cape Town.³⁹⁰ However, while the Cape was no longer popular among well-to-do sufferers, it still remained an important destination for the middle classes from Britain.

Despite Fuller's best efforts, the death rate from pulmonary tuberculosis continued to climb, and by 1899 it was claiming the lives of one out of every eight people of European descent, and one out of every six Coloured people. It was therefore the greatest cause of mortality in Cape Town.³⁹¹ What was needed was a new impetus in the fight against the disease. This came, not from the Cape, but from the increased awareness of the disease on the international front and in particular, from Britain's decision to establish a branch of the Association for the Prevention of Tuberculosis in 1898.³⁹²

Increase in Awareness of Tuberculosis

Britain joined the Association for the Prevention of Tuberculosis in 1898 and extended an invitation for the Cape Colony to join the association.³⁹³ This was the opportunity that Fuller had been waiting for. He immediately approached the Cape Town council, stressing that the city was in a unique position to play a leading role in

³⁸⁹ F.E. St. Leger, 'Consumptive Patients in Cape Town', *British Medical Journal* (hereafter *BMJ*), (21 January 1899), 192; and F.E. St. Leger, 'Somerset Hospital', *SAMJ* (January 1899), 200.

³⁹⁰ NLSA, G37-1899, *Cape of Good Hope, Reports of the Public Health Department for the Year 1898, including Reports of District Surgeons, Local Authorities and Medical Inspectors* (Cape Town: Government Printer, 1899), 107.

³⁹¹ CA, 3/CT 1/7/1/6, Health Report appended to Mayor's Report, 1899, cviii.

³⁹² See discussion in Chapter 2.

³⁹³ 'Some Points for Discussion on the Prevention of Tuberculosis', *SAMJ* (August 1899), 87. The formation and role of the Association for the Prevention of Tuberculosis is discussed in the next chapter.

the fight against tuberculosis.³⁹⁴ He believed that although the efforts of the council up to that point had helped to keep the Coloured death rate in check, more needed to be done. He added that he felt sure that the 'council, who have ever shown a disposition to have their Health Department in the van[guard] of sanitary progress, would be anxious to take its full share in helping to reduce the large mortality from tuberculosis'.³⁹⁵ With the buy-in from the council, Fuller was able to tackle tuberculosis with a new gusto.

Fuller was aware that from a practical point of view, there were a number of issues which needed to be addressed. As the identities of tuberculosis sufferers only became available when they died, he needed to know the location of existing patients so that they could be educated on precautionary measures to prevent the spread of the disease. An appeal was sent to all medical practitioners in Cape Town requesting them to notify the city's health department of any cases that came to their attention so that he could gauge the full extent of the problem, and provide the sufferers with educational material if they did not have a medical practitioner.³⁹⁶

The educational material provided by the Association for the Prevention of Consumption was a cost-effective solution and became the first step in the prevention of the disease.³⁹⁷ However, it was the middle-class white residents who gained the most benefit from these initiatives. It was precisely this group, as the more well-to-do white members of Cape society, who were the least affected by the disease. What was needed was a strategy to deal with other, less privileged residents, in particular those for whom poverty was endemic. It was these people, including impoverished whites, Coloureds and blacks, who were the most vulnerable to contracting tuberculosis.

³⁹⁴ This comment relates to Cape Town's position as the first port of call for ships from abroad, and the high death rate experienced among the Coloured residents.

³⁹⁵ CA, 3/CT 1/7/1/6, Health Report appended to Mayor's Report, 1899, cviii.

³⁹⁶ Ibid., cx. Compulsory notification only came into effect in the Cape Colony in 1903.

³⁹⁷ See Chapter 5.

The most urgent need was to address the social conditions, especially housing. The Cape Town council was aware of the housing shortages in the city. In 1897 this culminated in the construction of labourers' barracks, which provided accommodation for approximately 200 persons. This building was leased to the Salvation Army and came to be known as the 'Workmen's Metropole'.³⁹⁸ This initiative catered initially for the needs of the white, middle-class members of Cape society and made no provision for Coloured people. The Salvation Army also had a night-shelter which was opened in Anchor Street in 1883 providing cheap accommodation for able-bodied, unemployed white people.³⁹⁹ They were further advantaged by educational programmes and public works programmes.⁴⁰⁰

The provision of employment to these impoverished whites via public works programmes enabled them to obtain better nutrition and an improved standard of living than would otherwise have been the case. Although these measures did not prevent them from succumbing to tuberculosis it did increase their ability to deal with the disease. It was a clear manifestation of who Cape society believed to be 'the deserving poor'.

The South African War (1899-1902) and the Outbreak of Plague

With Cape Town's housing shortage already pushed to its limits, the worst was yet to come. By 1898 the colony was already sliding into a depression, precipitated by natural disasters such as drought and the rinderpest epidemic on the one hand, and troubles in the Transvaal contributing to a collapse of the share market on the other.⁴⁰¹ Unemployment began to rear its head as indigent refugees from the Witwatersrand began to flock into the city after October 1899 following the outbreak of the South African War. In order to deal with the large influx of refugees, the mayor set up a Relief Fund. Although it was part of a general relief fund and not

³⁹⁸ CA, 3/CT 1/7/1/5, Mayor's Report, 1898, 2-3; Van Heyningen, 'Public Health and Society', 438-439, 450-451.

³⁹⁹ Van Heyningen, 'Public Health and Society', 428-429. After objections were raised, this was extended to include the 'better and cleaner class of Coloured people' in 1905.

⁴⁰⁰ Bickford-Smith, *Ethnic Pride*, 119.

⁴⁰¹ Van Heyningen, 'Public Health and Society', 286.

specifically geared towards the sick, it did provide assistance to a number of white consumptives who were in an advanced stage of the disease.⁴⁰² By the time the Rand Relief Fund closed down in November 1902, it had assisted 11 800 individuals.⁴⁰³ Added to the refugees, Cape Town also had to deal with the imperial troops, many of whom entered the Cape through Cape Town.

As the war was conducted mainly on horseback it was necessary to import a large number of horses. Forage for their feeding was in short supply owing to the drought so that too had to be imported. The rats and fleas that accompanied the forage carried the plague bacillus and was responsible for the outbreak of the bubonic plague.⁴⁰⁴ Once the plague broke out in Cape Town in February 1901, the government was sufficiently concerned to take over all plague control and related expenditure in the city.⁴⁰⁵

One of the first actions of the Cape government was to rush a black township into existence under the *Public Health Act of 1883* at a forest station called Uitvlugt (later called Ndabeni), several miles from the town on the Cape Flats. In the midst of the plague during March 1901, some six or seven thousand blacks were moved to this township. By September 1901 the plague had receded in Cape Town. The death toll was high. Of the 807 cases of plague there were 389 deaths, 69 of whom were of white, 244 were Coloured people and 76 were blacks.⁴⁰⁶

The plague outbreak also had important long-term implications for the public health department because it enabled Gregory to assert its independence from the Cape colonial office. He later admitted that without the epidemic he could not have established a separate health administration.⁴⁰⁷

⁴⁰² CA, CO 7597, Correspondence between Revd Bender, the MOH and Colonial Secretary, undated.

⁴⁰³ CA, 3/CT 1/7/1/9, Corporation of the City of Cape Town, Minutes of his Worship the Mayor (Thorne) for Mayoral year ending 11 September 1902, 171.

⁴⁰⁴ M.W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1901', *Journal of African History*, 8, 3 (1977), 392.

⁴⁰⁵ Van Heyningen, 'Public Health and Society', 313.

⁴⁰⁶ Swanson, 'The Sanitation Syndrome', 394.

⁴⁰⁷ Van Heyningen, 'Public Health and Society', 323.

Anderson Takes over as Medical Officer of Health

Fuller resigned as the medical officer of health in 1901, since he felt that the time had come for a full-time appointment to be made.⁴⁰⁸ He had held the position for nearly eight years on a part-time basis, and made valuable strides in creating an awareness of tuberculosis, both within the council itself and among the population in general. This impact was not limited to Cape Town. In 1896 he was appointed as the editor of the public health section of the *South African Medical Journal (SAMJ)*, and he used this as a platform for constantly bringing the control of tuberculosis to the attention of medical practitioners throughout the colony.⁴⁰⁹ As a member of the South African branch of the British Medical Association, he was also able to influence that body by taking an active part in their discussions and providing details of the manner in which Cape Town was dealing with tuberculosis.⁴¹⁰ Fuller's efforts were considerably ahead of those of the public health department of the colony, and paved the way for Cape Town's city council to take the lead in the fight against the disease in the longer term, right up to and including the passing of the *Public Health Act of 1919*. Fuller was elected as a member of the city council in 1902 and appointed as the chairman of the health and building regulations committee.⁴¹¹ He was therefore well placed to ensure a smooth transition to his successor.

The person selected to take over from Fuller was Dr (Alfred) Jasper Anderson, who had held the full-time position of medical officer of health for the Blackpool corporation in Britain for the previous ten years. In that position he not only headed the health department but was in charge of the infectious diseases hospitals, slaughter houses and other bodies concerned with public health and for their

⁴⁰⁸ CA, 3/CT 1/7/1/8, Health Report appended to the Mayor's Report, 1901, cxliii.

⁴⁰⁹ E.B. Fuller, 'Public Health' *SAMJ* (April 1896), 335.

⁴¹⁰ Editorial, 'Some Points on the Prevention of Tuberculosis', *SAMJ* (August 1899), 87.

⁴¹¹ CA, 3/CT 1/7/1/9, Mayor's Report, 1902, 2.

bacteriological work.⁴¹² He was therefore very well qualified for the position in Cape Town.

Anderson soon became aware of the high death rate in Cape Town. The combined impact of the South African War and the poor living conditions that had been exposed by the plague meant that the improvement of sanitary conditions remained a key focus area. His first step was to reorganise the sanitary department. Among their other duties, the sanitary inspectors had the responsibility of moving people suffering from infectious diseases to hospitals (when beds were available) and for disinfecting the premises. Lodging houses and hotels were also routinely checked by the inspectors.⁴¹³

Anderson and the Fight against Tuberculosis

From the very outset, Anderson was determined to tackle the problem of tuberculosis in the city. In his first report, issued in 1902, he drew attention to the high death rate, especially among the Coloured residents, which stood at 9,55 per thousand (as opposed to 2,84 among white residents). He attributed this high mortality rate to the habit of expectorating onto the pavements; damp dwellings which lacked ventilation and sunshine; as well as to unhygienic 'ingrained habits'. Anderson called for the prevention of damp and the efficient lighting and ventilation of occupied rooms.⁴¹⁴ These were 'common-sense' measures which failed to take into account the slum conditions under which many of the poor lived and that windows were not opened in an effort to keep out the cold rather than to exclude ventilation. Anderson was also keen to put measures in place for the compulsory notification of the disease.

⁴¹² Anderson was a member of the Royal College of Surgeons and held the degrees MA, Bachelor of Medicine and a Diploma in Public Health. He also obtained First-class honours in the Natural Science School, Oxford, and was a Double Queen's Gold Medallist in Chemistry. His medical studies continued at St Bartholomew's Hospital (London) and the Universities of Oxford, Leipzig and Vienna. See CA, 3/CT 1/7/1/8, Mayor's Report for 1901, 182-183.

⁴¹³ CA, 3/CT 1/7/1/9, Health Report appended to Mayor's Report, 1902, lxxxiii.

⁴¹⁴ CA, 3/CT 1/7/1/9, Health Report appended to Mayor's Report, 1902, xc.

By the end of the war, Cape Town was still attracting consumptives from the surrounding areas who were relocating to the city in order to benefit from assistance offered by charitable institutions such as the Somerset Hospital and the Free Dispensary.⁴¹⁵ In 1903, tuberculosis remained the main cause of death in the city. Most of the sufferers were in the 15 to 45 year age group and many were unable to work for several years which in turn had serious economic implications.⁴¹⁶

Anderson's view was that one of the most important methods of curbing the spread of the disease was to prohibit expectoration, especially in public places and on pavements. The habit was of long-standing and had its origins in the eighteenth century, when spitting in public was a common and socially acceptable habit in Britain and elsewhere in Europe. Far from being frowned upon, spitting was even encouraged in etiquette manuals. Often associated with chewing tobacco, spittoons were used as containers for spit and could be found both inside and outside of public places such as public houses. By the late nineteenth century, manners had changed and there was a certain class-based repugnance at the habit of public spitting, which was reinforced by a greater awareness of the transmission of contagious diseases such as tuberculosis.⁴¹⁷ Anderson was determined to put a stop to the 'disgusting habit' and advised the council that it was universally recognised that the spread of tuberculosis was in great measure attributable to the habit.⁴¹⁸ As a first step, he proposed that pavements should be made from a non-absorbent material which could help to prevent the collection of dust and dirt (which would harbour the tubercle bacillus) and that the pavements should be cleansed regularly with seawater.⁴¹⁹ He further proposed that a regulation be promulgated prohibiting spitting and that penalties be imposed to deter offenders. He felt confident that if expectoration was prohibited; dwellings and the environment were improved; and

⁴¹⁵ CA, 3/CT 1/7/1/10, Corporation of City of Cape Town, Thorne, Minute of Mayor (Thorne) for the Mayoral Year ending 24 September 1903, 83.

⁴¹⁶ Ibid.

⁴¹⁷ <http://blog.wellcomelibrary.org/2014/03/an-anti-social-habit-in-the-war-on-tuberculosis/>
L. Kaplish, 'An Anti-social Habit and the War on Tuberculosis', Wellcome Library, Accessed 8 October 2016.

⁴¹⁸ CA, 3/CT 1/7/1/10, Mayor's Report, 1903, 84.

⁴¹⁹ CA, 3/CT 1/7/1/9, Health Report appended to Mayor's Report, 1902, xc.

that notification of cases of tuberculosis was properly carried out, the council could begin to check the spread of tuberculosis.⁴²⁰

In mid-1904 the council drafted a bye-law prohibiting expectoration in public carriages, waiting rooms and places of entertainment.⁴²¹ This was later extended to include public pavements. An abridged version of the bye-law was finally approved by government. The prohibition was limited to adult males and the fine reduced to forty shillings. Anderson was mystified and immediately, with justification, queried why young men and women were excluded. However, to avoid further delays in its implementation, the council opted to accept the bye-law on the understanding that it would apply for an extension of the provisions at a later stage.⁴²²

Initially the prohibition worked well in Cape Town, and it was unnecessary to institute any prosecutions for non-compliance.⁴²³ However, by 1909 people were beginning to disregard the regulation. The police were requested to ensure compliance, and enforcement was secured after several prosecutions.⁴²⁴ In 1913 the expectoration regulation was amended to apply to all persons and the penalty was raised to £3 for each offence, alternatively one month's imprisonment, with or without hard labour. To publicise the change, posters were displayed in English and Dutch in public streets with the inscription: "Don't spit, Penalty £3".⁴²⁵ Ultimately the prohibition only became law in 1917.⁴²⁶

Although Anderson had limited success in prohibiting the habit of expectoration, he did see his wish that tuberculosis become a notifiable disease reach fruition. In 1903

⁴²⁰ CA, 3/CT 1/7/1/10, Mayor's Report, 1903, 84.

⁴²¹ CA, 3/CT 1/1/1/58, Council Minutes, 2 June 1904. Regulation framed under and by virtue of the provisions of Section 170, Sub-section 14 of the Cape Town Municipal Act, No. 26 of 1893.

⁴²² CA, 3/CT 1/7/1/12, Corporation of City of Cape Town, Minute of Mayor (Lieberman) for Year ending 14 September 1905, 79-80; and CA, 3/CT 1/1/1/59, Council Minutes, 13 April 1905, 181.

⁴²³ CA, 3/CT 1/7/1/13, Health Report appended to Minute of the Mayor (Lieberman) for Year ending 13 September 1906, xxxi.

⁴²⁴ CA, 3/CT 1/1/1/66, City of Cape Town Mayor's Minutes, February 1909–December 1909, Meeting held on 1 July 1909, 185; and Meeting on 14 October 1909, 334.

⁴²⁵ Regulation promulgated in terms of Section 68 and 81 of the *South Africa Act of 1909*; and *Act No. 26 of 1893*. See CA, 3/CT 1/7/1/18, Corporation of City of Cape Town, Hands, Mayor. Minute of his Worship the Mayor (Hands) for Year ending 31 August 1913, 296.

⁴²⁶ *Government Gazette*, Promulgation No. 294 of 1917.

the government, on the initiative of Gregory, added tuberculosis to the list of diseases where notification was compulsory.⁴²⁷ Anderson immediately communicated with all medical practitioners in the greater Cape Town area, drawing their attention to the proclamation. He confirmed that the amount of two shillings and six pence (2/6d, a generous amount at the time) would be paid for each notification. He added a form for the medical practitioners to complete and return to him, reassuring them that if they did not want the sanitary inspectors to visit their patients, they simply had to endorse the form with the words 'do not call' and the patient's privacy would be respected.⁴²⁸ This guaranteed the dominance of the medical profession over the sanitary inspectors.⁴²⁹ He also enclosed a circular which could be distributed to patients, detailing the measures they should take to prevent the spread of the disease.⁴³⁰ In addition he undertook to arrange for a bacteriological examination of any secretions which were sent to him.⁴³¹

Anderson's leading role in providing information to medical practitioners about the need to notify cases of tuberculosis, and putting measures in place for dealing with these notifications, put Cape Town at the forefront in the fight against tuberculosis.⁴³² The publication of Cape Town's medical reports and statistics in the monthly *South African Medical Journal (SAMJ)* ensured that district surgeons throughout the colony were aware of the council's efforts and were reminded of the steps that Cape Town was taking in the fight against tuberculosis. Anderson was not alone in bringing publicity to the disease. He was aided by the activities of the Association for the Prevention of Consumption that was at its most active at this time.⁴³³

⁴²⁷ *Government Gazette*, Proclamation No. 93-1903.

⁴²⁸ CA, Archives of the Medical Officer of Health for the Cape Colony (hereafter MOH), MOH 195-86, Correspondence Dr A.J. Anderson to Dr Gregory, MOH for Cape Colony, 21 May 1904.

⁴²⁹ The sanitary inspectors employed by the Cape Town council were required to hold a certificate issued by the Royal Sanitary Institute. (3/CT 1/1/1/72 MM 15 October 1915, 164).

⁴³⁰ CA, MOH 195-86, Correspondence between Corporation of Cape Town, Dr A.J. Anderson to Dr Gregory, MOH for the Cape Colony, 21 May 1904.

⁴³¹ CA, 3/CT 1/7/1/10, Health Report appended to Mayor's Report, 1903, vii.

⁴³² This was in sharp contrast to the lack of guidance provided to other local authorities by the public health department, as discussed in Chapter 3 in the case of Cradock.

⁴³³ The role played by the Association for the Prevention of Consumption is discussed in Chapter 5.

Despite Anderson's best intentions, the notification of tuberculosis had special difficulties of its own, arising from the nature of the disease. Tuberculosis was very difficult to diagnose at a time when diagnostic tools were not readily available (use of the tuberculin test was not widespread) which meant that the disease was often not notified in its early stages when the taking of precautions would be most effective.⁴³⁴

Other difficulties arose from multiple notifications over an extended period of time. It was also a challenge to keep track of the sufferers because many of them changed addresses without leaving details of their new whereabouts. To remedy this particular problem, inspectors called on sufferers in their district on a regular basis and reported back on their ability to work; whether or not they were confined to bed; the state of cleanliness and ventilation of the room; and if they were making use of spit cups.⁴³⁵ In cases where deaths occurred, or when sufferers moved from one address to another, the premises were disinfected.⁴³⁶

The forms received from medical practitioners in outlying areas provided the Cape Town health department with valuable information and in some cases allowed the sanitary inspectors to call on sufferers and educate them while they were still in the early stages of their disease. However, in a town where approximately 18 per cent of the whites and about 60 per cent of Coloureds could neither read nor write it was vital that the information be conveyed orally as well.⁴³⁷ At the same time the inspectors attempted to gain information on the possible source of the disease to ensure that all practical precautions could be taken to minimise its spread.⁴³⁸ This method of enquiry brought to light cases which required isolation, and as far as possible the advanced cases were accommodated at the Old Somerset Hospital.⁴³⁹

⁴³⁴ CA, 3/CT 1/7/1/13, Health Report appended to Mayor's Report, 1906, xxix.

⁴³⁵ Ibid., xxiv.

⁴³⁶ Ibid., xxix.

⁴³⁷ CA, 3/CT 1/7/1/12, Health Report appended to Mayor's Report, 1905, iv.

⁴³⁸ CA, 3/CT 1/7/1/10, Health Report appended to Mayor's Report, 1903, xv.

⁴³⁹ CA, 3/CT 1/7/1/13, Health Report appended to Mayor's Report, 1906, xxix.

By 1906 the sanitary department inspectors were visiting 69 sufferers each fortnight to check how they were progressing. Most were unable to work because they were in an advanced stage of the disease. Some were not being properly cared for and were 'distributing infection far and wide'. Anderson's opinion was that the department's efforts to prevent the spread of tuberculosis were largely futile in cases such as these because without the facilities for their care, much of the advice provided to sufferers could not be acted upon.⁴⁴⁰

Although the Cape Town health department was doing everything it possibly could to minimise the spread of infection from tuberculosis, resentment did begin to set in against the sufferers. By 1906, hotels and boarding houses were refusing to accommodate individuals who displayed symptoms, regardless of how wealthy they were. Faced with no alternative, these individuals had to be accommodated at the City Hospital.⁴⁴¹

Shortage of Hospital Accommodation Reaches a Crisis Point

For those who were destitute, the situation was dire. By now the need for hospital accommodation or a sanatorium was becoming urgent. The Old Somerset Hospital was notoriously inadequate and the planned Alexandra Hospital, in which there were to be separate wards for the treatment of 100 tuberculosis cases, was not yet ready.⁴⁴²

In 1906, seeing no other way forward, Anderson appealed to the city authorities to place funds on the budget for the prevention of tuberculosis. He made two proposals, the first being to ask whether the government would grant the city health

⁴⁴⁰ Ibid., xxx. Anderson felt there was a need for a commission appointed by the governments of all South African colonies to establish the best way prevent tuberculosis. He had this matter raised at the Federal Council of Municipal Associations of SA. See CA, 3/CT 1/7/1/13, Health Report appended to Mayor's Report, 1906, xxxi. This is discussed in detail in the next chapter.

⁴⁴¹ Ibid., xxix-xxx.

⁴⁴² The hospital was used by the military during WW1, and for mentally challenged patients after 1920. See *South African Medical Record* (hereafter *SAMR*), 13 May 1915; CA, 3/CT 1/4/7/1/1/9, Health and Building Regulations Committee Minutes (11 September 1917 to 20 August 1918), Meeting on 11 April 1918, 116; and *SAMR*, 20 January 1920, 38. It was never made available to tuberculosis patients.

department the use of a corrugated iron building from the eviction camp at Maitland. Anderson suggested that this could be erected in the grounds of the City Hospital and used to accommodate 20 patients. This building, he explained, could also be used to teach poor people about preventative measures that could be taken against the disease in the hope that they would pass on this information to their own communities. It would also be used to accommodate poor, bedridden sufferers in an advanced stage of the disease, for whom there was quite simply no alternative accommodation.⁴⁴³

Anderson's second suggestion was to establish a Tuberculosis Dispensary on the lines of the one founded by Dr Philip at Edinburgh and similar dispensaries in France and other European countries.⁴⁴⁴ The objective was to provide free medical advice and medicines for the impoverished labourers in Cape Town. Anderson suggested it should ideally be centrally placed and be open at night so that workers would not lose any time from their employment. He pointed out that having such a facility would also increase the health department's chances of identifying individuals at an early stage of the disease.⁴⁴⁵ He felt that the council should approach the government for financial assistance and that the suburban municipalities might be encouraged to participate once the project had been started.⁴⁴⁶

In early January 1907 Anderson took a number of the council members to visit ten bedridden consumptives at their homes. These patients included both white and Coloured sufferers who were between 20 and 55 years of age.⁴⁴⁷ This was more than likely the first time that the councillors had been directly exposed to the living conditions of consumptives and judging from their support in voting for a

⁴⁴³ CA, 3/CT 4/1/1/75, Vol. 2, Corporation of City of Cape Town, Correspondence, Letter Dr Jasper Anderson to Public Health and Building Regulations Committee, 15 November 1906.

⁴⁴⁴ 'The Edinburgh Plan' was a system of institutional treatment established by Sir Robert Philip in 1887, and included institutional treatment and aftercare. See L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 91.

⁴⁴⁵ CA, 3/CT 4/1/1/75, Vol. 2, Correspondence between Anderson and Public Health and Building Regulations Committee, 15 November 1906.

⁴⁴⁶ Ibid.

⁴⁴⁷ CA, 3/CT 4/1/1/75, Vol. 2, Corporation of the City of Cape Town. Correspondence files. The visit took place on 16 January 1907.

financial contribution to be made for tuberculosis care shortly thereafter it is clear that the visit made quite an impression on them. Anderson followed up with a report in which he capitalised on their sympathy. In an emotional plea he stressed that there was an urgent need to provide hospital accommodation for advanced cases, as well as to make suitable provision for early cases with a view to curing the disease. He highlighted the fact that tuberculosis was the chief cause of death in Cape Town, being responsible for one out of every nine deaths (in the case of people of European descent) and one out of every seven Coloured deaths in 1905 and that the majority of these individuals were male adults in the prime of their lives. As the disease progressed, the wife was usually obliged to stay at home to nurse her husband. As money was obviously limited they would be forced to move to the cheapest possible accommodation, often with all the family members living together in one room. This virtually condemned the entire family to contracting the disease.⁴⁴⁸

Anderson was convinced that the reason other diseases, such as plague and smallpox, attracted more attention and had more money spent on them because of their 'more theatrical' appearance. However, the death-toll from the plague and smallpox was small in comparison to tuberculosis. There was also a great deal of money spent on leprosy, which was not as infectious or as common as tuberculosis.⁴⁴⁹ Anderson believed it was high time that the government made a similar financial contribution towards the care of tuberculosis sufferers. He proposed that much could be achieved by the addition of a small ward at the City Hospital.⁴⁵⁰

The Move towards Cooperation between Municipalities: Lack of Government Assistance

Once it was decided to approach government for assistance with the provision of additional hospital accommodation, it was felt that better results would be achieved if all the various mayors and medical officers of health in the Cape Peninsula

⁴⁴⁸ Ibid., Undated notice by Dr Jasper Anderson (possibly 16 January 1907).

⁴⁴⁹ Ibid.

⁴⁵⁰ Ibid.

combined their efforts. This was discussed at a conference of mayors and municipal medical officers of health held in May 1907. Gregory attended the meeting which was chaired by the mayor of Cape Town. The municipal medical officers who attended the meeting included Drs M. Hewat, Eyre, Batchelor, Griffin, Charles Anderson, A. Jasper Anderson, and F. Murray, the last named in his capacity as mayor of Sea Point. The mayors of Woodstock and Claremont also attended the meeting.⁴⁵¹ The mayor of Cape Town spoke of the alarming increase of tuberculosis, especially among the Coloured population and called for the appointment of an inter-colonial commission to take steps towards providing hospital accommodation for indigent persons suffering from tuberculosis, as well as the need to place some check on the new consumptive arrivals from Europe. It was decided to arrange for a deputation to the Cape colonial secretary to discuss these issues.⁴⁵²

Discussions with the colonial secretary met with some success and twelve beds were made available for consumptives at the Old Somerset Hospital.⁴⁵³ However, those wanting to make use of these facilities had to go through a complex procedure of approaching their local medical officer of health, who in turn had to approach Gregory to secure a bed in a hospital.⁴⁵⁴ Three months later only one case had been admitted. Several others died before admission could be arranged.⁴⁵⁵ The reaction to the arrangement was far from positive, especially as sufferers were placed in general wards together with those unaffected by the disease and this could result in the spread of the disease.⁴⁵⁶ Shortly thereafter the Victoria Cottage Hospital in Wynberg

⁴⁵¹ 'The Tuberculosis Question: Conference at Cape Town', *SAMR* (10 May 1907), 140.

⁴⁵² *Ibid.*, 140. There were demands to take steps to prevent consumptives, especially those who were poor and in late stages of the disease, from coming to the colony. This is discussed in Chapter 8.

⁴⁵³ CA, MOH 317-G117a, Letter from Municipality of Simonstown to Town Clerk, Simonstown, regarding isolation of tuberculosis sufferers, 12 August 1907.

⁴⁵⁴ CA, MOH 317-G117, Letter from Dr Percy Stubbs, MOH Wynberg to Mayor of Cape Town, 15 August 1907; 3/CT 1/7/1/15, Corporation of the City of Cape Town, Minute of Mayor (Baxter) for Mayoral Year ending 17 September 1908, 55. Gregory admitted, in the *Tuberculosis Commission Report, 1912*, that the hospital accommodation set aside by the government in the Old Somerset Hospital, was 'very inadequate and unsuitable'. See NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 19.

⁴⁵⁵ CA, MOH 317-G117a, Memorandum from A.J. Gregory, MOH of the Cape Colony, to the Cape colonial secretary, 22 November 1907.

⁴⁵⁶ CA, MOH 317-G117a, Letter from J. R. Finch, town clerk, Corporation of Cape Town to MOH for the Cape Colony, 14 November 1907.

circulated a letter to all hospitals in the Peninsula stating that it was 'undesirable' to admit tuberculosis patients. This letter was forwarded to the colonial secretary by the board of the Somerset Hospital, with an appeal that the government erect corrugated iron houses at Maitland on the site of the Alexandra Hospital, so that all the cases from the Somerset Hospital and those barred from other facilities in the Cape could be housed there.⁴⁵⁷

This change of attitude by the smaller hospitals meant that it was becoming increasingly difficult for patients who had the means to pay for hospital accommodation to receive treatment anywhere in Cape Town. With the procedural obstacles of accessing the twelve beds set aside by government, the lack of hospital accommodation for tuberculosis sufferers was reaching a crisis point.

Another high-level deputation from the Cape Town council to the colonial secretary followed. This meeting was doomed to failure even before it took place. In preparation for the meeting, Gregory prepared a memorandum to the colonial secretary in which he made no secret of his hostility towards the hospital authorities, accusing them of doing nothing beyond deputising and making strong representations to the government to provide the means for isolating people with tuberculosis. His resentment was based on a number of factors, chief of which was his protection of the government purse. The criticism of his handling of the allocation of the twelve beds at the Old Somerset Hospital (mentioned above), would not have helped matters. However, at the root of Gregory's hostility was his view that because tuberculosis had been proclaimed a notifiable disease in 1903, he considered that it was the *duty* of local authorities to take steps to prevent its spread. He went on to state that under these provisions the government was not required (nor indeed was it entitled) to contribute towards any portion of the expenditure incurred by a local authority in the carrying out of its duties. He added that the suggestion that government should immediately provide accommodation

⁴⁵⁷ CA, MOH 317-G117a, Letter from secretary/treasurer of the Somerset Hospital to colonial secretary, 11 November 1907.

on a large scale was quite impracticable, and that while government should provide for the treatment of destitute advanced cases, it was up to private and voluntary organisations to provide sanatoria. Referring to the criticism that the government had taken far more rigorous steps to isolate sufferers in the case of leprosy and that strong measures had been taken at the time of the plague outbreak, Gregory advised that this was because there were relatively few lepers and people suffering from plague. He could not resist one last 'dig' at the local authority – one which encapsulated his views about tuberculosis – that, in his view, tuberculosis was an easily controlled disease if the people themselves took appropriate steps. The main duty rested on the local authority to prevent overcrowding and improve domestic sanitation, and to act on notification by disinfection and instructing the patient on measures to prevent the spread of the disease.⁴⁵⁸

Against this background, it was hardly surprising that the colonial secretary's response to the plea for hospital accommodation and isolation of patients admitted to the Old Somerset Hospital was unsympathetic. In a brief letter he responded, stating that by setting aside the twelve beds at the hospital, he believed that government was doing its best to assist in the prevention of the spread of the disease, and that he felt certain that the hospital authorities would take precautions to ensure that the disease was not spread among the other patients at the hospital.⁴⁵⁹

By this time, the Cape Town council was exasperated because negotiations had clearly reached a stalemate with the government refusing to budge from its position. Faced with no alternative, the council decided to take the matter into its own hands. In 1908 it placed £1,000 on the budget estimates for the suppression of tuberculosis because, as Morris Alexander, one of the councillors pointed out, approaches to the government were a 'waste of time'.⁴⁶⁰

⁴⁵⁸ CA, MOH 317-G117a, Memorandum from A. J. Gregory, MOH of Cape Colony to the colonial secretary, 22 November 1907. Emphasis from the original memorandum.

⁴⁵⁹ CA, MOH 317-G117a, Letter from Noel Janish, under colonial secretary to Mr Finch, town clerk, Corporation of Cape Town, 4 December 1907.

⁴⁶⁰ *South African News*, 29 January 1908.

Anderson, after careful consideration, came to the conclusion that the best way to use these funds would be to put up five shelters for the accommodation of sufferers from tuberculosis. Each shelter had two beds, and were intended for males who had been resident in Cape Town for two years prior to admission. There also had to be some likelihood of improvement. These patients were initially admitted for six weeks, which could be extended by a further six weeks. During the period of treatment the patient had to perform certain unspecified exercises so that his condition could improve and he would be able to return to his ordinary employment once he had been discharged. All decisions relating to admission and the length of their stay were to be made by Anderson, whose decision was final. These shelters were erected at a cost of £289 and were completed in September 1909.⁴⁶¹ Female patients were accommodated at the Infectious Diseases Hospital.⁴⁶² The shelters were never full, and usually only occupied by about six or seven people. The main problem was that it was extremely difficult to persuade patients to undergo treatment in the early stages because they could not afford to be unemployed and in any event, they did not appreciate the necessity for treatment.⁴⁶³ There were some favourable results reported on the patients who agreed to undergo treatment. Success was attributed to good and plentiful food, careful nursing, attention to detail in matters of hygiene, graduated exercise and the advantages of fresh air.⁴⁶⁴

It was several years before additional accommodation was made available for tuberculosis sufferers. In 1911 it was decided to erect an additional ward for those suffering from tuberculosis at the City Hospital at the cost of £400.⁴⁶⁵ This consisted of a ward for ten female patients, allowing for five beds on the open stoep. This

⁴⁶¹ CA, 3/CT 1/7/1/15, Mayor's Report, 1908, 40-41; CA, 3/CT 4/2/1/1/77 491/10, Correspondence: City Engineer's Department, Letter, deputy acting city engineer to Public Health and Building Regulations Committee, 2 September 1909; A.M. Gray, 'Introduction to the Special Discussion, Medical Section, South African Medical Congress, 1910', *SAMR* (November 1910), 282.

⁴⁶² CA, 3/CT 1/7/1/16, Health Report appended to Mayor's Report, 1910, xxx.

⁴⁶³ Gray, 'Introduction to the Special Discussion', 282.

⁴⁶⁴ CA, 3/CT 1/7/1/16, Health Report appended to Mayor's Report, 1910, xxxii.

⁴⁶⁵ CA, 3/CT 1/1/1/66b, City of Cape Town, Mayor's Minutes, December 1910 – November 1911, Meeting held on 10 August 1911, 302.

accommodation was restricted to Cape Town cases only, and to those patients likely to benefit from open-air treatment.⁴⁶⁶ Just when the prospects of ever solving the problem of accommodating tuberculosis patients seemed to be helpless, John Garlick, a Cape Town businessman and member of parliament, made a generous donation of £25,000 towards the establishment of a sanatorium.⁴⁶⁷ The offer was made subject to certain terms and conditions that are discussed in Chapter 5. Ultimately the hospital was opened at Nelspoort in 1924.

Cape Town's city council never quite solved the problem on hospital accommodation; it was always hopelessly inadequate and did not even begin to touch the real sufferers, the Coloured poor. The council did, however, have another way of reaching out to sufferers. This was through the Free Dispensary.

The Free Dispensary and Notifications of Tuberculosis

Anderson saw the potential of opening the Free Dispensary as a means to reach out to tuberculosis sufferers. He estimated that there were approximately 4 000 individuals suffering from the disease in 1907.⁴⁶⁸ From 1908 he made arrangements that the dispensary would remain open for consultations on Friday afternoons and at night so that patients would be able to come for assistance without losing time from their employment.⁴⁶⁹

By 1908 the notification process had already been underway for five years. Anderson's initial efforts to ensure that medical practitioners were aware of the system was beginning to pay dividends in that the number of notifications was increasing steadily. In this regard Cape Town's efforts were well in advance of other local authorities in the Cape, who were for the most part ignoring their responsibility to notify cases of the disease. In Cape Town the sanitary inspectors were still visiting

⁴⁶⁶ CA, 3/CT 1/7/1/18, Health Report appended to Mayor's Report, 1913, xl.

⁴⁶⁷ CA, 3/CT 1/7/1/21, Corporation of City of Cape Town, Hands, Mayor. Minute of his Worship the Mayor (Hands), for Year ending 9 September 1918, 21.

⁴⁶⁸ CA, 3/CT 1/7/1/14, Health Report appended to Minute of Mayor (Lieberman) for Mayoral Year ending 12 September 1907, xxii.

⁴⁶⁹ CA, 3/CT 1/1/1/64, Mayor's Minutes, July 1907–March 1908. Meeting on 28 January 1908, 300.

sufferers who did not have their own medical practitioners and there was an increased awareness of the disease and the best way to prevent its spread. What was particularly encouraging was the number of notifications that were being received on the incidence among Coloured residents, who might have otherwise fallen through the cracks. The following table gives an indication of the number of notifications received.

Table 4.2: Number of Notifications of Tuberculosis, Cape Town 1903-1910⁴⁷⁰

Year	Notifications (white sufferers)	Notifications (Coloured sufferers)
1903-1904	53	91
1904-1905	126	249
1905-1906	80	280
1906-1907	122	282
1907-1908	90	308
1908-1909	80	313
1909-1910	111	347

One of the problems of the notification process was that the official list was sometimes exaggerated by the cases in which a faulty diagnosis had been made or by cases where the disease was dormant. To prevent this, patients could attend the Free Dispensary on a Friday afternoon or evening to have their diagnosis confirmed and to have their names removed from the official list. Anderson performed these consultations himself and used the opportunity to assess whether any of the people were suitable contenders for treatment at the City Hospital or the shelters which had been especially constructed for the treatment of tuberculosis cases.⁴⁷¹

⁴⁷⁰ CA, 3/CT 1/7/1/17, Health Report appended to Mayor's Report, 1912, xxxii.

⁴⁷¹ CA, 3/CT 1/7/1/17, Mayor's Report, 1911, 65. Anderson received no payment for these consultations. The funds allocated to the Free Dispensary by the city council covered the costs of maintenance.

To provide an indication of the scope of the work being done in Cape Town to prevent the spread of tuberculosis, in 1909 481 premises were disinfected after cases of were reported. In addition, 1 644 articles which might have been contaminated were disinfected.⁴⁷² In the same year regulations were implemented to prohibit the sale of second-hand mattresses, bedding and clothing that had previously belonged to a person suffering from an infectious disease, unless these items had been disinfected.⁴⁷³

Over time, more reliance was placed on the use of the tuberculin test as a diagnostic tool to gauge whether tuberculosis was present. Due to the high costs charged by the government analyst Anderson offered his services to conduct the tests at no cost to the council in 1909. The offer of free testing was extended to medical practitioners in the Cape Peninsula. Conducting these tests in his own time was a clear indication of his level of commitment to the fight against tuberculosis. It was his hope that these investigations would reveal more cases in the early stages of the disease so that they could be treated timeously.⁴⁷⁴

In 1910 political Union took place and the Cape Colony became part of the Union of South Africa. Public health matters were not high on the list of priorities for the new central government and the various colonies retained the health measures in existence prior to Union.⁴⁷⁵ With the status quo remaining as it was prior to political Union, Cape Town took several additional initiatives to curb the spread of tuberculosis. These included the appointment of a trained nurse to visit patients shortly after their health status was notified. Cases which she believed would benefit from treatment at the City Hospital were taken there if they consented.⁴⁷⁶ Any other cases of illness among other residents of the same house were noted and referred to

⁴⁷² CA, 3/CT 1/7/1/15, Health Report appended to Corporation of City of Cape Town, Minute of the Mayor (Baxter) for Mayoral Year ending 17 September 1908, xxxiv. By way of comparison, the total number of premises disinfected for all other diseases for that year was only 271.

⁴⁷³ CA, 3/CT 1/7/1/15, Mayor's Report, 1909, 37.

⁴⁷⁴ CA, 3/CT 1/7/1/16, Corporation of City of Cape Town, Minute of his Worship the Mayor (Smith) for Mayoral Year ending 19 September 1910, 77, 299.

⁴⁷⁵ See Chapter 6 for details of the public health changes which took place after Union.

⁴⁷⁶ CA, 3/CT 1/7/1/17, Health Report appended to Corporation of the City of Cape Town, Minutes of Mayor for 1911, xxxiii.

the medical practitioner; if they were poor they were referred to Anderson for diagnosis.⁴⁷⁷ The tuberculosis nurse also provided food parcels and other necessities to sufferers to ensure that they received appropriate nourishment.⁴⁷⁸ These parcels included milk, eggs, groceries, disinfectants and spit cups.⁴⁷⁹ The nurse received an annual salary of £144 and an amount of £156 was budgeted for the cost of food and other necessities, so this represented a generous contribution on the part of the city to the fight against tuberculosis.⁴⁸⁰ In 1911 alone the tuberculosis nurse made 2 770 visits, of which 451 were to white and 2 319 to Coloured residents.⁴⁸¹

Other attempts to prevent the spread of the disease included the passing of regulations in 1911 that persons suffering from infectious diseases were not permitted to work in laundries. Heavy fines of up to £10 sterling were imposed on employers allowing staff to contravene this regulation.⁴⁸² In 1916, regulations were put in place to ensure that hackney carriages and cabs used for public transport were cleansed or disinfected after being used by individuals who suffered from any contagious or infectious diseases.⁴⁸³ Hefty fines not exceeding £20 or imprisonment with or without hard labour ensured compliance by cab owners. It is likely that the sufferers had to bear the brunt of the stigma attached to their illness as a result of these regulations.

⁴⁷⁷ CA, 3/CT 1/7/1/18, Health Report appended to Mayor's Report, 1913, xxxviii.

⁴⁷⁸ CA, 3/CT 1/7/1/17, Health Report appended to Corporation of the City of Cape Town, Minutes of Mayor for 1911, xxxii. The nurse received an annual salary of £144, and an amount of £156 was budgeted for the cost of food and other necessities for tuberculosis sufferers. See CA, 3/CT 1/1/1/66b, City of Cape Town Mayor's Minutes, Meeting held on 23 February 1911, 112.

⁴⁷⁹ CA, 3/CT 1/7/1/17, Health Report appended to Corporation of City of Cape Town, Mayor's Minutes for 1912, xxxiii.

⁴⁸⁰ CA, 3/CT 1/1/1/66b, City of Cape Town, Mayor's Minutes, December 1910–November 1911, Meeting held on 23 February 1911, 112.

⁴⁸¹ CA, 3/CT 1/7/1/17, Health Report appended to Mayor's Report, 1912, xxxiii.

⁴⁸² CA, 3/CT 1/1/1/66b, City of Cape Town Mayor's Minutes, December 1910–November 1911, 378.

⁴⁸³ CA, 3/CT 1/1/1/73, City of Cape Town Mayor's Minutes, March 1916–April 1917, Meeting held on 11 May 1916, 57; Ordinance passed under the provisions of the Cape Municipal Ordinance No. 10 of 1912 and the City of Cape Town Unification Ordinance, No. 19 of 1913.

Conclusion

Cape Town was fortunate in that it had the services of dedicated health officers and sanitary officials who were driven by their training in medicine and their intimate knowledge of living conditions who were committed to do their best to prevent the spread of tuberculosis in the city. However, without the support of the town council, they would have been powerless to do anything meaningful. Through their combined efforts, and the use of effective bye-laws, they were able to help limit the spread of tuberculosis in the city. However, they failed in two main respects. The housing shortage was never adequately addressed and there was also an ongoing shortage of hospital facilities for sufferers.

Cape Town's biggest contribution to the fight against tuberculosis lay beyond the city limits. In the absence of government playing a central role, it was the city's health officials and practitioners who stepped in to fill the gap. This was done on several fronts. Fuller, in his capacity as editor of the public health section of the *SAMJ* was able to keep health issues in the spotlight. Anderson played a key role in the establishment of the South African Association for the Prevention of Consumption. The city council, by bringing the matter before the mayor's congresses and conferences, also played their part. These initiatives are discussed in Chapter 5.

Chapter 5

The Dawn of a New Era in the Fight against Tuberculosis, 1896-1910

The year 1896 saw a number of events take place on both the international and local stage which ensured that tuberculosis would not be forgotten. By 1896 more than a decade had passed since it was established that tuberculosis was caused by the tubercle bacillus. By this time there was a growing medical understanding of the disease. Medical science had advanced and it was widely known that tuberculosis was infectious and was spreading in many countries. There was clearly a need for global cooperation if any real inroads were to be made in bringing the disease under control. It was with this in mind that an Association for the Prevention of Tuberculosis was launched as part of the international campaign to eradicate the disease.¹ Once a branch had been established in Britain, the British committee extended an invitation to the Cape Colony to join the campaign. This invitation was accepted.

In this chapter the developments in the Cape Colony are seen against this international background. The Cape had its own unique set of challenges to face in the fight against tuberculosis. The awareness that disease does not respect territorial boundaries was not lost on the colonial public health department, who called for united action across the various South African colonies. This took place several years prior to political union, and in some ways anticipated Union.

While the public health department held a broad vision about disease control, what they failed to appreciate was that the local authorities did not share their expertise or commitment. Their failure to provide meaningful guidance and education to the local authorities has already been discussed in Chapter 3.

It was fortunate that there were several committed medical professionals who dedicated their own time and efforts to educate the general public and local

¹ This is discussed in more detail later in this chapter.

authorities about the ravages of tuberculosis and the steps that could be taken to prevent its spread. As already discussed, the city of Cape Town played a central role. On a wider platform health authorities were assisted by the Association for the Prevention of Consumption and several doctors, such as Dr Neil Macvicar. The various initiatives, which all interacted with one another, are discussed in this chapter.

INTERNATIONAL DEVELOPMENTS

In the early twentieth century there was a far greater public consciousness about tuberculosis than ever before. The disease, which had been a major cause of death and chronic illness throughout the nineteenth century, eventually attracted international attention. Health authorities in countries such as Britain and Sweden attributed the sudden awakening of interest mainly to the new, accurate knowledge of the disease. For decades they had recognised tuberculosis as ‘a catching disease’, but disagreement on the finer details of its transmission had stalled preventative action. Robert Koch’s identification of the tubercle bacillus in 1882 and subsequent experiments by him and other researchers had finally put an end to these deep-seated conflicts. The experiments had shown that in the majority of cases, the tubercle bacillus was transmitted from person to person by droplet infection and that it depended on the infected persons’ power of resistance whether they developed the full-blown disease or not. These new indisputable facts, so it was argued, equipped public health authorities to deal with the problem by prescribing the direction and form which an effective anti-tuberculosis campaign should take.²

The National Association for the Prevention of Tuberculosis (NAPT)

The founding of the NAPT in 1887 marked the beginning of an international campaign to eradicate tuberculosis. Its first international congress was held in Paris, followed by subsequent congresses in 1891, 1894 and 1898; another was held in

² M. Niemi, *Public Health and Municipal Policy Making. Britain and Sweden, 1900-1940* (Abingdon: Ashgate, 2007), 113.

Berlin in 1899 and one in Naples in 1900.³ It took some years before certain countries launched their own branches, for example Germany (1895); Britain (1898); Belgium (1898); Portugal and Italy (1899); Canada (1900); Denmark and Australia (in Victoria and in New South Wales) (1901); Sweden (1904); Japan (1908) and Norway and Russia in 1910.⁴ The object of the congresses was to exchange information on the experience gained throughout the world on treatment and the best methods of stamping out the disease. Subjects discussed included statistical and geographic analysis, the medical aspects of the disease, climatology and sanatoria.⁵

Britain joined the NAPT in 1898. Britain's decision to join the NAPT was at least partly motivated by the growing influence of Social Darwinism and the fear that deficiencies in the health of the nation made Britain less competitive in the struggle for survival between nations. The fact that tuberculosis was most prevalent among young adults gave the disease more prominence in the public health debate.⁶ At the time Britain was facing strong competition as a world power, particularly from Germany and the United States of America, and there was a belief that the root cause of Britain's imperial decline lay in the poor quality of its fighters and workers. This concern for national efficiency was intensified by the revelations of the poor physical condition of recruits who served in the South African War of 1899-1902, and this led to the setting up of an Inter-departmental Committee on Physical Deterioration in 1903.⁷

The campaign against tuberculosis in Britain took on an anti-urban emphasis with the disease being seen as one of the evils of urbanisation, but instead of attempting to reform urban conditions, a retreat to the countryside was seen as a solution. The NAPT also suggested that special institutions and sanatoria for the treatment of the

³ L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 5, 15-16.

⁴ *Ibid.*, 2.

⁵ Cape Archives (hereafter CA), Archives of the Cape Colony Colonial Office (hereafter CO), CO 7597-963, Correspondence between the British Congress on Tuberculosis, London and J. Chamberlain, 1 February 1901.

⁶ Niemi, *Public Health and Municipal Policy Making*, 114.

⁷ Bryder, *Below the Magic Mountain*, 21-22.

disease should be set up. Underlying this policy was a new confidence in the medical profession and what could be achieved through institutional treatment for tuberculosis.⁸ Various kinds of specialised hospitals and sanatoria appeared in the nineteenth century, including some specialist tuberculosis hospitals. Open-air treatment was also encouraged.⁹

There was an attempt to reach a wider public by establishing a tuberculosis dispensary movement with staff who would go to into the homes of patients. The first tuberculosis dispensary in Britain was set up in 1887 by Sir Robert Philip.¹⁰ There was also a strong focus placed on educating the general public about the dangers of the disease and the steps to be taken to prevent its spread, for example by condemning expectoration.¹¹

Tuberculosis treatment in Britain was given a boost when it received special attention in the 1911 *National Insurance Act*, which provided for the provision of free medical treatment by medical practitioners as well as sickness and disability benefits for insured workers. It also provided a 'sanatorium benefit'. Section 16 of the Act provided free institutional treatment for all insured persons suffering from tuberculosis, together with their dependants, as well as for the construction of sanatoria and other institutions by local authorities.¹² As a result the number of beds for tuberculosis treatment in Britain (excluding Poor Law institutions) rose from 5 500 in 1911 to 15 781 in 1920.¹³

The first two decades of the twentieth century thus witnessed the emergence of an extensive state-funded organisational network for the treatment of tuberculosis. This network viewed tuberculosis as a major *national* problem and heightened

⁸ At this stage, the medical profession encouraged more affluent patients to remain in Britain, rather than emigrating for 'the benefit of their health'. Middle class patients continued to travel to the colonies.

⁹ Bryder, *Below the Magic Mountain*, 21-23.

¹⁰ *Ibid.*, 33. A similar dispensary was established in Cape Town. See Chapter 4.

¹¹ *Ibid.*, 18.

¹² *Ibid.*, 36.

¹³ *Ibid.*, 44.

efforts in preventative work by the NAPT and the dispensaries.¹⁴ Ultimately there was a marked decline in the tuberculosis death rate. The reasons for this have been the subject of much scholarly debate, as discussed in Chapter 1.

In the next section the way the Cape Colony and its public health department approached the disease is explored.

LOCAL DEVELOPMENTS

Local developments include the role of the public health department in the fight against the disease; the work of the local branch of the Association for the Prevention of Consumption; the *South African Medical Journal (SAMJ)*; the Native Health Society and the contribution of Dr Neil Macvicar.

The Public Health Department and Tuberculosis

A government health department was established in the Cape in 1893 and was responsible for the oversight of public health in the various towns across the colony. By this time the practice of appointing district surgeons was already well established. During the 1880s the district surgeons had become the conduit through which the colonial office gained its information about the health of the rural areas. The preparation of reports made them more alert to the sanitary deficiencies of their district and keen to play their part in public health reform.¹⁵ Once the system of publishing annual reports came into operation in 1883 it gave district surgeons a new status in the colony.¹⁶ However, the relationship between them and the local authorities was not always harmonious because their reports provided the

¹⁴ Ibid., 45.

¹⁵ H. Deacon and E. van Heyningen, 'Opportunities outside Private Practice before 1860', in H. Deacon, H. Phillips, and E. van Heyningen, *The Cape Doctor in the Nineteenth Century. A Social History* (Amsterdam and New York: Rodopi, 2004), 158.

¹⁶ National Library of South Africa, Cape Town (hereafter NLSA), Official Publications (Cape Colony) Govt. Reports (hereafter G), G67-1884, *Cape of Good Hope, Reports of District Surgeons, 1883*. (Cape Town: Government Printer, 1884); and R.W.V. Rowland, 'Some Aspects of the 1912-1914 Tuberculosis Commission', BA Hons essay, University of Cape Town, 1978, 12.

government with information about conditions which would otherwise not have come under scrutiny.¹⁷

Public health was given a new status with the appointment of the first (part-time) medical officer of health for the colony in December 1893. The initial incumbent was Dr Alexander Edington. He was based in Grahamstown and therefore not at the centre of affairs. In June 1895, Dr George Turner took over the position on a full-time basis.¹⁸ In 1896 Dr John Gregory became his assistant and in March 1901 he succeeded Turner (who had left on active service in the South African War in 1900). Gregory retained this position until Union in 1910.

Gregory exercised a dominating influence over the Cape medical profession during his years in office. He was described as a man with a forceful personality, autocratic and self-confident. Although he was a very competent administrator he was not popular. There was little related to public health and local government which escaped his attention and under his guidance the provision of medical care in the Cape was far in advance of that of the other South African colonies.¹⁹

Gregory recognised that disease knows no boundaries and that health care should be consistent across South Africa. To achieve this he called for a conference of the principal medical officers of health countrywide. This was held from 13 to 26 November 1906 and was chaired by Gregory. It established working relations between the medical officers of the colonies and the machinery was set up for the effective co-operation between the different health administrations.²⁰ This move towards unification in health matters was significant because it came several years before, and perhaps anticipated, political union.

¹⁷ See Chapter 3, Cradock. The relationship between the health officers and city officials in Cape Town was an exception, that described in Chapter 3 was more common.

¹⁸ 'News of the Month', *South African Medical Journal* (hereafter *SAMJ*) (June 1895), 36-37, E.B. van Heyningen, 'Public Health and Society in Cape Town, 1880-1910', PhD thesis, University of Cape Town, 1989, 245.

¹⁹ E. van Heyningen, 'Gregory, Alfred John', in C.J. Beyers (ed.), *Dictionary of South African Biography Vol. 5* (Pretoria: HSRC, 1981), 301.

²⁰ Van Heyningen, 'Public Health and Society', 477.

Gregory was faced with a number of challenges which severely restricted the functioning of the public health department. As a career civil servant he was accountable to the Cape colonial secretary. The incumbency of that position changed on a regular basis, leaving Gregory constrained by the current holder's attitudes towards public health. He was also dependent on parliamentarians to pass public health legislation. Many of these individuals represented largely rural populations that were opposed to public health legislation primarily because they felt that regulations would restrict their powers. The attitude of Cradock, discussed in Chapter 3, was fairly typical and demonstrated the obstacles that were placed in the way of making progress in the passing of public health legislation. Despite this, Gregory was the prime instigator of the *Public Health Act, Act No. 23 of 1897* which gave the Cape its first modern health legislation, based on the acts in Britain and the Australian Colony of Victoria.²¹

Parliamentarians also controlled another important aspect of health care. They were responsible for the passing of the annual estimates or budget. The amount allocated to public health was never generous, simply because priorities lay elsewhere. Van Heyningen has indicated that,

Underlying the problem of funding were more fundamental issues of power. In the last resort decisions about Colonial health were made by Central Government. On a variety of levels the central state, which controlled the final allocation of resources, could be accused of failing to take the question of the survival of its citizens sufficiently seriously. The issue of tuberculosis was never raised in parliament. The Government's financial commitment consisted of the publication of a few pamphlets, the funding of half-a-dozen hospital beds and the administration of the notification of the disease. Its major objective was to force the Local Authorities to take on a responsibility which the majority were even more unfitted to bear than Cape Town.²²

The financial constraints placed on Gregory by the government were critical in establishing the early strategy for combating tuberculosis. As an officer of the central government he was concerned mainly with formulating policy. He was determined that government should avoid unnecessary expenditure. His view that tuberculosis

²¹ E.B. van Heyningen, 'Agents of Empire: The Medical Profession in the Cape Colony', *Medical History*, 33 (4) (1989), 468-469.

²² Van Heyningen, 'Public Health and Society', 484.

was the product of urban conditions fitted in conveniently with such notions.²³ It allowed him to direct attention to living conditions and to place the responsibility for the control of tuberculosis on the shoulders of the local authorities. This was achieved by the local authorities through the passing and enforcement of bye-laws which regulated issues such as overcrowding and proper ventilation of housing.²⁴

By 1893 it was becoming clear from the district surgeon reports that tuberculosis was no longer confined to consumptive immigrants, but was spreading to the local population.²⁵ Statistics made available following the implementation of the *Births and Deaths Registration Act, Act No. 7 of 1894*, revealed that the mortality among the Coloured population from tuberculosis stood at 12,43 per thousand in Port Elizabeth; 6,46 per thousand in Graaff Reinet; Oudtshoorn at 7,03 and 8,72 per thousand in Beaufort West.²⁶ Subsequent annual reports continued to report increases in the prevalence of tuberculosis.

Matters came to a head following the shortage of hospital accommodation in Cape Town as the hospital boards and city council sought government assistance in dealing with the problem.²⁷ It no doubt occurred to Gregory that requests for funding for the prevention of the spread of tuberculosis would continue to take place. A solution to formalise the matter would be to add tuberculosis to the list of infectious diseases.

Tuberculosis Declared an Infectious Disease, 1903

By the time the South African War ended in 1902, Gregory was under increasing pressure from the medical profession to do something about the disease. On 4 February 1903 he submitted a memorandum to the Cape government in which he

²³ Ibid., 474.

²⁴ The *Municipal Act, Act No. 45 of 1882* was extended in 1895 so local authorities could act to stop overcrowding. See Section 4 of *Local Authorities Increased Powers Act, Act No. 30 of 1895*.

²⁵ NLSA, Union of South Africa, Govt. Reports (hereafter UG), UG34-1914, *Union of South Africa, Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 17.

²⁶ NLSA, G5-1897, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony for the Year 1896* (Cape Town: Government Printer, 1897), 19.

²⁷ See Chapter 4, Cape Town.

drew attention to the prevalence and the alarming spread of tuberculosis. He strongly recommended that it be listed as a contagious and infectious disease. Following input from the colonial Medical Council tuberculosis was, by Proclamation 93 of 20 March 1903, added to the list of contagious and infectious diseases in terms of both Section 27 of the *Public Health Amendment Act, Act No. 23 of 1897* and the *Public Health Act, Act No. 4 of 1883*. Tuberculosis thus became a notifiable disease in much the same way as smallpox, cholera, diphtheria, enteric fever and typhoid fever.²⁸

There was, however, a crucial difference in the procedural aspects between the proclamation of tuberculosis as infectious and contagious when compared to other diseases. This revolved around the government's financial contribution towards the costs associated with these diseases, which is regulated by Section 38 of the *Public Health Amendment Act, Act No. 23 of 1897*. In terms of this stipulation a proportion not exceeding four-fifths of the expenditure incurred by the local authority could be claimed from and refunded by the government. Tuberculosis (and enteric fever) were not added in terms of this section, and therefore did *not* qualify for financial assistance.²⁹ The financial burden of taking care of tuberculosis sufferers therefore continued to rest with the local authorities.

It was this omission that proved to be a huge stumbling block in the fight against tuberculosis. Local authorities were just as keen as the government to avoid having to incur the financial burden associated with the fight against the disease. They saw tuberculosis as a national problem which required government intervention. This led to a situation where their focus of attention was on the need to have a commission of enquiry appointed which would devise and implement a consolidated plan for dealing with tuberculosis. From a practical point of view, this meant that very little action to curb the spread of the disease was taken by the majority of local

²⁸ NLSA, G35-1904, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health and on the Government and State-aided Hospitals of the Colony, together with the Annual Health Reports of District Surgeons and Local Authorities for the Year 1903* (Cape Town: Government Printer, 1904), lxi-lxii.

²⁹ 'The Association of Municipal Corporations of the Cape Province', *The Municipal Journal of South Africa* (September 1918), 19.

authorities while they waited for the commission to relieve them of their responsibilities in this regard. In the meantime, the disease continued to spread.

Although tuberculosis was now on the list of infectious and contagious diseases, this received very little publicity, even among district surgeons and medical practitioners.³⁰ No detailed information which might have been used to educate the wider public was forthcoming until 1909, six years after the proclamation of the disease.³¹ A further failure was that there were no consequences for local authorities who did not act on notifications, or for those who simply refused to accept them. The level of non-compliance was extremely high. Of a total of 290 local authorities only 80 received any notifications at all during the period 1905-1912, although it was known that cases of tuberculosis did occur.³² In some Cape towns, such as Kimberley, the board of health actively discouraged the receipt of notifications.³³ When questioned about this by Gregory, they enquired about the possibility of bringing tuberculosis within the ambit of Section 38 of the *Public Health Amendment Act, Act No. 41 of 1885* (which would give local authorities access to a proportion of the costs entailed in dealing with tuberculosis sufferers). Gregory's response was to state that government did not have the necessary funds from which such expenditure could be defrayed.³⁴ The case of Kimberley points to an example of a stalemate being reached, with neither the local authority nor the government willing to bear the costs of tuberculosis.

³⁰ By comparison, the rinderpest regulations were the subject of full-page advertisements in the newspapers. These detailed the symptoms and precautionary measures to prevent its spread. See *Cradock Register*, 5 January 1897.

³¹ CA, Archives of the Municipality of King William's Town (hereafter KWT), 3/KWT 4/1/199, Memorandum, Prevention of Spread of Tuberculosis or Consumption to Accompany Circular Letter 12, 9 June 1909, MOH, Cape Colony, to all Local Authorities in the Colony, Addendum A.

³² NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 42.

³³ NLSA, G40-1907, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health for the Calendar Year 1906* (Cape Town: Government Printer, 1907), 25; CA, Archives of the Medical Officer of Health (hereafter MOH), MOH 195, Folio 86, Correspondence from Gregory to Board of Health, Kimberley, on the notification of tuberculosis, 27 May 1907.

³⁴ CA, MOH 195, Folio 86, Correspondence Gregory to Board of Health, Kimberley, on the notification of tuberculosis, 29 June 1907.

Although this ‘costs issue’ was central to the impasse reached between the Cape government and the local authorities, it became impossible to continue to ignore the march of tuberculosis. This was especially the case after the end of the South African War and the outbreak of the bubonic plague. These events created the necessary catalyst for increased interaction and cooperation between the medical profession and the local authorities.

The Association for the Prevention of Consumption Formed in the Cape Colony

An invitation from the German government, who were organising the event, was extended to Joseph Chamberlain, the British secretary of state for the colonies, to send representatives to attend the congress on tuberculosis held in Berlin in 1899.³⁵ Chamberlain, in turn, requested the Cape Colony to send a representative.³⁶ The invitation was declined as a suitable delegate was not available as there was a need to retain medical officials in the Colony due to the outbreak of plague.³⁷ The invitation was in line with one of the core principals of the international association – that the disease required national intervention, and that countries worldwide had a key leadership role to play in combating the disease.

Britain joined the Association for the Prevention of Consumption in 1898. Dr Alfred Hillier was appointed to the organising committee. Hillier had strong ties to the Cape. He had practised medicine in East London for some time and had been the president of the first South African medical congress held in 1892.³⁸ He believed that

CA, CO 7597, Folio 963, Correspondence between the German Embassy, Britain, to Joseph Chamberlain dated 11 February 1899. This letter contained a request that the invitation should be extended to ‘persons interested in the prevention of tuberculosis.’

³⁶ CA, CO 7597, Folio 963, Correspondence between the office of Joseph Chamberlain, British secretary of state for the colonies and Noel Janisch, Under Colonial Secretary, Cape Colony, dated 1 November 1899.

³⁷ CA, CO 7597, Folio 963, Correspondence between Colonial Secretary, Cape Colony and Acting Consul General for Germany, Cape Town. Copy of letter to be read at Berlin Conference on Tuberculosis, 2 May 1899.

³⁸ Biographical Database of Southern African Science, Internet download from: http://www.s2a3.org.za/bio/Biograph_final?serial=1296 accessed 4 May 2015; Van Heyningen, ‘Regularly Licensed and Properly Educated Practitioners’, 204.

the Cape would benefit from the establishment of its own branch of the association and expressed this opinion in a letter addressed to the *SAMJ*.³⁹

Hillier's suggestions did not fall on deaf ears. His proposal was followed up on 19 May 1899 when the Cape of Good Hope Branch of the British Medical Association held a meeting at which a tuberculosis and sanitary control sub-committee was appointed to discuss the formation of a South African Association for the Prevention of Consumption. The committee's main starting point was the acceptance that tuberculosis in South Africa was increasing and every possible measure should be taken to prevent its spread and lessen its impact. The *modus operandi* agreed upon at that meeting formed the basis of the operations of the local association once it was formed. It decided to focus on education; the encouragement of voluntary notification; the establishment of sanatoria; stopping the dangerous habit of expectoration; and discouraging the arrival of immigrants suffering from the disease by passing appropriate legislation. It was felt that the best way to achieve these objectives was by the formation of a local branch of the association.⁴⁰ In September 1899 an organising committee was appointed. The initial members included, among others, Drs Barnard Fuller, Gregory, G. Anderson, Dodds, Darley-Hartley, Murray and Turner.⁴¹ However, the following month the South African War began and brought plans to form an association to a virtual standstill.

The matter was raised again at the 1903 medical congress.⁴² Approximately six months later, in June 1904, the Association for the Prevention of Consumption and other forms of Tuberculosis was launched at a well-attended public meeting held in Cape Town. The launch was presided over by the Cape governor, Sir Walter Hely-Hutchinson. In his address he declared that he sympathised with the objectives of the association and gave an undertaking that he would do everything in his power to further its aims. Hely-Hutchinson spoke of the rapid increase of tuberculosis in the

³⁹ A. Hillier, 'The Prevention of Tuberculosis', *SAMJ* (February 1899), 221-222.

⁴⁰ 'Cape of Good Hope Branch BMA, June 22, 1899', *SAMJ* (August 1899), 87.

⁴¹ 'Cape of Good Hope Branch, British Medical Association, 28 July 1899', *SAMJ* (September 1899), 107.

⁴² NLSA, UG34-1914, *Report of the Tuberculosis Commission, 1914*, 18.

colony and the fact that the disease was now endemic. He added that the practice of sending sufferers out [to the Cape] in the last stages of the disease had become for England 'a very nice and convenient way of getting rid of an unpleasant burden'.⁴³ He spoke of the improved death rate among white residents in Cape Town, which he attributed to the improvement of sanitation in the town.⁴⁴ Dr Jasper Anderson also addressed the meeting, outlining the association's aims and objectives.⁴⁵

At the end of the meeting Hely-Hutchinson was invited to become the patron of the newly-formed association. Dr L.S. Jameson, the prime minister, was elected as president. Other high-ranking officials, including the mayor of Cape Town, the president of the British Medical Association, the colonial secretary, Rabbi A.P. Bender, and the president of the Cape Medical Council, were elected as officials.⁴⁶ The mayor of Cape Town, as well as Sir Pieter Faure (colonial secretary), and Doctors Barnard Fuller, John Gregory, G.G. Eyre, W. Darley-Hartley, C.F.K. Murray, Claude Wright and Matthew Hewat were elected as office bearers, together with Dr Jasper Anderson as chairman and B.J. Guillemard as secretary.⁴⁷ This brought together a high-level team of politicians and some of the most respected medical professionals of the day.

The establishment of the Cape branch of the Association for the Prevention of Consumption led to increased interest in tuberculosis among the public, medical profession and local authorities. It also provided the administrative structure to carry out the objectives of the organisation. The appointment of Hely-Hutchinson as its patron was particularly important because it gave the association some influence in government circles. Furthermore the role of the association and the *SAMJ* was significant because it emphasised the importance of the Cape Colony creating its

⁴³ CA, MOH 61, Folio 82, City of Cape Town, Report on Public Meeting, 3 June 1904 to form an Association for the Prevention of Consumption and other Forms of Tuberculosis, 3.

⁴⁴ One of the first things Hely-Hutchinson had done on his arrival in Cape Town in April 1901 was to visit the slum areas. See *Midland News*, 24 April 1901.

⁴⁵ CA, MOH 61, Folio 82, Meeting to form Association for the Prevention of Consumption, 4.

⁴⁶ *Ibid.*, 6.

⁴⁷ CA, Archives of the Municipality of Cape Town (hereafter CT), 3/CT 1/7/1/11, Corporation of the City of Cape Town, Minute of Mayor (Thorne) for Year ending 22 September 1904 (Cape Town: Government Printer, 1904), 60.

own narrative in the fight against tuberculosis. It was clear that in addressing the issue of the disease, the Cape could not follow the British example.

While the Cape's Association for the Prevention of Consumption played a key role in spreading awareness of tuberculosis, it was greatly assisted by the changing circumstances in the medical profession. For a start, by 1893 there was an improved medical infrastructure which facilitated the communication between medical professionals by means of a monthly medical journal and attendance at annual medical conferences. In addition, the medical profession was beginning to gain more respect from the local authorities and the general public following the establishment of public health institutions.⁴⁸ This was enhanced by the introduction of public health legislation. The importance of the bacteriological revolution and knowledge about the tubercle bacillus also contributed to an increased confidence in the medical profession.⁴⁹ The association capitalised on all these avenues, for example by publishing regular articles in the *South African Medical Record (SAMR)* and by addressing the annual medical conferences and the mayoral conferences.

Following the inauguration of the association, a number of public lectures on the prevention of tuberculosis were held from 24 August to 19 October 1904. These were presented by Drs Darley-Hartley, G.A. Batchelor, Ardene Wilson, Jasper Anderson, Guillemard, Simpson Wells and Charles Anderson and were held in Woodstock, Wynberg, Simonstown, Sea Point, Stellenbosch, Claremont and Observatory.⁵⁰ With the exception of Stellenbosch, all the venues were in the greater Cape Town area. The lectures, together with the circulation of educational material, were part of the association's objectives to educate the public on tuberculosis.⁵¹

Education played a very important role in the control of tuberculosis, particularly among the poor. While much attention was paid to the fact that tuberculosis is a

⁴⁸ Van Heyningen, 'Regularly Licensed and Properly Educated Practitioners', 213.

⁴⁹ Bryder, *Below the Magic Mountain*, 45.

⁵⁰ CA, MOH 61, Folio 82, Invitation from B.J. Guillemard and A. Crichton Morris, Association for Prevention of Consumption and other Forms of Tuberculosis in the Colony, undated.

⁵¹ *Ibid.*, Meeting to form Association for Prevention of Consumption, no page number.

social disease which spreads when there are unhygienic housing conditions, insufficient ventilation and overcrowding, there was little that the indigent residents could do to improve their circumstances. By teaching them about the nature of tuberculosis and the steps to be taken to limit its spread, such as not spitting and keeping windows open, education was an important weapon in the armoury against the disease. This was especially the case at a time when no medical solutions were available. Education was not limited to members of the general public but was also extended to medical practitioners and local authorities by the publication of tuberculosis-related articles in the *SAMR* and presenting talks on the subject at annual conferences held by the local authorities and the medical profession, as discussed later in this chapter.

In addition to its educational role, the association also tackled several other issues, such as monitoring how railway staff cleaned the railway carriages at the Cape Town station. At the time spitting was still a common practice and any sputum that had traces of the bacillus could spread the disease. Requests to cleanse the carriages away from the station platforms were found to be impracticable, but a compromise was reached in that disinfectant was sprinkled inside carriages and on the platforms before they were swept.⁵²

Another of the association's initiatives was to discourage consumptive immigrants from coming to the Cape. This was only achieved after Union when legislation was passed in terms of *The Immigrants Regulation Act, Act No. 22 of 1913*. In the interim, Guillemard recommended that government should draw the attention of the steamship companies to the fact that tuberculosis was a notifiable disease in the Cape Colony. He suggested that notices to this effect should be printed on the tickets issued to prospective passengers, and be prominently displayed on the ships themselves. His hope was that this would act as a deterrent to those suffering from

⁵² 'Passing Events', *South African Medical Record* (hereafter *SAMR*) (September 1904), 176; *Midland News*, 29 August 1904.

the disease.⁵³ No evidence could be found that the government acted on this recommendation. In the absence of government intervention, the association communicated directly with the shipping companies about the carriage of consumptives and the precautions they had to take in disinfecting the cabins.⁵⁴

The association's remaining original objective was the establishment of sanatoria for the housing and nursing of consumptives. Although it viewed potential building sites at Touws River and just outside Laingsburg (both in 1905), nothing came of these plans.⁵⁵ In August 1905 Guillemard addressed an appeal to all district surgeons and railway medical officers with local knowledge to notify him of sites they thought would be suitable for a sanatorium.⁵⁶ A response was received in the form of an offer of 100 acres (or more) of land at no cost on the Milneweveld Plantation, some 500 feet above sea level.⁵⁷ This information was forwarded to Guillemard.⁵⁸ As on the previous two occasions, nothing came of this offer.

It was almost a decade later that the plan to establish a sanatorium became a reality. The establishment of the Nelspoort Sanatorium in 1924 was largely the result of an initial donation of £25,000 from the philanthropist and departmental store owner, John Garlick, together with contributions from the government and local authorities.⁵⁹

In the meantime, the local branch of the NAPC continued to receive support from its international counterparts. This continued after Union, and took the form of educational brochures which were printed in England on behalf of the Department

⁵³ CA, MOH 61, Folio 82, Handwritten memorandum from Guillemard to Mitchell, 31 August 1904.

⁵⁴ Ibid.

⁵⁵ *Cape Times*, 14 February 1905 (Touws River); CA, MOH 61, Folio 82, Correspondence between Gregory and Guillemard, 23 February 1905.

⁵⁶ 'Annotation', *SAMR* (August 1905), 166.

⁵⁷ CA, MOH 61, Folio 82, Telegram from Truter, Beaufort West to Public Health Department, Cape Colony, 21 September 1905.

⁵⁸ Ibid., Correspondence, Gregory to Secretary, Association for the Prevention of Consumption, 22 September 1905.

⁵⁹ CA, 3/KWT 4/1/199, Minutes of Meeting of the King William's Town Council, 14 July 1919; CA, 3/CT 1/1/1/75, Minutes of Meeting of Cape Town Mayoral Council, 10 February 1919, 314.

of Public Health for the Union of South Africa. Two such examples are displayed in the following pages. Unfortunately the examples were not dated or accompanied by a covering letter.⁶⁰

⁶⁰ See pages 147 and 148.

WAR ON CONSUMPTION.

IN CASE OF CONSUMPTION, LOOK TO THESE FOR CURE



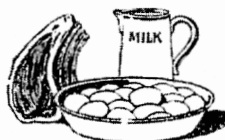
The Doctor



Sunlight



Out-door Air



Good Food

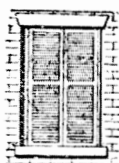


Rest

CONSUMPTION'S ALLIES—AVOID THEM & YOU ARE SAFEGUARDING AGAINST THE DISEASE



Intemperance and other Excesses



The Closed Window



Overwork



Crowded Sleeping, Living and Working Rooms



Smoke and Dust



Mouth Breathing often due to Adenoids

A CAREFUL CONSUMPTIVE—NOT DANGEROUS TO LIVE WITH—



Coughs, Spits and Sneezes into Paper or Cloth



Burns or Boils it before it dries



Or puts it into a Disinfectant



Washes her Hands before and after Eating



Always uses the same dishes and boils them in water before washing with other dishes



And Sleeps alone

HOW THE GERMS OF CONSUMPTION ARE CARRIED FROM THE SICK TO THE WELL



Consumptive spitting on floor, flies feeding on it, carry the germs of the disease to food.



The spit dries, and careless sweeping, dusting or draughts cause the germs to float in the air.



The germs may enter the bodies of children playing on the floor, through sores or wounds.



Others may get the disease by breathing or swallowing the germs. Spray given off in sneezing or coughing contains germs in a moist and active state.

Putting food, money, pencils, etc., into the mouth after a consumptive has poisoned them with his spit.

DEPARTMENT OF PUBLIC HEALTH.

Union of South Africa.

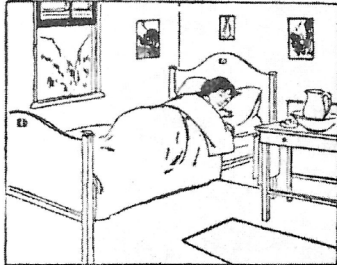
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WAR ON CONSUMPTION.

WHICH WAY ARE YOU GOING?

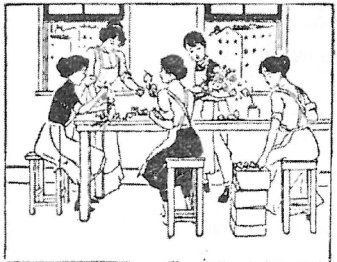
To Good Health and Long Life

To Consumption and Early Death



Sleep
With the
Windows Open

Clean Air
Pure Blood
Good Health



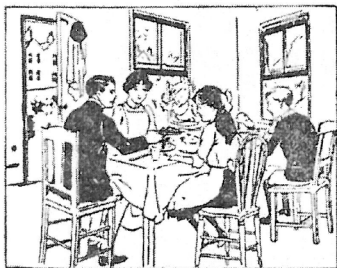
Work
and Study
in Pure Air

Pure Air
Makes Mind
and Body Alert



Play in
the Clean
Open Air

Keep out
of Doors as
Much as Possible



Eat Clean
Nourishing
Food

Keep
Flies and Dust
Away from Food



Closed
Windows
Mean Dirty Air

Dirty Air
Poisoned Blood
Death



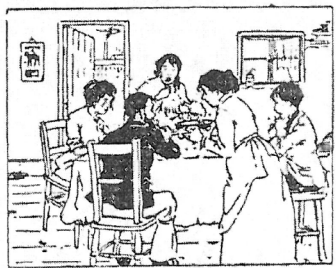
Dirty, Dusty,
Hot Rooms
are Dangers

Destructive to
Health and
Efficiency



Indoor Play and
Play in Dusty
Places is
Not Healthful Play

Exercise
in Dirty Air
is Dangerous



Dirty
Food Kills
Thousands

Flies
and Dust
Contaminate Food

NEVER DO THESE THINGS

Don't spit in public places; no spit no consumption.
Don't "swap" sweets, apples, etc.
Don't put pencils or money in mouth; there's spit on pencils and filth on money

Don't eat sweets, fruit or pastry that has been exposed to flies or dust; there are all kinds of germs on such.
Don't sneeze or cough in another's face.
Don't let others infect you this way

DEPARTMENT OF PUBLIC HEALTH.
Union of South Africa.

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The South African Medical Journal (SAMJ)

In a colony where medical professionals often lived and worked in small villages that were great distances away from the main centres, the establishment of a medical journal was an important tool to disseminate information and keep colleagues up-to-date with current topics. *The SAMJ* was first published in 1884.⁶¹ Financial difficulties caused it to close in 1889.⁶² The idea to re-establish a medical journal was proposed by Dr Arthur Fuller at the first medical congress held in Kimberley in 1892.⁶³ In April 1896, his brother Dr Barnard Fuller was appointed as the editor of the public health section of the *SAMJ*. He used this platform on a regular basis to bring the subject of tuberculosis to the attention of medical practitioners throughout the colony.⁶⁴

Fuller, as the part-time medical officer of health in Cape Town, was able to make use of the procedures established in the town as an example of what needed to be done to limit the spread of the disease. The practice of publishing the Cape Town health reports in the *SAMJ* was put in place in October 1893.⁶⁵ By careful analysis of the Cape Town health reports Fuller was able to draw attention to the fact that tuberculosis was no longer restricted to consumptives coming to the colony for the 'benefit of their health' but was spreading rapidly among the Coloured residents by 1896.⁶⁶

⁶¹ *The Birmingham Medical Review*, (April 1884), 183.

⁶² J.P. Van Niekerk, 'South African Medical Journal. First Published January 1884', (April 2010), 189. The *SAMJ* suspended its operations in 1899 during the South African War. *The South African Medical Record (SAMR)* began publication in March 1903.

⁶³ 'Introduction', *SAMR* (May 1893), 1-2; A. Fuller, 'A Medical Journal for South Africa', *SAMJ* (May 1893), 3-4. Dr A. Fuller was the brother of Dr Barnard Fuller, the part-time MOH in Cape Town. He was also the author of A. Fuller, *South Africa as a Health Resort, with Especial Reference to the Effects of the Climate on Consumptive Invalids, and Full Particulars of the Various Localities most Suitable for their Treatment, and also of the Best Means of Reaching the Places Indicated* (London: W.B. Whittingham & Co., 1886). This book was first published in 1886 and was reprinted five times.

⁶⁴ E.B. Fuller, 'Public Health', *SAMJ* (April 1896), 335.

⁶⁵ 'Health Reports (Cape Town)', *SAMJ* (October 1893), 113-115.

⁶⁶ E.B. Fuller, 'Public Health', *SAMJ* (September 1897), 126-127.

Fuller was acutely aware of the snail's pace at which health legislation was passed in the Cape Colony and that it was highly unlikely that anything would be done about tuberculosis at an early date. That being the case, he felt that the medical profession should educate themselves and take the necessary steps to prevent the spread of the disease. He also believed that continual pressure on the authorities by the medical profession would ultimately force the various legislatures to take action.⁶⁷

The *SAMJ* played a crucial role in educating medical practitioners about tuberculosis. This was especially important because there were dissenting views on the cause of the disease, with some practitioners maintaining that it was caused by 'hereditary tendencies' in certain families, while others still believed in the ability of the climate to 'cure' the disease or at least make it more bearable to live with.⁶⁸ In some cases, there were different points of view held by members of the same family.⁶⁹ Barnard Fuller's opinion was that tuberculosis was highly infectious and that measures should be taken to limit contagion. By the careful selection of *SAMJ* articles he was able to hammer this point home.

Fuller was also aware that tuberculosis thrived in conditions of poverty. By drawing attention to this fact and that the disease flourishes in the unhygienic conditions so prevalent among the poverty-stricken residents, Fuller was sounding a warning that if these conditions were not addressed, the disease would continue to spread. While it was impossible for medical practitioners and district surgeons to take measures to improve the standard of living of the indigent families as this responsibility lay on the shoulders of the local authorities, Fuller could only hope that the readers of the *SAMJ* would convey this information to their local authorities.

⁶⁷ E.B. Fuller, 'Public Health: Phthisis a Compulsory Notifiable Disease', *SAMJ* (August 1896), 92.

⁶⁸ This belief persisted for decades, and was the subject of a minority report issued by Maynard in response to the findings of the Tuberculosis Commission (1914). See G.D. Maynard, 'The Relative Importance of Infection and Heredity in the Spread of Tuberculosis', *SAMR* (26 October 1912), 433-450.

⁶⁹ Fuller's brother, Arthur, was a case in point. As discussed in Chapter 8, it was only in 1898 that he conceded that tuberculosis was an infectious disease. See Fuller, 'South Africa as a Health Resort' (1898), 6.

In August 1896, detailed instructions on the steps to be taken by individuals to prevent the spread of the disease were published in the *SAMJ*.⁷⁰ This information was remarkably similar to the details provided in Gregory's 1909 health report, which was published in 1911 (already referred to).⁷¹ It is perhaps this example which demonstrates most forcibly the important role played by the *SAMJ* in the guidance of medical practitioners. It is also an indictment of the apathy of the health department in the field of tuberculosis.

Annual Medical Congresses and Mayor's Conferences

Another way medical professionals could share their experience and expertise was through the holding of annual medical congresses. Similar conferences were also held by the mayors. These conferences were important instruments to disseminate information between colleagues in a colony where many towns were situated in remote locations. Practical difficulties led to the cancellation of the meetings during the South African War. When the practice resumed in 1903 there was a marked change in attitudes and priorities. The war itself, coupled with the experience of the bubonic plague in 1901, had led to the sobering reality that serious health threats could not be ignored indefinitely.

It was against this background that the mayor's conference took place in Queenstown in 1903. Up until that point, matters concerning public health had not featured as a subject of discussion. The Queenstown meeting saw a break with that tradition, in that both tuberculosis, and in particular, expectoration, as well as the training of sanitary officials, aroused intense discussion.⁷²

The subject of tuberculosis was raised once more at the 1905 medical congress held in Pietermaritzburg. It was decided that a special committee would be appointed to

⁷⁰ Fuller, 'Public Health: Phthisis a Compulsory Notifiable Disease', 92-93.

⁷¹ NLSA, UG1-1911, *Cape of Good Hope. Report of the Medical Officer of Health for the Colony on Public Health and Cognate Matters Including the Registration of Births, Deaths and Marriages for the Calendar Year 1909* (Cape Town: Government Printer, 1911), 65.

⁷² CA, 3/CT 1/1/1/57, Minutes of Cape Town City Council, August 1903–May 1904, Meeting of council, 14 March 1904, 369; *Midland News*, 14 March 1903.

conduct an independent enquiry to investigate the prevalence of tuberculosis and to consider what action could be taken to stop the spread of the disease. This enquiry did not rely on government participation or sanction and was not restricted to the Cape Colony, but was extended to all the British South African colonies and Portuguese East Africa. It was an indication of the increased collaboration in the medical profession at a time when political union had not yet taken place.

The committee consisted of Drs Jasper Anderson and C.F.K. Murray (Cape Colony); P. Murison and A. Murray Gray (Natal); A. Ramsbottom and G. Pratt-Yule (Orange River Colony); Drs D. Macaulay and Charles Porter (Transvaal) and Dr Leal (Portuguese East Africa). Dr W. Watkins-Pitchford was appointed as the general secretary. The committee's findings were reported back to the medical congress in 1908.⁷³ This committee was comprised of some of the most prominent medical practitioners of the day and included the medical officer of health for the Orange River Colony and the Transvaal. No mention was made of extending an invitation to Gregory to join the initiative, perhaps anticipating his reaction and his penchant for placing the blame for the spread of tuberculosis on the local authorities and the people themselves. It was also widely known that Gregory was opposed to the appointment of a commission.

At the next meeting of the medical congress held in Bloemfontein in 1906, tuberculosis was discussed at great length. On this occasion it was recommended that the notification of individuals who had been diagnosed as having tuberculosis should be made compulsory throughout South Africa, and that laws adopted by any of the colonies should be uniform countrywide.

Other subjects discussed included the advisability of teaching schoolchildren about tuberculosis; the establishment of additional branches of the association in the Transvaal and Orange River Colonies; and the establishment of sanatoria for white

⁷³ 'Report of Standing Committee on Tuberculosis of the South African Medical Congress', *SAMR* (25 February 1908), 53.

and Coloured sufferers, including administrative and funding models.⁷⁴ Resolutions on the immigration of tuberculosis sufferers were also taken.⁷⁵ The 1906 medical congress was of particular importance because it signified that the medical profession recognised the prevalence of tuberculosis was serious enough to warrant the appointment of a standing committee to make recommendations to curb its spread. The intention was to influence the passing of legislation and to encourage the various colonial governments to recognise the need for uniformity by emphasising that diseases do not recognise political boundaries.⁷⁶

By 1906 the time was ripe to launch educational programmes. Tuberculosis had become a widely debated issue and topic of conversation. This period was characterised by different groups, such as the medical profession, the local authorities and the government all striving to give their divergent views on the disease. What was needed was leadership from government and in particular, the public health department. It was perhaps in recognition of the need for this centralised leadership that the Federal Council of Municipal Associations made a decision at its meeting held on 12 April 1906 (proposed by the mayor of Cape Town) to approach the respective governments of the South African colonies about appointing a commission of enquiry which would then report back with recommendations on the best means of curbing tuberculosis. The resolution was unanimously adopted. An appeal in this regard was duly made to the Cape government in May 1906.⁷⁷ The government responded that ‘the matter was being referred to the meeting of the principal medical officers of health for its report’.⁷⁸

Conference of Principal Medical Officers of Health, 1906

The conference of principal medical officers of health was initially the brainchild of Gregory who saw the need for the different British South African colonies and

⁷⁴ ‘South African Medical Congress’, *BMJ* (2 March 1907), 530-531.

⁷⁵ These resolutions are discussed in Chapter 6, with special reference to tuberculosis.

⁷⁶ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 16.

⁷⁷ *Ibid.*, 19.

⁷⁸ CA, MOH 407, Folio G117, Corporation of the City of Cape Town, Memorandum from Dr Jasper Anderson to Mayor and Councillors, 21 April 1907, 1.

neighbouring territories to meet on a regular basis for the purposes of discussing matters affecting them jointly, and of making recommendations.⁷⁹ Tuberculosis was not on the original agenda but was added on the instruction of the colonial secretary.

The conference took place in Cape Town in November 1906, and was attended by the medical officers of health of the Cape Colony (Gregory); Natal (Dr Ernest Hill); Transvaal (Dr George Turner); Orange River Colony (Dr G. Pratt-Yule); Southern Rhodesia (Dr A.M. Fleming); Basutoland (Dr E.C. Long), and Bechuanaland Protectorate (Dr J.M. MacRae). Gregory was elected chairman, with Dr E.N. Thornton, one of Gregory's staff members, named as secretary.⁸⁰ Dr Pratt-Yule, who had attended the Bloemfontein medical congress held shortly before, read the resolutions taken there.⁸¹ The discussion and resolutions agreed upon at the Cape Town conference were taken with these in mind, including the proposed restriction of immigration of persons suffering from tuberculosis, an issue which had been placed on the agenda at the request of the colonial secretary in Natal.⁸² Also discussed were what measures should be taken to prevent the spread of tuberculosis among all sectors of society. After discussion of the matter, the delegates passed the following resolution:

Regarding the spread of tuberculosis, all the representatives at the Conference are unanimous in their opinion as to the gravity of the matter, and especially as to the danger threatening the Native and Coloured races from the extension of the disease. The Conference, however, recognises the difficulty of adopting effective measures of a direct kind towards its check, and considers that the main reliance must be placed upon

⁷⁹ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 19.

⁸⁰ Dr E.N. Thornton was appointed as provincial medical adviser for the Cape Province after Union. See CA, 3/CT 1/7/1/18, Corporation of the City of Cape Town, Minutes of Mayor (Hands), for Year ending 31 August 1913 (Cape Town: Government Printer, 1913), 90.

⁸¹ NLSA, G39-1906, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health and on the Government and State-aided Hospitals of the Colony together with the Reports of District Surgeons and Local Authorities for the Two Calendar Years 1904 and 1905* (Cape Town: Government Printer, 1906), lxxxiii; NLSA, G48-1907, *Report of the Conference of the Principal Medical Officers of Health for the different British South African Colonies, together with the Minutes of Meetings, Cape Town, 13-26 November 1906* (Cape Town: Government Printer, 1907), Minutes of the Second Meeting of the Conference of Principal Medical Officers of Health, 16 November 1906, 21.

⁸² CA, MOH 317, Folio A117a, Correspondence, Colonial Secretary, Pietermaritzburg to Colonial Secretary, Cape Town, May 1906; Correspondence, Gregory to Under Colonial Secretary, Cape Colony, 30 May 1906. This matter is discussed in more detail in Chapter 6.

the steps for improving the standard of personal and domestic hygiene and of general sanitation.⁸³

The passing of the above resolution was a clear indication that the most senior medical officers of health in the various colonies accepted the status quo. By focusing on education and personal hygiene, delegates absolved the governments of having to take steps to improve the standard of living of the majority of their residents or of having to incur any expenditure. Predictably, the conference recommended that local authorities be responsible for the strict enforcement of bye-laws on housing standards, especially in respect of air-space, light and ventilation.⁸⁴

The resolutions passed reiterated those taken at the Bloemfontein medical congress. The delegates also recommended that the notification of cases of tuberculosis should be made compulsory in all South African colonies. Their view was that the establishment of sanatoria was not an urgent matter. However they acknowledged that government should provide suitable asylum accommodation for indigent persons suffering from advanced tuberculosis, chiefly in order to prevent them from being a source of infection to others in the community.⁸⁵

One of the positive outcomes of the 1906 conference of principal medical officers of health and the 1906 Bloemfontein medical congress was that the resolutions taken at both were circulated to the various governments of the South African colonies. This increased the awareness of public health matters in government circles. What was notable was that it was not Gregory, but Lord Selborne, the high commissioner, who collated the responses from the various governments and circulated their views to all concerned, including the medical congress organisers.⁸⁶

⁸³ NLSA, G48-1907, *Conference of the Principal Medical Officers of Health, 1906*, 7.

⁸⁴ *Ibid.*, 7-8.

⁸⁵ *Ibid.*

⁸⁶ CA, MOH 323, Folio G117b, Correspondence between Selborne, High Commissioner's Office and Sir Walter Hely-Hutchinson, Governor Cape Colony, 2 December 1907.

For Anderson, the resolutions passed at the 1906 conference of principal medical officers were disappointing. He had understood that the appointment of a commission to investigate tuberculosis would be discussed at the conference, and that its constitution and terms of reference would be formulated. Instead, only a portion of the time was allocated to the discussion of tuberculosis. Anderson stated that in his opinion, the 'subject was too vast, too urgent, and too financially important to be dismissed in this summary fashion'.⁸⁷ Gregory held a different view. He was opposed to the appointment of a commission because he felt it would not provide any additional information other than what was already available.⁸⁸

Following this, the battle lines between the public health department and the Association for the Prevention of Consumption were firmly drawn, especially regarding the provision of sanatoria and the appointment of a commission. Part of the reason for Gregory's animosity towards the association was that for a brief period the association had extended its objectives to include matters on public health. Gregory believed that this infringed on his terrain and resigned from the association as soon as the resolution had been accepted.⁸⁹ In an anonymous letter to the *SAMR* he was virtually accused of paranoia, with his reaction being described as 'really extraordinary'.⁹⁰ The sentiments expressed in this letter were borne out in some measure in a private communication from Gregory in which he complained that the association had 'the avowed objective of controlling the government and to doing this through ordinary political channels'. He maintained that the association's efforts to establish sanatoria misdirected the attention of local authorities away

⁸⁷ CA, MOH 407, Folio G117, Corporation of the City of Cape Town, Memorandum from Dr Jasper Anderson to Mayor and Councillors of Cape Town, 21 April 1907, 1.

⁸⁸ NLSA, G33-1908, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health for the Calendar Year 1907* (Cape Town: Government Printer, 1908), xxxvii.

⁸⁹ NLSA, G39-1906, *Health Report for 1904 and 1905*, lxxxiii; NLSA, G48-1907, *Conference of Principal Medical Officers of Health, 1906*, 21.

⁹⁰ 'Passim', *SAMR* (25 March 1906), 78-79. As it turned out, the expanded responsibilities of the association only lasted for two years. In July 1908 the decision was taken to revert back to the original intentions of the association and it was renamed 'The Society for the Prevention of Consumption and other Forms of Tuberculosis in the Colony of the Cape of Good Hope'. Its objects and methods reverted to its original concepts. See CA, MOH 318, Folio G 117A, Annual Report of the Society for the Prevention of Consumption, 11 July 1908.

from the need to enforce bye-laws, giving them the impression that 'the whole responsibility and any attendant expense should be placed on the government'.⁹¹

It was becoming increasingly evident that Gregory would not budge on his views and would not use his influence to propose the appointment of a commission of enquiry. His entrenched position was also manifested in his reaction to the request for the provision of government funding towards or the allocation of hospital beds in Cape Town, as discussed in the previous chapter.

By 1908 the delegates at the congress of municipal corporations added their voice to the medical profession's calls for the appointment of a commission of enquiry.⁹² The subject of tuberculosis was again raised at a meeting in 1910. On this occasion Anderson, in his capacity as chairman of the Association for the Prevention of Consumption, discussed the disease. Because political union was imminent, he also used the opportunity to set forth his vision for public health in the future. This included the appointment of a minister and the passing of a new public health and municipal act. Of particular significance was his view that although tuberculosis was notifiable in terms of the same section of the Public Health Act as other diseases such as smallpox and scarlet fever, it should be treated differently because it presented challenges which were not the same as other diseases. By this time Anderson had spent almost a decade trying to instil a sense of urgency and appreciation for the ravages of the disease and spoke of his frustration at the lack of progress. Some gains had been made, for example the establishment of the Tuberculosis Dispensary in Cape Town and the inclusion of information about tuberculosis on the curricula at schools. However, he bemoaned the fact that the association lacked the financial resources to make significant inroads on the provision of sanatoria, although some progress was made following the generous

⁹¹ CA, MOH 317, Folio G117a, Correspondence between A.J. Gregory and K.H.A. Bauer, Colonial Office, 6 June 1908.

⁹² CA, 3/CT 1/7/1/15, Corporation of the City of Cape Town, Minutes of the Mayor (Baxter), for Year ending 17 September 1908 (Cape Town: Government Printer, 1908), 22.

donation by John Garlick, which ultimately resulted in the building of the Nelspoort sanatorium.⁹³

While the association had made some headway, especially relating to education, for the most part this was limited to the white residents. It was fortunate that there were other, quite separate, initiatives at work. These included the efforts of Dr Neil Macvicar and those of the Native Health Society; both took up the challenge to ensure that the black population was also educated about tuberculosis and advised on the steps they should take to limit its spread.

Dr Neil Macvicar

Dr Neil Macvicar was a medical missionary who was born in Scotland in 1871. His father was a church minister who had inculcated a deep spirituality into his son. As a young man, Macvicar developed a keen interest in Africa and was determined to travel to Africa to make a difference in the lives of the indigenous people. He established that the best way he could realise this ambition was to train as a medical doctor. He completed his degree at Edinburgh University and initially went to work as a medical missionary in Blantyre, Malawi. In 1902 he was offered the position of superintendent at the Lovedale Hospital in Alice (Eastern Cape) where he remained for 35 years.⁹⁴

While at Lovedale, Macvicar completed an investigation of tuberculosis in the context of the social and cultural habits of blacks living in the rural areas near the mission station. His journal articles were not only of educational value, but also provided valuable insight into the lives of rural blacks and the particular challenges

⁹³ CA, MOH 407, Folio G117B, A.J Anderson, 'Tuberculosis and its Prevention in Cape Colony', Paper by Anderson, president of the Association for the Prevention of Consumption, and MOH, city of Cape Town, read at the Fifth Session of the Association of Municipal Corporations of the Cape Colony, Port Elizabeth, March 1910, 1-8. Ultimately the difference between tuberculosis and other diseases was recognised and it did receive separate attention in terms of *The Public Health Act, Act No. 36 of 1919*.

⁹⁴ R.H.W. Shepherd, *A South African Medical Pioneer: The Life of Neil Macvicar* (Lovedale: The Lovedale Press, 1952).

they faced in the fight against tuberculosis. He also explored topics such as the relationship of climate and altitude to the spread of the disease; the history and distribution of tuberculosis in South Africa; and the incidence of bovine tuberculosis. His observations were recorded in a series of articles published in the *South African Medical Record (SAMR)*.⁹⁵ They generated so much interest that in 1909 they were re-published in the British *Journal of Tuberculosis*. In the same year Macvicar also presented a paper entitled 'Tuberculosis amongst the Natives of South Africa' at the South African medical congress held in Durban in August 1909.⁹⁶

Macvicar was a firm believer in education as a means of preventing the spread of the disease, particularly at elementary school level. To achieve this objective he advocated the training of black teachers.⁹⁷ In 1904 he delivered his first lecture on 'Education and Health' to the Victoria East branch of the Teacher's Association of the Cape Colony. In 1909 he began teaching a health course at Lovedale. Among the topics covered were preventing the spread of enteric fever and tuberculosis, school hygiene and first-aid. These classes were taught until 1919, when physiology and hygiene were introduced into the official syllabus of the Cape's education department.⁹⁸

In addition to offering these courses, Lovedale introduced the training of female black nurses. While certificates were initially issued by Lovedale, by 1931 all students countrywide were writing the examinations of the South African Nursing Council. The nurses trained at Lovedale were employed at hospitals such as Butterworth and Klerksdorp. The mining industry also proved a valuable source of employment, with nurses working in places such as the Indwe Collieries and Crown Mines. In time,

⁹⁵ See N. Macvicar, 'The Relation of Altitude and Dryness of Atmosphere to the Spread of Consumption among the Native Races of South Africa', *SAMR* 4, 9 (25 May 1908), 133-134; 'Tuberculosis among the South African Natives: Distribution of Tuberculosis', *SAMR* (10 June 1908), 161-176; and 'Tuberculosis among the South African Natives: The Relation of Bovine to Human Tuberculosis in South Africa', *SAMR* (25 June 1908), 181-185. He also wrote a series in three parts, 'Tuberculosis among the South African Natives: The Distribution of Tuberculosis among the Natives of Past Times', *SAMR* (10 July 1908), 197-208; *SAMR* (25 July 1908), 213-222; and *SAMR* (10 August 1908), 229-235.

⁹⁶ 'Passing Events', *SAMR* (25 May 1909), 146.

⁹⁷ *The Christian Express*, 1 September 1905.

⁹⁸ Shepherd, *A South African Medical Pioneer*, 122-123.

municipalities became the main employers of black nurses, especially in Bloemfontein, Port Elizabeth, East London and Johannesburg.⁹⁹ In Cradock, for example, a nurse who was educated at Lovedale was employed to look after cases of illness in the town location.¹⁰⁰ Macvicar's aims to train blacks in healthcare did not stop there. In November 1909 he founded the Native Health Society to educate Coloureds and blacks in health matters.

The Native Health Society (also known as The South African Health Society)

The Native Health Society was founded as an initiative to teach black students about Western medical principles. This was done by providing classes in health to senior students at Lovedale, including instruction on the use of microscopes and anatomy lessons using lifelike models. These lectures were given to students in the ten-year period from 1909 to 1919. It was only when the Cape government's education department agreed to include courses in physiology and hygiene to prospective teachers that Macvicar discontinued his classes.¹⁰¹ In addition to teaching, the Native Health Society turned its attention to the printing and distribution of pamphlets on issues such as the prevention of scurvy; public health administration under Union (post-1910); syphilis; enteric fever and the feeding of babies. Three separate pamphlets about tuberculosis were also made available. These focused on the prevention of tuberculosis; how tuberculosis was spread in families; and an additional pamphlet on questions and answers about tuberculosis. This latter brochure was labelled the 'Tuberculosis Catechism'. The pamphlets were available in six South African languages so that all sections of the population could be reached. Within the first five years of its existence, the Native Health Society published over 100 000 copies of these pamphlets. In addition, the society also published and distributed nearly 50 000 anti-tuberculosis cartoons.¹⁰² Other publications included an illustrated anti-consumption calendar printed in IsiXhosa; and placards (in

⁹⁹ Ibid., 108.

¹⁰⁰ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 131.

¹⁰¹ Shepherd, *A South African Medical Pioneer*, 120-123.

¹⁰² Ibid., 124-125.

IsiXhosa and English) warning against expectoration. Large numbers of these posters were purchased by the railways and displayed at the various stations in the Cape.¹⁰³

At least one of the tuberculosis pamphlets was written by D.T. Msikinya, who had been a student at Lovedale and was subsequently employed as an orderly at a mine hospital in the Transvaal. The pamphlets were available in a number of black languages and had directions on precautions against infection. They were edited by Macvicar and circulated through the Lovedale Book Store.¹⁰⁴ In 1911 the De Beers Company distributed 2 000 copies of the IsiXhosa edition on the prevention of tuberculosis among its labourers.¹⁰⁵ Other large orders for pamphlets were received from the Glen Grey district council and the King William's Town special magistrate acting on behalf of the minister of native affairs.¹⁰⁶ By 1913, 35 000 copies of an anti-consumption cartoon, with special illustrations and text in English, IsiXhosa, IsiZulu and Sesotho had been distributed throughout South Africa. Cartoons, printed in IsiXhosa, were also supplied to every one of the 1 400 black schools in the Cape Province.¹⁰⁷

Conclusion

The period between 1896 and 1910 was characterised by improved medical understanding and organisation, as well as growing concern about the need to do something to curb the spread of tuberculosis. This took place on both the international and the local stage. In the Cape Colony, progress was hampered by the government's lack of leadership, its placing of the responsibility for the disease on local authorities and an unwillingness to contribute financially in the fight against the disease.

¹⁰³ N. Macvicar, 'The Native Health Society', *SAMR* (27 September 1913), 406-407.

¹⁰⁴ 'A Kaffir Pamphlet on Tuberculosis', *SAMR* (25 April 1909), 115.

¹⁰⁵ 'Passing Events', *SAMJ* (22 July 1911), 205.

¹⁰⁶ Macvicar, 'The Native Health Society', 407.

¹⁰⁷ *Ibid.*, 407.

In the light of government's attitude, the Association for the Prevention of Consumption, individual doctors such as Neil Macvicar, and organisations such as the Native Health Society, played an important role in creating public awareness. Even with these initiatives, there was still much to be done. With government entrenched in its views, it was fortunate that political unification was on the horizon. Even then, public health was not an immediate priority. Notwithstanding this, two of the major concerns of the association were addressed within the next few years. The first was the restriction of consumptive immigrants; and the second was the appointment of a commission of enquiry into the prevalence of tuberculosis across South Africa. A new Public Health Act was only implemented in 1919.

In the next chapter the focus is on the end of the colonial period in the Cape and what this meant for public health in general and tuberculosis in particular. Thereafter attention shifts to the implementation of the *Immigration Restriction Act*.

Chapter 6

Transitions: Tuberculosis from Colony to Union; and the Regulation of Tubercular Immigrants, 1910-1913

Since 1903 South African medical practitioners had been working towards a unified approach to medical challenges. Their efforts preceded those of the politicians, whose negotiations culminated in a meeting in Durban in 1908 to discuss the terms of political Union. Representatives of the Cape Colony, Orange River Colony, Natal and Transvaal attended the National Convention of 1908. Proposals were incorporated into a bill which was duly passed by the British parliament, inaugurating the Union of South Africa on 31 May 1910 in terms of the *South Africa Act*.¹

This chapter discusses the impact of political union on public health. While the logical conclusion is to assume that medical matters would have been addressed in the *South Africa Act* this was not the case. The reality was that public health was not an immediate priority for the Union government. It took almost another decade before this was fully addressed in the *Public Health Act, Act No. 36 of 1919*. Tuberculosis was one of the first diseases to receive attention. This was the result of a combination of factors. As we have seen, internationally tuberculosis was receiving increased attention. There was also a global trend to re-evaluate immigration policies. The growing influence of eugenics, particularly the fear of 'degeneration', influenced the type of individuals who would be welcome. In the newly-unified South Africa desirable immigrants did not include tubercular sufferers.

Political Union and Public Health

Because the new political Union did not provide for a central department of health, the responsibility for health care fell primarily to the four provincial governments.² The Union government was responsible for the control of infectious diseases

¹ C.F.J. Muller (ed.), *Five Hundred Years. A History of South Africa* (Pretoria: Academica, 1975), 376.

² *Ibid.*, 376-378.

hospitals and the supervision of the local authorities with regard to vaccinations for diseases such as smallpox, and the care of those suffering from infectious diseases, including tuberculosis.³ Despite this, the central government contended that the care of tubercular paupers was the responsibility of the local authorities.⁴

Without any further provisions for public health, the Union government was left with no alternative but to allow the provinces to continue with the arrangements that existed prior to unification. This created a variety of problems. For instance, in Natal the *Public Health Act, 1901* required annual parliamentary renewal and had been allowed to lapse after Union, leaving no public health legislation in place. The Transvaal also lacked a general Public Health Act but had a number of laws dealing with infectious diseases.⁵ In Johannesburg, for example, voluntary notification of tuberculosis had been in place since July 1907,⁶ and it was added to the list of infectious diseases in the province in July 1914.⁷ In the Orange Free State public health was administered under Ordinance No. 31 of 1897. While this empowered the government to proclaim provisions preventing the spread of tuberculosis, local authorities had to apply for its implementation, with the result that it was only operational in a few municipalities.⁸

Political union had important ramifications for the Cape. For a start, the executive was based in Pretoria, moving the centre of power away from the Cape. In addition, the Cape health department ceased to exist when the *South Africa Act* came into operation. It was Gregory who bore the brunt of the change. In 1909 he had acknowledged that the annual report for that year was likely to be his last on the

³ National Library of South Africa, Cape Town (hereafter NLSA), Union of South Africa, Govt. Reports (hereafter UG), NLSA, UG34-1914, *Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 241.

⁴ 'The Association of Municipal Corporations of the Cape Province', *Municipal Journal of South Africa* (September 1918), 19.

⁵ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 254-255.

⁶ *Ibid.*, 45.

⁷ 'Report of the Medical Officer of Health for Johannesburg', *South African Medical Record* (hereafter *SAMR*) (24 July 1915), 214.

⁸ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 255.

status of public health in the Cape.⁹ Gregory's predictions were well-founded. In 1910 his authority as head of the public health department was revoked, and although he undertook to 'loyally' carry out instructions from the minister of the interior, he was informed that his staff would no longer be under his direct authority. His position from then onwards was to advise the minister if and when advice was requested.¹⁰ It was not long thereafter that Gregory was placed 'on pension'.¹¹ The British Medical Association of the Cape led a campaign in support of Gregory being appointed as medical officer of health (MOH) for the Union, citing his many years of experience and his competence as both an administrator and organiser. Copies of the resolution were forwarded to various government officials as well as all medical societies and the press.¹² Despite these efforts, Gregory did not receive the post. Instead, he was offered a position in the census department, which he declined.¹³

In February 1911, the government took the first steps to appoint a MOH for the Union.¹⁴ The post was only filled in 1913, and in the interim public health remained under the control of the minister of the interior. In 1913 an advisory MOH, Dr Arnold, was appointed. Three additional assistant health officers were also appointed for the provinces, and these posts were based in Cape Town, Durban and Bloemfontein.¹⁵ Dr E.N. Thornton, who had previously worked for Gregory and was

⁹ NLSA, UG1-1911, Cape of Good Hope, Report of the MOH for the Colony on the Public Health and Cognate Matters Including the Registration of Births, Deaths and Marriages for the Year 1909 (Cape Town: Government Printer, 1911), 74.

¹⁰ Cape Archives (hereafter CA), Archives of the Medical Officer of Health (hereafter MOH), MOH 415, Correspondence H.B. Lowe to J. Gregory, 25 August 1910 and 30 August 1910.

¹¹ CA, Archives of Municipality of King William's Town (hereafter KWT), 3/KWT, 4/1/204, Minutes of Town Council of KWT meeting, 17 June 1911, Resolution on Gregory, MOH, Cape Colony.

¹² 'British Medical Association C.G.H. (Western) Branch', *SAMR* (8 July 1911), 187-188; and *SAMR* (22 July 1911), 203.

¹³ CA, MOH 396, Folio U52, Letter Dr Gregory to Dr Dirk de Vos Hugo, Worcester, 29 August 1910. In 1912 Gregory was appointed as chairman of the Tuberculosis Commission.

¹⁴ CA, Archives of the Municipality of Cape Town (hereafter CT), 3/CT 1/1/1/66b, City of Cape Town Mayor's Minutes, 13 March 1911, 142. Government Notice No. 308/1911 contained in the *Government Gazette*, 20 February 1911.

¹⁵ J.E. Holloway, *Official Year Book of the Union of South Africa and of Basutoland, Bechuanaland Protectorate, and Swaziland Statistics Mainly for the Period 1910-1924*, No. 7-1924 (Pretoria: Government Printer, 1925), 185.

the secretary at the 1906 conference of principal medical officers of health for the colonies, was appointed as the provincial medical adviser for the Cape Province.¹⁶

There were two attempts to enact very limited public health bills in 1911 and 1912, but these encountered so much opposition, particularly from local authorities who felt that the bills were impinging on their powers, that they were dropped. A further reason for delaying the passing of a Public Health Act was that the Tuberculosis and Venereal Disease Commissions were sitting at the time and had not yet submitted their reports. By delaying legislation, it was anticipated that some of the recommendations made by these Commissions could be incorporated into the legislation. Thereafter a comprehensive new bill was drafted and widely circulated for comments. The outbreak of the First World War in 1914 further delayed the consideration of a public health bill for nearly three years.¹⁷

In the meantime, the medical profession continued with the practice of holding annual medical congresses. The main preoccupations regarding tuberculosis remained the same – the appointment of a commission of enquiry and appeals to the government to contribute towards the costs of fighting the disease.¹⁸ While calls for financial assistance fell on deaf ears, a commission of enquiry was indeed appointed in February 1912. The work of this commission is discussed in the next chapter. One of its terms of reference was to make recommendations on the restriction of immigrants suffering from tuberculosis. This formed the subject of a separate report, which was completed two years prior to the main Tuberculosis Commission Report.¹⁹ This issue is discussed in the next section.

¹⁶ CA, 3/CT 1/7/1/18, Corporation of the City of Cape Town, Minute of the Mayor (Hands), for Year ending 31 August 1913 (Cape Town: Government Printer, 1913), 90.

¹⁷ H. Phillips, 'History of Medicine: Origin of the Public Health Act of 1919', *SAMJ*, 77 (May 1990), 531.

¹⁸ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 20.

¹⁹ NLSA, UG42-1912, Tuberculosis Commission, Report on Admission of Tuberculous Immigrants into the Union (No publishing details).

The Regulation of Tubercular Immigrants

As we have seen, the restriction of tubercular immigrants received attention prior to Union. In the Cape Colony the main bone of contention was the financial burden which resulted from the care of indigent consumptives. Although the Cape Colony had issues with accepting tubercular immigrants, it was Natal that was in the forefront of the fight against the entry of sufferers into that colony. It was on their initiative that the matter was raised at the 1906 conference of medical officers of health.²⁰ Although they had the means to restrict their entry into Natal in terms of the *Immigration Restriction Act, Act No. 1 of 1897* (Natal Act) they had not yet enforced the provisions of the act insofar as tuberculosis was concerned. The primary object of the Natal Act was to exclude Indians, but because they were British subjects this had to be achieved by covert means. Joseph Chamberlain, the British secretary of state for the colonies at the time, explained that he was

...very much opposed to any such legislation specially directed against persons of a particular race or colour, though he would not have the same reasons for objecting to local legislation imposing restrictions upon the immigration of indigent or ignorant persons, on the ground that they were liable to become a charge upon the Colony ...²¹

This led to the incorporation of a 'means test' to satisfy the 'indigent' component, and the 'education test' to deal with 'ignorant persons'.²² A further clause was included to bar entry for those 'suffering from a loathsome or a dangerous contagious disease'.²³ These clauses opened the door for the exclusion of consumptives. Heavy penalties were imposed on the master and owners of ships who allowed prohibited persons to land. Fines of £100 sterling for one infringement,

²⁰ This conference is discussed in more detail in the next section.

²¹ Cited in J. Martens, 'A Transnational History of Immigration Restriction: Natal and New South Wales, 1896-97', *Journal of Imperial and Commonwealth History*, 34, 3 (September 2006), 333.

²² *Immigration Restriction Act, Act No. 1 of 1897* (Natal), Section 3(a). Any person who, when asked to do so by an officer appointed under this Act, shall fail to write out and sign, in the characters of any language of Europe, an application to the Colonial Secretary in the form set out in Schedule B of this Act. Section 3(b) Any person being a pauper, or likely to become a public charge.

²³ Section 3(c) (e) and (f) of the *Immigration Restriction Act, Act No. 1 of 1897* (Natal).

rose to as much as £5,000 sterling, with vessels being executable until penalties were paid.²⁴

The Natal law became a dubious but significant model which was used as the basis for Australian immigration legislation and for the Cape's *Immigration Restriction Act* of 1902.²⁵ The fact that Chamberlain had given such legislation his blessing gave these measures greater sanction throughout the British Empire. As Martens has pointed out,

In the grand imperial scheme of things, the small Colony of Natal was an insignificant and peripheral dominion and yet its solution to the 'Asiatic question' in 1897 was to have a significant impact on the history of immigration restriction in the British Empire. The Commonwealth of Australia, New Zealand, the Cape Colony and Transvaal all adopted the 'Natal test', as did South Africa following the creation of the Union.²⁶

The New Zealand response was more complex since there were two schools of thought about tubercular immigrants. Although the government distributed promotional literature in favour of the colony as a destination for consumptives, several parliamentarians spoke out against the practice as early as 1897-1898. The debate focused on infectious diseases, among which tuberculosis had a place. While the legislation was finally dropped as part of an amendment to New Zealand's Public Health Act, a clause restricting entry of 'persons suffering from a contagious disease which is loathsome or dangerous' was slipped into the New Zealand Immigration Restriction Bill and was enacted in 1899.²⁷

In November 1902, the topic of immigration restriction was raised in the Cape parliament. In opening the debate, Peter Faure, the Cape colonial secretary, confirmed that the bill had been largely influenced by the Natal Act, and was designed to exclude 'a class of people whom [South Africans] did not desire to see

²⁴ Section 8 of the *Immigration Restriction Act, Act No. 1 of 1897* (Natal).

²⁵ Martens, 'A Transnational History of Immigration Restriction', 323.

²⁶ *Ibid.*, 339.

²⁷ L. Bryder, 'A Health Resort for Consumptives: Tuberculosis and Immigration to New Zealand, 1880-1914', *Medical History*, 40 (1996), 459-461. This clause was modelled on the Natal Act of 1897. New Zealand, dubbed a 'social laboratory' was an example of the challenges in restricting the entry of consumptives. By 1904 New Zealand relied heavily on discouraging the practice of sending out sufferers from Britain for the 'benefit of their health'. *Ibid.*, 461-462.

here'.²⁸ For the most part the debate was directed against the immigration of Indian and Chinese people, as well as East European Jews.²⁹ Before 1900 Asian immigration was not an issue; it was only when the number of Indian and Jewish migrants increased during the South African War that government administrators wished to take legislative action.³⁰

During the parliamentary debate Colonel Tamplin, representing Victoria West, drew attention to the need for the restriction of tubercular immigrants. He was keen that sufferers should be excluded altogether but his proposal did not gain sufficient support and ultimately he was forced to back down.³¹ However, the 1902 *Immigration Restriction Act* also sought to exclude immigrants without the financial resources to support themselves.³² Clause 2 (b) stated that 'any person who is not in possession of visible means of support or is likely to become a public charge' should be excluded. A minimum of £20 was considered to be sufficient to keep an immigrant for a reasonable time while such individuals looked for employment.³³

It was this clause which could be used to bar entry to indigent people suffering from tuberculosis. However, as a tool for the management of tuberculosis, it was a blunt instrument. Although port health officials were on the look-out for the disease, early cases were difficult to diagnose. Ultimately, in Cape Town only nine tuberculosis sufferers who were deemed to lack 'visible means of support' were detected in 1904, and in 1905 there were only 10 such persons.³⁴ These individuals were

²⁸ NLSA, *Cape of Good Hope, Debates in the House of Assembly, 1902. Fourth Session of the Tenth Parliament of the Cape of Good Hope, 20 August to 14 November 1902* (Cape Town: Government Printer, 1903), 12 November 1902, 666.

²⁹ R. Mendelsohn and M. Shain, *The Jews in South Africa: An Illustrated History* (Johannesburg: Jonathan Ball, 2008), 14-15.

³⁰ V. Bickford-Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town* (Johannesburg: University of the Witwatersrand Press, 1995), 148.

³¹ 'Report of Proceedings of the House of Assembly', *Cape Times*, 13 November 1902.

³² *The Immigration Act, Act No. 47 of 1902* (Cape Colony).

³³ NLSA, Official Publications (Cape Colony), Govt. Reports (hereafter G), G48-1907, *Report of the Conference of the Principal Medical Officers of Health for the different British South African Colonies, together with the Minutes of Meetings*, Cape Town, 13-26 November, 1906 (Cape Town: Government Printer, 1907), 23.

³⁴ NLSA, G39-1906, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health and on the Government and State-aided Hospitals of the Colony together with*

required to provide a bond for their upkeep.³⁵ Several admitted on this basis depleted their funds within a few months and there was no alternative but to admit them to the New Somerset Hospital, where they were treated and maintained at public expense.³⁶

The 1906 Medical Congress, the Conference of Principal Medical Officers of Health and the 1906 Cape Immigration Act

By 1906 immigration was again a hot subject of discussion, with parliamentarians seeking new ways to improve on the 1902 legislation. For the medical profession this was an ideal opportunity to call for the restriction of consumptive immigrants into the country, and they raised the matter at the annual medical congress in Bloemfontein that year. Much of the emphasis was placed on the role of the shipping companies. Since they had marketed the colony as a destination for sufferers, the medical profession felt that the shipping companies should take responsibility for their passengers and that if sickly and indigent immigrants were denied entry, the shipping companies should be obliged to return them to their port of embarkation. The delegates also stressed the importance of not allowing sufferers to share cabins with healthy individuals, and the necessity of disinfecting their cabins after use. However, the doctors felt that sufferers with financial resources should be granted entry if they undertook to take reasonable precautions to prevent the spread of their disease. They would also be obliged to notify officials of their address and any changes of residence. The congress also held the view that any prospective legislation should be uniform throughout South Africa.³⁷

The idea of a uniform policy was also being raised in government circles. At the request of Natal's colonial secretary, the issue was added to the agenda of 1906

the Reports of District Surgeons and Local Authorities for the Years 1904 and 1905 (Cape Town: Government Printer, 1906), Report no. A-17 and no. A-18.

³⁵ Ibid., Report no. A-18.

³⁶ NLSA, G48-1907, *Report of the Principal Medical Officers of Health*, 23.

³⁷ CA, MOH 323, Folio G117b, Resolutions of the South African Medical Congress, 1906.

conference of the South African principal medical officers of health.³⁸ In an internal document between Gregory and the Cape colonial secretary, Dr Gregory admitted that he did not see how such a restriction could be ‘successfully or humanely’ implemented. Diagnosing sufferers would present a challenge, especially when the disease was in its early stages. He also thought it would be unreasonable to exclude a few individual sufferers on the grounds of public health when the disease was already so rife in the colony and so little was being done to prevent local consumptives from spreading the disease. Gregory did, however, feel that from an immigration standpoint the matter was worth considering. He thought the restriction should apply only to pulmonary tuberculosis and to advanced cases; and that the circumstances of the sufferers, especially their financial means, should be taken into account.³⁹

The discussion at the 1906 conference of principal medical officers of health did not take the matter much further. Dr Hill, the MOH for Natal was the most vocal of all the delegates. He made no secret of the fact that he wanted to place a ‘strong restriction’ on consumptives unless they had independent means. He made the point that the patient could just as easily be treated in a sanatorium in England. He added that Natal could, in terms of its *Immigration Restriction Act of 1897* exclude persons who showed outward visible signs of disease. All that was needed was for the Natal government to tell the immigration officer to exclude them as ‘undesirable immigrants’. He was convinced that under these circumstances, the shipping agents would take care not to allow them to travel in the first place.⁴⁰

Dr Fleming, representing Southern Rhodesia (now Zimbabwe) reminded the delegates that they should not forget that some of the country’s ‘best men’ had come to the country as phthisical patients.⁴¹ Gregory, in turn, was not in favour of

³⁸ CA, MOH 317, Folio A117a, Letter from Colonial Secretary, Pietermaritzburg, to Colonial Secretary, Cape Town, 9 May 1906.

³⁹ CA, MOH 317, Folio A117a Memorandum from A.J. Gregory to Under Colonial Secretary, 30 May 1906.

⁴⁰ NLSA, G48-1907, *Report of the Principal Medical Officers of Health*, 23.

⁴¹ *Ibid.*, 23.

drastic measures to exclude diseased persons, but thought the governments should put their foot down in not accepting 'derelicts' from other countries.⁴²

Ultimately the delegates came to the conclusion that no special measures other than those which applied to all indigent, sick persons, could be employed in the case of consumptives with justice and efficacy. They believed that efforts should be made to deter the immigration of consumptives from abroad. Once they were in the colony, internal measures should apply regardless of whether the consumptive was a local resident or an immigrant.⁴³ The conclusions taken in 1906 demonstrate the reluctance of the various government health departments to tackle the problem of tubercular immigration restriction head-on. This was particularly evident in the comment that 'the imposition of restriction would be problematical, and not produce adequate results because the disease was already established in the country'.⁴⁴

Meanwhile, shipping companies had already begun to take precautions to safeguard their own interests. They began charging the traveller for the return voyage before departure if there was reason to suspect that entry to South Africa might be denied. The cost of the return ticket was refunded if the immigrant was granted entry.⁴⁵

Unfortunately, although tuberculosis was at the forefront of these meetings, and while there was no shortage of opinions, the discussions failed to translate into a cohesive policy framework. Neither meeting took cognisance of the fact that immigration to the colonies by consumptives was already on the decline.⁴⁶

In the Cape parliament the debate on the 1906 immigration regulations featured tuberculosis more prominently than in the 1902 discussions. It focused on the clause classifying those 'suffering from a contagious or incurable disease of a loathsome or

⁴² Ibid., 13-26, 23-24.

⁴³ Ibid., 8-9.

⁴⁴ Ibid., 8.

⁴⁵ Ibid., 23.

⁴⁶ NLSA, G40-1907, *Cape of Good Hope, Report of the Medical Officer of Health for the Colony on the Public Health for the Calendar Year 1906* (Cape Town: Government Printer, 1907), 14.

dangerous character' as prohibited immigrants.⁴⁷ However, as was usual in discussions on tuberculosis, opinion was divided on whether consumptives should be allowed into the country. On the one hand, there was the view that entry should not be denied to those who could benefit from the climate as 'many consumptive people had come here and lived to a ripe old age'. There was also concern expressed that consumptives who travelled abroad would be refused re-entry to the Cape should the clause be retained. A proposal that tuberculosis should be exempted from the operation of the clause was not entertained. On the other hand, the opinion was aired that tuberculosis had spread to the black and Coloured population from consumptives who had come to the Cape for health reasons and therefore the clause should be retained and be made more stringent. A further view was that the various diseases classified as 'contagious and incurable' should be named and that this list should be capable of amendment by way of regulation. After some discussion, the decision was taken to omit the clause altogether.⁴⁸ The end result was that it was only lunatics who were excluded from the Cape Colony for purely health reasons.⁴⁹

The act itself was only promulgated on 13 February 1907. The task of implementing and administering the law fell on Gregory's shoulders. In his opinion, the 1906 act was a 'great advance on the previous law' because the number of undesirable persons who could claim exemption had been more carefully limited. Ordinary immigration was not affected, but wider and stronger powers were given for restricting the entry of 'the undesirable, the vicious and the criminal'.⁵⁰

Although the 1906 act did provide some mechanisms to exclude consumptives, it did not address the issue directly. This opportunity came four years later, when the Cape

⁴⁷ NLSA, House of Assembly Bills, AB11-1906, Bill to Amend the Law Placing Restrictions on Immigration and Providing for the Removal from the Colony of Prohibited Immigrants. To be Read a Second Time on Wednesday 20 June 1906, 1.

⁴⁸ NLSA, *Debates in the House of Assembly, 1906, Third Session of the Eleventh Parliament of the Cape of Good Hope, 25 May to 20 August 1906* (Cape Town: Government Printer, 1906), 14 August 1906, 584-585.

⁴⁹ Section 3(d) of the *Immigration Act, Act No. 30 of 1906* (Cape Colony).

⁵⁰ NLSA, G21-1907, *Cape of Good Hope, Colonial Secretary's Ministerial Division, Report on Immigration and Labour for the Year ending 31 December 1906* (No publ., 1907), 8.

Colony was incorporated into the Union of South Africa along with the Transvaal, Natal and Orange River Colony in 1910.⁵¹ Union had a direct impact on immigration because it was necessary to consolidate the policies in place in the various colonies and to create a new vision for the Union as a whole.

Regulation of the Immigration of Tubercular Immigrants: The Debate Continues after Union

The restriction of entry of tubercular immigrants was raised again after Union at a time when the issue of immigration was centre-stage. There were now four provinces, each with its own identity and challenges as far as immigration was concerned. One of the main tasks the legislators faced was to repeal existing laws and replace them with a consolidated act that satisfied each of the four provinces.

The new central government had its own set of concerns. One challenge was to build a nation from a population wracked with tension and conflict. Less than 10 years earlier, all its people had been involved in the long and bloody South African War (1899-1902). The bitter legacy of the war was difficult to erase. Although much of the recent work on this war has shown that the entire population was impacted by the conflict, parliamentary discussions of the 'racial question' at the time of Union referred almost exclusively to animosity and friction between Afrikaners and English speakers. This legacy persisted far beyond the formative years of the Union, as did the contestations over the relationship between the Union and Britain.⁵²

Central to the definition of the South African immigration policies was, first, the attempt by whites to maintain and increase their racial dominance by increasing their numbers; and secondly, the intense competition for power and status between the two white language groups consequent upon the emergence of an Afrikaner

⁵¹ This was achieved in terms of British legislation as *The South Africa Act, 1909*.

⁵² S. Peberdy, *Selecting Immigrants. National Identity and South Africa's Immigration Policies 1910-2008*. (Johannesburg: Wits University Press, 2009), 31-32.

nationalism that was fearful of British domination.⁵³ For most of the twentieth century, immigration in South Africa meant white immigration. However, some whites were considered more acceptable than others. According to Peberdy,

The criteria used for the selection of immigrants revealed a great deal about the white minority government's prejudices. Immigrants who were permitted into the country were those seen to be potentially useful members of society or those who would 'fit' into society. While immigrant selection may have been tied to productivity, class, wealth and skills, the process conveyed powerful ideas about the self-image of the state, about race and national origins, and about the stereotyping of peoples and territories.⁵⁴

It was the opinion of Jan C. Smuts, who was the minister of the interior in 1913, that '... those who were in a country had the right to the selection of those entering that country'.⁵⁵ It had been with this type of sentiment in mind that the existing law in Natal had sought to exclude the entry of Indians; while in the Cape, legislation was geared towards anti-Jewish and anti-Chinese sentiment.⁵⁶ Similarly, the Transvaal also wished to exclude the Chinese.⁵⁷

In addition to taking cognisance of the legislation of the various provinces, the Union government was also influenced by the wider international framework of immigration legislation, especially in the British Empire. The relationship with Britain was governed by the fact that the Union of South Africa was not a fully autonomous, independent state; rather, it was subjected to the influence of the British government because of its dominion status. All legislation passed in South Africa was subject to the ratification or assent of the British monarch, or his/her representative

⁵³ E. Bradlow, 'Immigration into the Union, 1910-1948', PhD thesis, University of Cape Town, 1978), 174.

⁵⁴ Peberdy, *Selecting Immigrants*, 2.

⁵⁵ *Ibid.*, 1.

⁵⁶ *The Immigration Restriction Act, Act No. 1 of 1897* (Natal); *The Chinese Exclusion Act, Act No. 37 of 1904* (Cape Colony); and *The Immigration Act, Act No. 30 of 1906* (Cape Colony).

⁵⁷ The Transvaal Labour Importation Ordinance, No. 17 was passed on 11 February 1904. See also K. Harris, 'Paper Trail: Chasing the Chinese in the Cape (1904-1933)', *Kronos*, 40, 1 (November 2014), 137.

in South Africa, the governor-general, and no act of the Union could conflict with British legislation.⁵⁸

The difficulty facing the state was how to reconcile these various interests to build nationhood, but at the same time appease Britain. One of the central issues on immigration in 1913 was the vision of South Africa as a 'white man's land'.⁵⁹ There were two primary aspects to this at the time – the exclusion of Indians, and the exclusion of certain categories of Europeans, for example, those who suffered from tuberculosis. The twist was that Indians, as well as many of the tuberculosis sufferers, were British subjects. The way this had been approached previously has already been discussed. The situation faced by the Union government was familiar terrain.

In a frank discussion in parliament in April 1913, Jan Smuts admitted that to call a 'spade a spade' and define exactly what type of person the Union would like to bar from entering the country was by no means straightforward, because the Union was an integral 'part of the British Empire' and as such had certain obligations. But South Africans, he said:

...wanted to be masters in their own house, and they wanted to be in a position to say whom they did not want in the country ... they all knew it was the intention of South Africa to exclude Asiatics ... it was a matter of the self-preservation of the white man in South Africa ... Therefore, they would avoid naming any race by name, and excluding them on that account, but [at the same time] ... make it clear that they deemed the European civilisation the desirable one from which to see progress and advancement of the country.⁶⁰

The desire to exclude Indians was only one aspect of the legislation.⁶¹ But while the government was keen to attract white immigrants, this did not include those who were referred to as 'the diseased and the degenerate'. As discussed by Peberdy:

⁵⁸ Peberdy, *Selecting Immigrants*, 32.

⁵⁹ *The Immigration Regulation Act of 1913* applied for immigration from abroad not migration from elsewhere in Africa. By this time such migration was well established in the mining industry.

⁶⁰ NLSA, House of Assembly Debates, 30 April 1913, 2050-2051.

⁶¹ The education test enshrined in Section 3(a) of the *Natal Immigration Restriction Act of 1897* was to keep Indians out without naming them. This also became law in Western Australia, New

Although white immigration was desirable, individual white immigration might not be. Considerable effort and debate were devoted to determining who was and who was not a 'threat' to the health of the imaginary nation. Buttressed by biological and medical metaphor, the State defined for exclusion those who might pollute the moral fabric of the nation, as well as those whose physical characteristics and state of health would corrupt and undermine the vitality of the national body.⁶²

Persons who might 'pollute the moral fabric of the nation' had already been targeted in the 1902 Cape colonial legislation on immigration restriction.⁶³ This was in terms of Section 2 (e) of the Act, which denied entry to anyone, male or female, who lived on or received any part of the proceeds of prostitution. Those with criminal records were also barred from entering the Cape.⁶⁴ Prostitutes and pimps were likewise denied entry in terms of the 1913 Act.⁶⁵

The 1913 Immigration Act extended the list of those who could be refused entry on medical grounds. The 1902 *Cape Immigration Restriction Act* only excluded lunatics. In terms of Section 4 (h) of the 1913 Act, lepers and those afflicted with 'infectious and contagious' diseases defined by regulation (other than tuberculosis) were denied entry.⁶⁶ Also excluded were the physically or mentally disabled unless they were accompanied by a person who was prepared to offer security for their support.⁶⁷ Physically or mentally disabled people were not only seen as a threat to the existing population, but to future generations, as 'there would be no security against such persons marrying and reproducing their kind in this country'.⁶⁸

The situation as far as tuberculosis was concerned was not as cut and dried. Recognising this to be the case, and its importance, the matter was referred to the Tuberculosis Commission for its report and recommendations.

South Wales and Tasmania in 1897. See J. Bashford and C. Gilchrist, 'The Colonial History of the 1905 Aliens Act', *Journal of Imperial and Commonwealth History*, 40, 3 (2012), 418.

⁶² Peberdy, *Selecting Immigrants*, 34.

⁶³ *The Immigration Act, Act No. 47 of 1902*.

⁶⁴ *The Immigration Act, Act No. 47 of 1902*.

⁶⁵ Section 4 (e) of *The Immigrants Regulation Act, Act No. 22 of 1913*.

⁶⁶ The regulations for tuberculosis sufferers were different, see later in this chapter.

⁶⁷ Section 4(g) of *The Immigrants Regulation Act, Act No. 22 of 1913*.

⁶⁸ NLSA, *House of Assembly Debates, 1913*, 20 May 1913, 2610.

Report of the Tuberculosis Commission regarding Tubercular Immigrants

There were several reasons why the question of tubercular immigrants was referred to the Tuberculosis Commission. First of all, the fact that the commission had already been appointed provided an ideal opportunity to tap into its views on the subject, and those of the medical profession. Previous discussions on tuberculosis had always been highly emotive, yielding sharply divided opinions.

There was now a wider global stage and several other countries were taking action to restrict the entry of consumptives. Referring the matter to the Tuberculosis Commission gave parliament the benefit of the commissioners' insight into the steps being taken in other parts of the world. In the United States of America, for example, restrictive legislation against consumptives was enacted in 1907. This was in terms of the *Immigration Act of 20 February 1907*, which read: 'Persons afflicted with tuberculosis or with loathsome or dangerous contagious diseases shall be excluded from admission into the United States'. The Act further provided that all arriving aliens would be subject to 'physical and mental' inspections by medical officers. The problem was that the medical inspection was cursory at best, with approximately two minutes devoted to each examination. About 70 per cent of prospective immigrants were admitted after this examination. The remainder were subjected to a more extensive investigation. Very few cases of tuberculosis were detected. In 1909, for example, there were 751 786 immigrants admitted while only 10 411 were barred from entry, of whom only 82 were suffering from tuberculosis.⁶⁹

The Tuberculosis Commission recounted the American experience in much detail to demonstrate that even when tuberculosis was rigidly excluded and there was a well-organised system of medical examination in place, it was difficult to detect the disease.⁷⁰ Those suffering from tuberculosis were also excluded from entry into

⁶⁹ NLSA, UG42-1912, *Union of South Africa. Tuberculosis Commission, First Report on the Question of the Admission of Tuberculous Immigrants into the Union* (No publishing details), 2.

⁷⁰ *Ibid.*, 3.

Canada. Experience had shown that they, too, faced the same difficulties in the detection of cases.⁷¹

Western Australia shared a similar history to the Cape Colony in dealing with consumptive immigrants. By 1906 its medical profession was calling for the exclusion of tubercular sufferers. The appropriate legislation was enacted in 1912 and in terms of the *Immigration Act No. 38 of 1912* all persons suffering from pulmonary tuberculosis were barred from admission to Western Australia. Even with the provision in place, some sufferers still managed to slip through the cracks. The response by the public health department was to deport newly arrived immigrants who suffered from the disease. However, unless they were in a public institution and were a drain on the government's financial resources, this proved difficult. The shipping companies were held financially responsible for the sufferers' care until they were deported, and had to bear the cost of the return voyage. Patients who were in an advanced stage of the disease and unable to travel were permanently incarcerated at the Wooroloo Sanatorium until their death.⁷²

It was against this international backdrop that the Tuberculosis Commission prepared its report on the question of the admission of tuberculosis immigrants into the Union. After setting out the history of those travelling to the country for 'health reasons', and how the disease had spread to the local population, the commissioners discussed the difficulty of diagnosis and that it would be impossible to exclude all sufferers. They argued in support of allowing sufferers into the country on humanitarian grounds, especially those who were in an advanced stage of tuberculosis, feeling that the rigours of the return voyage would probably hasten their death.⁷³

⁷¹ Ibid.

⁷² C. Fitzgerald, 'Kissing can be Dangerous: The Public Health Campaigns to Prevent and Control Tuberculosis in Western Australia, 1900-1960' (Crawley: University of Western Australia Press, 2006), 35.

⁷³ NLSA, UG42-1912, *Report on the Admission of Tuberculous Immigrants*, 3.

A further reason advanced in support of allowing consumptives, especially those in the early stages of the disease, to remain in South Africa was that there were many cases, including some who had testified before the Tuberculosis Commission, who had travelled to the country 'in search of health' and had gone on to make a full recovery. It was felt that it would be difficult to justify denying admission to consumptives if there was a possibility that living in the Union might assist their recovery. A further consideration was that the imposition of rigid exclusion might lead to consumptives concealing their condition, thereby increasing the risk of infecting others. The flip-side of the debate was that consumptives frequently became, at some stage or another, a liability to the state.⁷⁴

Faced with these difficulties, the commission recommended that every effort should be taken to discourage consumptives from coming to South Africa. Those who still elected to come would have to comply with certain regulations, including applying for the minister's consent to enter the country; providing proof of adequate financial resources; and agreeing to observe certain conditions relating to residence. A further recommendation was that they should only be permitted to enter at certain pre-defined ports.⁷⁵ The commission went on to provide very detailed recommendations on the role of the shipping companies, medical practitioners, and the consumptives themselves.⁷⁶

An important recommendation, based on the practice in USA and Canada, was that a medical examination should be carried out at the port of embarkation, as well as the port of arrival. The plan was that the cost of the initial examination should be borne by the shipping company, as well as the costs of the return voyage if the passenger was not granted admission. This examination would relate not only to tuberculosis, but to cases of persons who were either mentally or physically challenged or suffering from contagious diseases. It was also the duty of the shipping company's

⁷⁴ Ibid., 2.

⁷⁵ Ibid., 3.

⁷⁶ Ibid., 2-6.

surgeon to attest to the particulars contained in the initial report, with penalties accruing to the shipping company in all cases of inaccurate reports.⁷⁷

The final recommendation made by the commission was that a board of enquiry should be set up to deal with queries. In order to cover the costs of the board, it was suggested that a levy be placed on each incoming immigrant.⁷⁸

Parliamentary Discussion on Restriction of Tubercular Immigrants, 1913

When the question of tubercular immigrants was discussed in parliament as part of the wider immigration debate, it was clear that opinion was divided. Those who argued that restrictions should not be imposed on the entry of sufferers emphasised the contributions of eminent sufferers to the development of South Africa. Others were more concerned that people with tuberculosis posed a threat to South Africans, resorting to the usual metaphors and images to press their case. The view was expressed that tuberculosis had not only been spread in the Union by people seeking health cures, but that

... the descendants of tuberculosis people were also sick or weakly. The South African people had already ceased to be as sturdy as they formerly were, and why ... should they weaken the race further? ... It was their duty, in fairness to the coming generation, to exclude these people.⁷⁹

The origin of this type of rhetoric had its roots in the eugenics movement in the 1860s when Francis Galton began to explore the inheritance of natural ability.

⁷⁷ Ibid., 5-6. The 1910 Canadian Act prohibited the entry of 'idiots, imbeciles, feeble-minded persons, epileptics and insane persons'. See A. Bashford, 'Internationalism, Cosmopolitanism and Eugenics', in A. Bashford, and P. Levine (eds), *The Oxford Handbook of the History of Eugenics* (New York: Oxford University Press, 2010), 159.

⁷⁸ NLSA, UG42-1912, *Report on the Admission of Tuberculous Immigrants*, 7.

⁷⁹ NLSA, *Union of South Africa, House of Assembly, Debates of the Third Session of the First Parliament, 1913*, 24 January to 16 June 1913 (Cape Town: Government Printer, 1913), 20 May 1913, 2610. What is interesting is the similarity of this debate to those in New Zealand in 1897, when a plan to restrict entry of those suffering from tuberculosis was discussed in parliament. Comments focused on heredity, rather than the infectious nature of the disease. One of the comments was that it was regrettable that more attempts were not made to prevent marriages 'with those who will hand down the hereditary form of this dire disease [tuberculosis]'. See Bryder, 'A Health Resort for Consumptives', 453-471.

Defined as the science of the 'well born', eugenics was intended as a social programme dedicated to the improvement of racial 'stock'. By about 1883 it began to attract widespread interest as a social philosophy. It drew strongly on social phobias arising from industrialism and urbanisation.⁸⁰

Twentieth-century eugenic societies and associations inherited a rich nineteenth-century tradition of international science meetings. Migration and its regulation was a popular topic. The organisers were assiduous about publishing their proceedings widely and quickly, providing detailed papers for scientific and social analysis. According to Bashford,

This period's phenomenal uptake of migration law and the eugenic clauses and powers was arguably the most internationally consistent manifestation of eugenic ideas not just as policy, but also as practice. The various immigration statutes were remarkably similar across time and national contexts, in their fairly sudden appearance, in their drafting, and in their increasingly eugenic rationales.⁸¹

Although there was a strong desire to attract immigrants, the experience of the South African War undoubtedly loomed large. It had seen many Britons volunteering for active service, only to be turned away due to poor-health. This had led to a wide-ranging debate about racial decline and national efficiency.⁸² It was only a matter of time before this line of thinking extended to include persons suffering from tuberculosis. The debate, in the South African context, was brought to the fore by Dr G.D. Maynard in 1912. As discussed in connection with the Tuberculosis Commission, Maynard's argument was that in his opinion, tuberculosis was *not* an infectious disease (in the sense that close contact with the sick was not a material risk) but that tuberculosis was first and foremost a *hereditary* disease. He maintained that the decreasing tubercular death rate could not be attributed to sanitary improvements, but was the result of the evolutionary concept of the 'selective death rate'.⁸³

⁸⁰ S. Dubow, 'Biological Determinism and the Development of Eugenics', in S. Dubow, *Illicit Union Scientific Racism and Modern South Africa* (Cambridge: Cambridge University Press, 1995), 120.

⁸¹ Bashford, 'Internationalism, Cosmopolitanism and Eugenics', 155.

⁸² A.S. Thompson, *Imperial Britain: The Empire in British Politics, c. 1880-1932* (London: Pearson Education, 2000), 140.

⁸³ Dubow, 'Biological Determinism', 142.

In medical circles, especially in the Cape, there was a strong focus on the fact that tuberculosis was an infectious disease that was spreading rapidly among the Coloured population. However, there was no mention of the infectious nature of the disease during the parliamentary debates.⁸⁴

The Immigration Regulation Act, Act No. 22 of 1913

The *Immigration Regulation Act* which was ultimately promulgated was a testament to the fears, prejudices and concerns of the period. Section 4 defined who could and could not enter South Africa. As enacted, it had two main purposes: to consolidate the immigration legislation of the provinces that made up the Union, and to halt any further immigration of people of colour.⁸⁵ In line with previous legislation, this was done by means of the 'education test'. The enforcement of this test on all immigrants would, however, have meant that unskilled agricultural workers and miners would also be excluded. This difficulty was overcome by exempting them, along with domestic servants and artisans, members of the military and mechanics, from the operation of the act providing that these prospective immigrants had pre-arranged employment of a minimum duration of one year.⁸⁶

Before discussing the regulations under which those suffering from tuberculosis were permitted to enter South Africa, there were two other prohibitions that would-be tuberculosis immigrants had to overcome. The first was the so-called 'means test' clause which was already in place in Natal and earlier Cape acts. This applied to individuals who were likely to 'become a public charge' because they lacked sufficient financial means. The clause also had reference to those suffering from

⁸⁴ South Africa was not alone in neglecting to discuss the infectious nature of tuberculosis in the parliamentary debates. Speaking on New Zealand's Public Health Act in 1897, Dr Francis McKenzie expressed the view that 'Those suffering from tuberculosis have so often the power of increasing rapidly, and the progeny have a tendency to develop the disease more readily than an ordinary person'. The bill, he claimed, did not result from a fear of spreading infection but rather from a desire to 'exclude people who are more likely to contract it'. See Bryder, 'A Health Resort for Consumptives', 460.

⁸⁵ Peberdy, *Selecting Immigrants*, 38.

⁸⁶ Sections 4(b) and 5(h) of *The Immigrant Regulation Act, 1913*.

'infirmary of mind or body' thereby bringing the ill and mentally challenged within its ambit.⁸⁷

In addition to these restrictions the minister had the discretion, in terms of Section 4 (a), to exclude anyone who 'on economic grounds or on account of standard or habits of life' was deemed 'to be unsuited to the requirements of the Union or any particular province thereof'. It was this section, in particular, which addressed the popular concerns about degeneration expressed in parliamentary debates that the government 'only wanted to encourage strong, healthy immigrants to come here'. It was, the minister of the interior declared, 'of vital importance whether a person was of sound physique, and did not bring disease into this country'.⁸⁸

This type of rhetoric was not new, and neither were the prejudices associated with it. Immigration restriction and regulations provided the ideal platform from which to control new arrivals to ensure they conformed to the national vision of an 'ideal society'. It was Section 4 (a) of the act, in particular, which gave expression to these prejudices. As it was so widely framed, it effectively gave the minister carte-blanche to determine who would be granted entry to South Africa, and in particular, gave him the power to bar the so-called 'degenerates' from entering the country.

Potential immigrants who were refused entry on medical grounds were those who were deaf, dumb, blind or otherwise physically afflicted, unless they were accompanied by a person who could provide for their permanent support. Also prohibited were lepers and those suffering from infectious and contagious diseases, other than tuberculosis. Those suffering from tuberculosis were required to apply for a permit to gain entry into the Union.⁸⁹

⁸⁷ Section 3(b) of the Cape *Immigration Act of 1906* had merely excluded those who 'were not in possession of visible means of support or likely to become a public charge', whereas Section 3 (b) of the Natal Act stipulated that 'any person being a pauper, or likely to become a public charge' were deemed prohibited immigrants.

⁸⁸ Peberdy, *Selecting Immigrants*, 51.

⁸⁹ Sections 4(g) and 4(h) of *The Immigration Regulation Act, Act No. 22 of 1913*.

Tuberculosis was only mentioned once in the act. This was in Section 4 (g) in terms of which sufferers were excluded altogether unless they were in possession of a permit granted by the minister. This permit not only granted permission for their entry, but also gave detailed instructions on what was expected of them during their stay in South Africa.⁹⁰ The legislature's acceptance of the recommendation made by the Tuberculosis Commission regarding admitting those with tuberculosis demonstrated that it recognised that this was a disease which, due to its unique characteristics of dormant and infectious stages, had to be treated differently from other infectious diseases.

The first stipulation was that sufferers were only permitted to land either at Cape Town or Durban. Prior to the issue of the permit, the applicant was required to sign a document which set out the conditions under which he/she was permitted to stay in the country. These conditions laid down:

- (a) That the place of residence and every change of residence of the holder of the permit and his/her manner of transport were subject to the approval of the immigration officer.
- (b) That the holder of the permit should not share a bedroom or other sleeping accommodation used by any other person.
- (c) That the holder had to follow the instructions of the local health authority with regard to the disposal of sputum, disinfection, and generally for preventing the spread of infection. In the event of there being no local health authority, the instructions were provided by the district surgeon or other authorised officer.
- (d) That the holder was required to present him/herself for regular medical examinations, and that the holder was responsible for the costs of the examinations.⁹¹

In addition to these stipulations, there were certain additional requirements which had to be met. A fee was levied for the issue of the permit and in addition the applicant was required to deposit a certain amount of money (ranging from £10 to £100) as security that he/she would observe the conditions imposed under the

⁹⁰ These were published in the *Government Gazette*, 11 July 1913, as Regulation no. 1079.

⁹¹ Section 18, 'Permits to Persons Suffering from Tuberculosis', Regulation no. 1079.

permit. These conditions were to ensure that the holder would keep the authorities informed of place of residence and provide proof of identity. Permits issued by the immigration officer were limited to seven days. The minister could issue permits valid for periods up to twelve months.⁹²

In line with the recommendations of the Tuberculosis Commission, an Immigration Board was set up. There was a right of appeal against the decisions of the Board.

The implications of the *Immigration Regulation Act* for those suffering from tuberculosis meant that only the wealthy were welcome in South Africa. Attitudes towards the disease had gone the full-circle, from a time when sufferers were welcomed, to the point when this was no longer the case.

Fortunately, at least for consumptives from Britain (who had always comprised the large majority of those travelling to South Africa) attitudes in Britain had also gone the full-circle. While nineteenth-century British medical practitioners may well have welcomed the opportunity to get rid of incurable cases of tuberculosis by recommending 'travel for a health cure', and may even have believed in the therapeutic value of migration, by the early twentieth century, attitudes in Britain were changing. By this stage 'open-air' treatment was growing increasingly popular and the treatment of tuberculosis was becoming a medical specialisation in its own right. These British specialists were now reluctant to lose their patients to foreign institutions and actively discouraged them from travelling abroad to seek relief from the disease.⁹³

The care provided in Britain to those suffering from tuberculosis was far in advance of anything on offer in South Africa. Faced with an administrative nightmare to obtain a permit; onerous conditions of residence; and the declining popularity of

⁹² Section 20, 'Permits and Certificates', Regulation no. 1079.

⁹³ Bryder, 'A Health Resort for Consumptives', 458. See Chapter 5 for a discussion of the improvements in the care of those suffering from tuberculosis in Britain.

'travel for a health cure', the passing of the *Immigration Regulation Act of 1913* no doubt spelt the end of an era for consumptive immigrants.

That was not the end of the story. As is so often the case, the closing of one door led to the opening of another. In this instance the positive outcome was the recognition by government and parliamentarians of the need to be guided by the medical profession in matters relating to public health. The formulation of the *Immigration Regulation Act* was the first occasion when the advice of experts regarding tuberculosis was actively sought – thereby setting the stage for greater cooperation between the legislature and public health officials when the 1919 Health Act was drafted.

Chapter 7

The Tuberculosis Commission, 1912-1914

The appointment of the Tuberculosis Commission on 26 February 1912 marked the culmination of years of pressure from both the medical profession and the local authorities in the Cape. One of the main rallying points had been the need for a national plan of action to deal with tuberculosis, and now that political Union had been formalised, it was felt that the implementation of a national policy would be somewhat easier to implement, although the absence of a department of health was an obstacle.

In a surprising move, Gregory, who had always been opposed to the appointment of a Tuberculosis Commission of Inquiry, was elected as the chairman. There were four other members, namely Drs R. Jameson, T. Te Water, Charles Porter and G.A. Turner.¹ Jameson did not play an active role in the proceedings of the commission although he was the president of the Association for the Prevention of Consumption.² This was a high-level team, each of whom was able to bring something unique to the table.

In the case of Gregory, it was his intimate knowledge of the Cape, gained over almost three decades, that led to his appointment. He had virtually created the Cape health department single-handedly, and retained this position until 1911. He had received strong support from the medical profession to take the helm as the Union's medical officer of health (MOH).³ Despite this he did not receive similar recognition from all government officials, particularly General Smuts, then the minister of the interior, with whom he had a serious personality conflict, to the point that Smuts

¹ National Library of South Africa, Cape Town (hereafter NLSA), Union of South Africa Govt. Reports (hereafter UG), NLSA, UG34-1914, *Union of South Africa. Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 257.

² Cape Archives (hereafter CA) Archives of the Municipality of Cape Town (hereafter CT) CA, 3/CT 1/7/1/11, Corporation of the City of Cape Town, Minute of Mayor (Thorne) for the Mayoral Year ending 22 September 1904 (Cape Town: Government Printer, 1904), 60.

³ 'British Medical Association C.G.H. (Western) Branch', *SAMJ* (22 July 1911), 203-204.

was opposed to Gregory holding any permanent government public health position. This opinion was confirmed by Gregory in a private communication between himself and Dr Dirk de Vos Hugo, district surgeon of Worcester and his personal friend, when he stated that,

As you know, when I went to Pretoria I did not find General Smuts by any means sympathetic to me or my work, and his first action in coming into office was to abolish the Health Department down here [Cape Colony] and attempt to remove me entirely from Public Health by putting me on to the Census, and it was only when he absolutely refused to give me any assurance with regard to Public Health that I declined to have anything to do with the Census. ... Since then I may mention, confidentially, that he has made an attempt to shunt me on to the Provincial Administration, with the distinct stipulation that I should do no Public Health work. Naturally I declined.⁴

His appointment as the chair of the Tuberculosis Commission may have been the result, at least in part, of sympathy felt by other government and medical professionals about the way he had been treated by Smuts. Gregory was familiar with the various towns in the Cape and had personal knowledge of the challenges faced by the district surgeons, medical officers of health, and the local authorities. In addition, he was experienced in report writing and the drafting of legislation.

Dr George Turner was probably the most notable medical doctor in the country. After leaving the Cape, where he had held the position of medical officer of health, he was appointed as MOH for the Transvaal in February 1901, a position he held until 1908.⁵ He was also a medical adviser to the Witwatersrand Native Labour Association (WNLA) providing advice pertaining to migrant mineworkers recruited from outside South Africa's borders.⁶ It was Turner who had a very personal contribution to make to the commission. He had contracted tuberculosis as a student at Guys College in London but had subsequently recovered. His son had also

⁴ CA, Archives of the Medical Officer of Health (hereafter MOH), MOH 396, Folio U52, Private communication between Gregory and Dr Dirk de Vos Hugo, 29 August 1910.

⁵ C.J. Beyers and J.L. Basson (eds), *Dictionary of South African Biography*. Vol. 5 (Pretoria: Human Sciences Research Council (hereafter HSRC), 1981, 665-666; 'Sir George Turner, MD', *British Medical Journal* (hereafter *BMJ*) 1, 2717 (25 January 1913), 188.

⁶ A. Digby, 'Medicine, Race and the General Good: Career of Thomas N.G. Te Water (1857-1926), South African Doctor and Medical Politician', *Medical History*, 51, 1 (January 2007), 40, 48.

contracted tuberculosis, presumably as a result of sharing a cabin with a person suffering from the disease, during a voyage to the Cape.⁷

Dr Charles Porter was the MOH for Johannesburg, a position that he had held since 1901.⁸ Prior to this appointment he worked in a similar capacity in Britain, including in Stockport for seven years. Stockport was a major industrial town in close proximity to Manchester where Porter gained experience of working-class living conditions. He held a law degree and was a member of the Bar and possessed a wide knowledge of the law of public health in Britain. He had a special interest in town planning, and was the president of the Transvaal Town Planning Association. Furthermore he had been involved in various commissions, including the Miners' Phthisis Commission of 1902, and an official investigation into insanitary areas that was followed by a report released in 1906. He was also responsible for the publication of annual reports on the public health of Johannesburg.⁹ In his capacity as MOH for Johannesburg he conducted personal visits to the insanitary areas in the city and had first-hand experience of the health challenges suffered by residents, especially the poor.¹⁰ His expertise in town planning matters was especially valuable because much of the report focused on housing conditions.

The remaining commissioner was Dr Thomas Te Water. Te Water was a member of a well-known family in Graaff Reinet, where he spent most of his life. He received his medical degree at Edinburgh University in Scotland. This was followed by two years of post-graduate work in Berlin, Vienna, Strasbourg and London. He qualified in 1881 and returned to Graaff Reinet in 1883 where he was the district surgeon and ran a private medical practice. In contrast to his work as a private practitioner, which

⁷ 'Cape of Good Hope Branch BMA, June 22, 1899', *South African Medical Journal* (hereafter *SAMJ*) (August 1899), 89.

⁸ V.A. Zangel, "'The Seething Masses': Housing, Water and Sanitation in the Lives of Johannesburg's Poor 1886-1906' (MA dissertation, North-West University, 2004), 45.

⁹ C. Adler, 'Dr Charles Porter, MB ChB (Hons and Exhibition) Ireland 1889, MRCS (Eng) 1891; DPH (Camb) 1889, Barrister-at-law Gray's Inn 1890', *Adler Museum Bulletin*, Vol 10, 2.

¹⁰ As a case in point, it was Porter to whom Mahatma Gandhi turned when conditions deteriorated in the Indian township in Johannesburg. Porter recommended that the residents be removed urgently, but before his warning could be acted upon the plague broke out in the area and the township was burnt to the ground in 1904. See Zangel, 'The Seething Masses', 70-75.

focused almost exclusively on white patients, Te Water treated patients of colour in his capacity as district surgeon. Here he was responsible for the medical care of prisoners, paupers and those suffering from syphilis and leprosy.¹¹ His district surgeon reports were unusually detailed, and he was one of the first doctors to draw attention to the increasing prevalence of tuberculosis in the Coloured community in the 1893 Cape public health report.¹²

In 1893, Te Water was elected as a member of the Cape parliament, and from January 1896 to May 1898 he held the post of colonial secretary in Sir Gordon Sprigg's cabinet. He also served as minister without portfolio under W.P. Schreiner from October 1898 to 1900.¹³ While he was a member of parliament, Te Water showed much determination in tackling issues of public health and was also somewhat unique in that he took a special interest in veterinary matters, an attribute which stood him in good stead in the Tuberculosis Commission's discussions on bovine tuberculosis.¹⁴

While there was no doubt that the commissioners brought a wealth of knowledge and expertise to bear on the Tuberculosis Commission, from the very outset there were divisions in the team. To some extent this may have had its foundation in matters unrelated to the commission itself. Within the small professional world of public health, Gregory, Porter and Turner had had interlocking professional careers that may well have produced hidden resentments. Turner had worked with Gregory in the Cape; and Porter was an unsuccessful applicant for the post to which Turner was appointed.¹⁵ Gregory had harboured ambitions of a senior public health appointment in the Union government, only to have been ousted altogether.¹⁶

¹¹ Digby, 'Medicine, Race and the General Good', 40, 48.

¹² NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 17.

¹³ Beyers and Basson (eds), *Dictionary of South African Biography*. Vol. 5, 766-767; Digby, 'Medicine, Race and the General Good', 52.

¹⁴ Digby, 'Medicine, Race and the General Good', 52.

¹⁵ *Ibid.*, 11.

¹⁶ It is possible that Gregory's ambitions went back to 1906 when the first meeting of principal MOHs was held in Cape Town. The idea was to hold annual meetings to promote cooperation but this did not materialise. See CA, Archives of the Municipality of King William's Town

Arguably a more substantive cause of disagreement and friction was that Porter and Turner had more professional experience on health issues in the mining industry than Gregory.¹⁷

The Commission's Terms of Reference

The terms of reference of the Tuberculosis Commission were extremely wide. The commissioners were required to investigate the extent of and reasons for the prevalence of tuberculosis among the different racial groups, especially as far as immigration, race, housing and living conditions were concerned.¹⁸ Once this was complete, they were required to provide advice on the best procedures to be followed by the government, local authorities and others to control the disease among those already affected and how to prevent its spread into new areas. In addition, the commission was required to investigate the extent and causes of the mortality of blacks employed on the Witwatersrand gold mines and their susceptibility to pneumonia, with special reference to those coming from tropical areas, and to make recommendations on the matter.¹⁹ Given its broad terms of reference, and the magnitude of the task facing the commissioners, it was hardly surprising that the report took more than two years to produce. During this time the commissioners interviewed a wide range of people throughout the country.²⁰

The commission had barely begun its proceedings when cracks emerged between the four members of the team. They held different points of view on the extent to which the infectiousness of the tubercle bacillus was responsible for the spread of tuberculosis.²¹ This became apparent after evidence was provided to the

(hereafter KWT) CA 3/KWT, 4/1/204, Minutes of Meeting of town council of KWT, 17 June 1911, Resolution on Dr Gregory, MOH for the Cape Colony.

¹⁷ Digby, 'Medicine, Race and the General Good', 11.

¹⁸ The findings of the commission on immigration are discussed in Chapter 6. They were contained in a separate report: NLSA, UG42-1912, *Tuberculosis Commission, First Report on Question of the Admission of Tuberculosis Immigrants into the Union* (Cape Town: Government Printer, 1912).

¹⁹ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 1.

²⁰ *Ibid.*, 3.

²¹ *Ibid.*, 118.

Tuberculosis Commission by Dr G.D. Maynard (at the time assistant medical officer to the WNLA, later assistant director of the South African Institute for Medical Research).²² This difference of opinion centred primarily on the role of heredity in causing tuberculosis. For the benefit of the readers of the report, it was decided that each commissioner would provide an interpretation and synopsis of his particular views.²³

The dominant view held in the Cape was that tuberculosis was caused by the tubercle bacillus, and nothing else, and that the disease could be controlled by the improvement of sanitary conditions.²⁴ However, in the Transvaal, tuberculosis was often associated with the mining industry. The challenges it faced were different from those facing the Cape (with the obvious exception of the Kimberley diamond mines). In the Transvaal the debate focused squarely on the causes of black susceptibility to tuberculosis, and most especially in the context of securing a reliable labour force.

Turner was a proponent of the view that tuberculosis among blacks was the result of 'their incomplete and inadequate adjustment to the conditions of urban life, their ignorance of sanitary habits, and their adoption of European patterns of dress and behaviour, symbolised by the wearing of European clothing'.²⁵ He believed that when these clothes were wet and were not changed, the resultant cold led to chronic bronchitis, which in turn reduced the powers of resistance to tuberculosis.²⁶

Despite the differences of opinion between members of the commission, they did not materially affect the measures recommended for combating the disease in the

²² Ibid.

²³ This aspect is discussed in more detail later in this Chapter, together with a discussion of Dr Maynard's views.

²⁴ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 118, 5.

²⁵ R.M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989), 48-49.

²⁶ Packard, *White Plague, Black Labour*, 49. See later in this chapter for a discussion on the implications and history of this and similar comments.

Union.²⁷ The reason for this is that the commission's recommendations were calculated to protect the health of the white inhabitants.

Difficulties Faced by the Commission

Once the commission turned its focus to addressing the present-day situation and controlling tuberculosis, it was faced by two main difficulties. In the first place there was an almost a complete lack of technical research available, particularly about how blacks, Coloureds and white South Africans experienced tuberculosis, especially in comparison to people living in Europe.²⁸ The other difficulty was the lack of statistics. Although official statistics on tuberculosis were kept in the Cape Colony, for the most part this was only the case from 1896 when the *Registration of Births and Deaths Act* came into force. There was very little statistical information available from Natal.²⁹ In the Orange Free State it was only the deaths of white people that were registered, and although it was fairly complete in the urban areas, it was virtually non-existent in rural areas.³⁰ The absence of statistics on workers at the Witwatersrand gold mines brought enquiries to a virtual standstill. This meant that the commission had to turn to the WNLA for assistance on information about repatriated black workers.³¹

To counter the difficulties raised by the lack of statistics, the commissioners relied on a very extensive interview process. This methodology had positive as well as negative aspects. It relied heavily on the memories of those interviewed and these recollections were often impressionistic and coloured by the recent publicity given to the disease.³² From another perspective the interviews were a snapshot of the current thinking and prejudices of ordinary people, and in that respect provided a powerful commentary on social history at the time. Chief among these was the

²⁷ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 118.

²⁸ *Ibid.*, 3. To some extent, particularly as far as African mineworkers were concerned, this was addressed in a later report commissioned by Transvaal Chamber of Mines in 1925. This focused on individual case studies which was lacking in the 1914 Report. See SA Institute for Medical Research, *Tuberculosis in South African Natives with Special Reference to Mine Labourers of the Witwatersrand*, Vol. 5, Report no 30 (Johannesburg: SA Institute for Medical Research, 1932).

²⁹ *Ibid.*, 83-85.

³⁰ *Ibid.*, 59.

³¹ *Ibid.*, 196-197. See later in this chapter for more information.

³² *Ibid.*, 35.

commonly-held opinion that tuberculosis among blacks was closely associated with their adoption of Western values, as discussed above.³³ Another view was that blacks and Coloureds were 'to blame' for their poor living conditions.³⁴

Despite these views and prejudices, and those of the commissioners themselves, there was some level of awareness that the black and Coloured people could not shoulder all the blame for their current state of affairs. Even before the commission began its proceedings, there was an acknowledgement that the rapid spread of tuberculosis was the result of the 'very wretched conditions' under which blacks and Coloureds lived, and that very little had been done to effect improvements in that direction. The commissioners recognised that the main reason for this failure to address the problem at an early stage was the unwillingness – on the part of government, local authorities and individuals – to incur financial expenditure.³⁵

There was also an admission that whites enjoyed a higher standard of living and, that for the most part, they had sufficient resources to spend on housing and nutrition and were therefore the least affected by the disease.³⁶ Tuberculosis, by its very nature, is an opportunistic disease which preys on the most vulnerable members of society. In the Cape, this was generally members of the Coloured and black communities. In the Transvaal the most vulnerable people were the blacks workers employed in the mining industry, particularly in the mining of gold and coal. In these circumstances, an evaluation of their working conditions was given top priority. Because accommodation was provided for the mineworkers in compounds as part of their employment contracts, their poor living conditions were a major factor. The investigation in Natal was a mixed bag, consisting of investigations in the larger towns such as Durban and Pietermaritzburg, as well as how tuberculosis had

³³ See comment by Turner on his view that the increase in tuberculosis among Africans 'arises from the use of European clothing' referred to earlier in this chapter.

³⁴ Barnard Fuller expressed this view prior to the evacuation of Africans to the Uitvlugt (Ndabeni) township during the outbreak of plague in Cape Town. See M.W. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1901', *Journal of African History*, 8, 3 (1977), 392. See also Chapter 4.

³⁵ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 21.

³⁶ *Ibid.*, 89.

impacted on the lives of indentured Indians working on the sugar estates. The conditions on the Natal coalfields were also investigated. The Orange Free State received less attention, with only two towns visited, because the commission argued that the province only had a small white population of 119 844 people in 1911, and only 15 deaths from tuberculosis had occurred in that year.³⁷

The Cape

The commission began by conducting interviews with ‘witnesses’ in Cape Town. These were people who were presumed to have ‘special knowledge’ of the disease.³⁸ Some of them had lived in the Cape for many years, which had the added benefit not only of their current experiences, but also their historical knowledge of the disease.³⁹ Those interviewed in Cape Town included Drs Jasper Anderson, and A.H. Reid, the chairman of the Society for the Prevention of Consumption. Also interviewed was Dr D.P. Marais who was one of the first South African doctors to specialise in the care of persons suffering from tuberculosis and was a regular contributor of articles on tuberculosis to the *SAMR*.⁴⁰ Marais ran a small sanatorium in Sea Point, Cape Town.⁴¹ The commissioners visited his sanatorium and they also inspected the Old Somerset Hospital, the Free Dispensary and the Cape Town City Infectious Diseases Hospital.⁴²

They also visited a number of towns in the Karoo which had been popular with consumptives who visited the country in search of a ‘climate cure’. These included Cradock, Beaufort West and Graaff Reinet.

³⁷ Ibid., 59.

³⁸ Ibid., 2.

³⁹ Ibid., 2-3.

⁴⁰ See D.P. Marais, ‘The Prevention of Consumption’, *South African Medical Record* (hereafter *SAMR*) (10 February 1912), 40-43; D.P. Marais, ‘Tuberculin in the Diagnosis and Treatment of Pulmonary Tuberculosis’, *SAMR* (14 September 1912), 364-372; D.P. Marais, ‘Dr Maynard’s Views on Tuberculosis’, *SAMR* (28 September 1912), 387-391. Marais was outspoken in his opposition to Maynard, as discussed later in this chapter.

⁴¹ The sanatorium was called ‘Highlands’ and was situated in an elevated position on Table Mountain. See ‘Natal Medical Council’, *SAMR* (11 March 1911), 78.

⁴² NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 306.

In Beaufort West the field cornet had a very interesting story to tell. He had arrived there in 1881, at about the same time the railway reached the town. He recalled that there were a few consumptives who had travelled there by wagon even prior to this date. They told him they had come to Beaufort West on the advice of their medical practitioners in England and Scotland, because the climate was 'so perfect' that they would certainly recover. In those years he, like the other local residents, was not familiar with the disease. He also recounted that another young man had been told that his recovery was a certainty if he stayed in Beaufort West for three months. He had invited the man to dinner at his home on the Sunday evening. The following Wednesday he responded to a knock at his front door, only to find the young man dying from haemorrhaging.⁴³ This story points to the unrealistic expectations given to consumptives by their medical practitioners. Such individuals, already in poor health, undertook arduous journeys over many thousands of kilometres, when in fact they would have been better off dying in their homes in Britain in the company of family and friends.⁴⁴

The field cornet also testified that many consumptives came to the town in search of tutoring posts on the surrounding farms. In his ignorance of the infectious nature of the disease, he had assisted a number of them in acquiring positions. He only became aware of the spread of tuberculosis, especially among the Coloured residents, in the years immediately preceding the commission.⁴⁵

Further interviews were conducted in King William's Town, Mossel Bay, Uitenhage, Stellenbosch, Worcester, Oudtshoorn and Alice. The evidence was virtually unanimous that the disease was spreading rapidly, especially among the Coloured people. The discussions in Alice were conducted with Dr Neil Macvicar, mentioned in a previous chapter as a champion of tuberculosis sufferers.

⁴³ Ibid., 29.

⁴⁴ F.E. St Leger, 'Consumptive Patients in Cape Town', *BMJ* (21 January 1899), 192; and F.E. St Leger, 'Somerset Hospital', *SAMJ* (January 1899), 200.

⁴⁵ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 30.

The Coloured people constituted the largest component of the population in the Cape Province (not including the so-called 'native territories').⁴⁶ The commissioners came to the conclusion that the disease usually ran a rapid course among them.⁴⁷ Derogatory remarks on the Coloureds' physique, lack of 'moral stamina' and intelligence attest to the influence of Social Darwinism on the thinking of the commissioners. Racial stereotyping was very evident in the report. The majority of the Coloured people were described as living in a 'very insanitary manner' in 'dwellings which are generally of very inferior description and overcrowded'. The report went on to state:

... they work very intermittently, and are unlike the Native in having any crops or cultivated ground to rely upon, they are often ill-nourished and dependent upon such food as their number who are in domestic service can bring away from the houses where they are working. They are apt to spend their money injudiciously and many are inclined to intemperance.⁴⁸

It was with these preconceived notions that the commissioners investigated the housing conditions of most Coloureds. Not all Coloureds in the Cape lived in townships. Many of them, especially those commonly known as 'better class' Coloureds lived in their own homes or in lodging houses in the towns. In some towns there were no residential areas set aside for them (as was often the case for blacks) and they lived among the white residents. In many towns, such as Kimberley, Mossel Bay and Worcester, property owners had been permitted to erect lodging houses or tenement blocks for Coloured residents on an extensive scale. In many cases high rentals were charged although the properties were not suitable from a sanitary point of view. In quite a number of these cases, the buildings were built 'back-to-back' with one another.⁴⁹

However, it was the dwellings that the Coloured and black people occupied in the townships on the outskirts of the towns that came in for the harshest criticism. The

⁴⁶ Ibid., 89.

⁴⁷ Ibid. The comment on the 'disease running a rapid and hopeless course' was probably because of the failure to seek medical attention until the disease was in its final stages.

⁴⁸ Ibid., 90.

⁴⁹ Ibid., 124-125.

commissioners found fault with virtually every aspect of their living conditions. Many of the sites were unsuitable and water supply was often restricted to a 'donga' (gully) of the river. Many of the houses were built on rocky ground, close to the town's refuse dump and the slaughter poles. The sites were irregular in size and not clearly marked out.⁵⁰

Very few of the townships possessed adequate sanitary facilities. There were normally no private facilities, and public latrines were few in number or entirely absent. Those that were provided were often inaccessible and infrequently used. In East London, for example, there were no latrines located within the township boundaries in 1912. Instead the 8 500 residents had to use latrines that were set up on the perimeter of the township. This policy, which reduced the cost of servicing the latrines, hardly encouraged sanitary behaviour on the part of the residents.⁵¹ Although poor sanitary conditions did not contribute directly to the spread of tuberculosis, they certainly encouraged the spread of other diseases, especially water-borne and parasitic diseases such as dysentery and hookworm. These infections may well have contributed indirectly to the development of tuberculosis because parasites drain individuals of the nutrients in a diet already deficient of proteins and vitamins. This lowered the individual's resistance to tuberculosis and encouraged tubercular infections to develop into active disease. In this way, lack of sanitation contributed to the growing pool of infections and the dissemination of the disease.⁵²

It was, however, with the houses themselves that the most fault was found. With few exceptions they were found to be a disgrace and the majority were quite unfit for human habitation. The commissioners found that,

... speaking generally the dwellings are mere shanties, often nothing more than hovels, constructed out of bits of old packing case lining, flattened kerosene tins, sacking and other scraps and odds and ends. They are put up on bare ground, higgledy-piggledy, without any sort of order, often propped up against another. ... The dwellings are low,

⁵⁰ Ibid., 126.

⁵¹ Packard, *White Plague, Black Labor*, 55.

⁵² Ibid., 57.

dark and dirty, generally encumbered with unclean and useless rubbish, mud floors are the rule, often below the ground level and consequently sometimes apt to be flooded in the wet weather. Overcrowding is frequent; and altogether one can hardly imagine more suitable conditions for the spread of tuberculosis.⁵³

Although most municipal township bye-laws laid down that a person renting a plot should erect a dwelling to the satisfaction of the township superintendent, in the majority of cases this requirement had remained a dead-letter.⁵⁴ There were a number of reasons why inhabitants did not improve their homes. Many simply did not have the financial resources to do so. The other important reason was that they lacked security of tenure because occupancy was determined on a month-to-month basis. Occupants were charged a monthly rental varying between eighteen pence (18d) to five shillings (5/-) which was added to various charges for water and sanitary services in cases where these were supplied.⁵⁵ Occupation was generally restricted to one family per plot, and could be terminated by the municipality if the rent was in arrears. It could also be terminated if the occupant did not comply with the bye-laws, which included provisions such as being in satisfactory employment; having a 'stable character'; and not convicted of any breach of the law. Although the local authority was both judge and jury in these matters, officials tended to be lenient and to view occupants as having a reasonable right to occupy their properties.⁵⁶ The occupant also had the authority to dispose of his property when leaving the township. In practice, occupants generally abandoned their properties. In a large number of cases, it was found that these abandoned shacks, which were often unfit for human habitation, were taken over by the local authority and rented out to new tenants without any improvements or disinfection taking place, thereby putting the new occupants at risk in cases where prior residents had suffered from tuberculosis.⁵⁷

⁵³ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 126.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*, 127.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

In some instances the local authorities elected to provide housing in the townships and to allow residents to rent such properties from them.⁵⁸ This was the case in Cradock where the local authority built 32 back-to-back tenements that were rented out at rentals varying from two shillings and six pence (2/6) to five shillings and six pence (5/6) per month. The mayor admitted that these houses were unsatisfactory, that ventilation was far from adequate and they were often overcrowded. Night-soil was not removed and only a limited number of latrines were provided on the outskirts of the township. Despite this the local authority made a handsome profit of more than £1,100 by renting them out in 1910.⁵⁹

The other Cape townships discussed in the Tuberculosis Commission's report were Grahamstown, Graaff Reinet, Kimberley, Beaufort West and East London. None of these townships were found to be satisfactory.⁶⁰ In the majority of cases, conditions were so bad that they were a 'menace to the health of their inhabitants, and indirectly to the health of the town'.⁶¹ Ultimately, when all was said and done, the concern was not so much about the townships themselves, but rather about how the 'unhealthy' inhabitants would affect the white residents in the adjacent town. Te Water had already expressed his concern on this while he was colonial secretary in the Cape Colony when the debate on the 1897 Public Health Act was under way, and now, more than a decade and a half later, the priorities had still not changed.⁶²

The main finding of the Tuberculosis Commission was encapsulated in a simple message – unless and until improvements in living conditions took place, tuberculosis would continue to spread.⁶³ The commission recommended that, as a starting point, attention should be given to the selection of suitable sites which could be laid out with enough space for roads and other infrastructure, and that the local

⁵⁸ Ibid.

⁵⁹ Ibid., 131. The profit made in 1911 was £794, and in 1912 it was £901. For further discussion, see Chapter 3.

⁶⁰ Ibid., 133-140.

⁶¹ Ibid., 125.

⁶² See discussion on Dr Te Water earlier in this chapter.

⁶³ The disease itself could remain dormant, often for long periods, until such time as the powers of resistance were significantly lowered or depleted.

authorities should have the power to remove townships from unhealthy sites and to demolish houses that were unsuitable for human occupation.⁶⁴ The commissioners also took the view that the 'central authority' should have the power to compel the local authorities to comply with their obligations.⁶⁵

'Native Territories' (Transkei)

The commissioners also visited the Transkei. In 1911 the Transkei covered an area of 16 370 miles. At the time the population was predominately African, and consisted of 871 602 individuals.⁶⁶ Until that time most of the focus in the Cape had been on the small rural towns, but this brought them into the countryside where they were able to witness at first-hand the impact of tuberculosis on African people living in rural areas. There was evidence of the extensive and increasing prevalence of tuberculosis. A case in point was the situation in Butterworth in 1908, where the district surgeon reported that 10,8 per cent of all patients he saw were suffering from tuberculosis. By 1909 this figure had increased to 18,5 per cent, and although it dropped slightly in later years it remained at over 10 per cent.⁶⁷

It was also found that the spread of tuberculosis was not limited to those who had been exposed to industrialisation and urbanisation, but that it had spread to the general African population, mainly as a result of the migrant labour system. It was well known that Africans were generally reluctant to seek assistance from Western medical practitioners.⁶⁸ This, together with the absence of accurate statistics, points to a situation where the known cases of tuberculosis were probably only the tip of

⁶⁴ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 140-141.

⁶⁵ *Ibid.*, 141. At the time of compiling the Tuberculosis Report, public health legislation had yet to be passed. Owing to the uncertainty of where the ultimate responsibilities would lie (i.e. with the provinces or central government) the term 'central authority' was used as a generic term. Some of the recommendations on townships were incorporated into the 1919 *Public Health Act*.

⁶⁶ NLSA, UG18-1924, *Report of the Tuberculosis Survey of the Union of South Africa by Peter Allan* (Cape Town: Government Printer, 1924), 12.

⁶⁷ *Ibid.*, 81.

⁶⁸ *Ibid.*, 82.

the iceberg and that the disease was in all likelihood a great deal more prevalent than was commonly believed.⁶⁹

Natal

The commission then turned its attention on Natal, where several towns, including Durban, Pietermaritzburg and Dundee were visited.⁷⁰ Natal was confronted by tuberculosis on two major fronts. Similar to the Cape, Natal was a popular destination for consumptive immigrants from abroad. Just as Cape Town had been proactive in the fight against tuberculosis, the city council of Durban had commissioned a comprehensive report on the subject. The report recommended that sanatoria and agricultural colonies be provided to segregate and treat cases of curable tuberculosis. It also called for the provision of institutional accommodation for advanced cases and the establishment of a tuberculosis bureau. In April 1911, Durban appointed a tuberculosis expert, Dr Basil Adams, to take charge of a tuberculosis bureau. He was to provide advice and supply spit cups and disinfectants to sufferers. However, the office was abolished after two years and although the town council set aside land for the erection of a sanatorium, nothing further came of the idea.⁷¹

The second major challenge Natal faced was the high rate of tuberculosis among its Indian population, especially the indentured Indians employed in the Natal coal mines and the sugar estates.⁷² These Indian people were 'imported' into Natal, by arrangement with the Indian Immigration Board, for an indenture period of five years. Thereafter they continued to be represented by the so-called protector of Indian immigrants. It was found that some of them developed tuberculosis during the voyage, and many were found to be suffering from hookworm on their arrival.⁷³

⁶⁹ For more information on tuberculosis in rural areas, see Packard, *White Plague, Black Labor*.

⁷⁰ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 3.

⁷¹ *Ibid.*, 20.

⁷² *Ibid.*, 3.

⁷³ The role of hookworm in depleting the body of nutrients has already been discussed.

Between 3 000 and 4 000 indentured Indians were employed on the Natal coal mines, where they worked on the surface and also underground. The rate of sickness and mortality among them was severe, particularly from tuberculosis and pneumonia. There was a system in place whereby their employment was automatically terminated if they were permanently disabled and this included contracting tuberculosis. For the most part these individuals were repatriated. In the period 1908-1911 the death rate of Indians employed on the Natal coal mines was as high as 6,14, with another 15,79 per thousand being repatriated because of the disease. In total, tuberculosis affected 23,15 per thousand indentured Indians in Natal.⁷⁴

On the sugar estates, the situation was even worse. The long hours took a considerable toll on them – labourers began working at dawn with a break for meals, and continued until it was dark. On one estate the death rate from tuberculosis was 39 per thousand.⁷⁵ The practice of importing indentured Indians began in 1860 and came to a stop in July 1911.⁷⁶

The Transvaal Collieries

Staying with the coal mines, the commissioners also examined conditions at two of the most important coal mines in the Transvaal. Most of the collieries in the former Transvaal are in the Middleburg and Witbank (Emalahleni) area of what is now Mpumalanga Province. The average number of Africans employed at these collieries at the time of the commission's visit in about 1912 was 6 633. Most were migrant labourers from the east coast. A system of repatriating miners who suffered from poor health was also in operation at these coal mines.⁷⁷

It was the Transvaal collieries that received the harshest criticism from the commission. At the Witbank Colliery labourers worked twelve-hour shifts, with no

⁷⁴ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 92.

⁷⁵ *Ibid.*, 92.

⁷⁶ *Ibid.*, 91.

⁷⁷ *Ibid.*, 190.

lunch breaks. In 1912 each worker was given a loaf of bread and a mug of cocoa when he went into the mine in the morning. This was his 'midday meal', and was supposed to be eaten while at work. At the Coronation Colliery, labourers worked for eleven hours each day because a lunch break of an hour was allowed. So appalled were the commissioners at this unacceptable state of affairs that they remarked:

The average owner of a horse would not think of working it like this, for he would know that he would be running the risk of breaking down or killing his animal. Even the mechanic responsible for the working of a mere engine knows that it must not be overloaded and it cannot work without fuel and oil in due proportion.⁷⁸

Under these circumstances, it was hardly surprising that the tuberculosis mortality rate was extremely high. At the Witbank Colliery it stood at 7,85 in 1909, with an additional 16,31 per thousand workers being repatriated in the same year. In 1911 the death rate was 8,01, with 14,02 per thousand workers being repatriated.⁷⁹

Witwatersrand gold mines

The main investigation into tuberculosis in the Transvaal revolved around its prevalence among blacks employed on the Witwatersrand gold mines. This topic has been the subject of extensive research by Randall M. Packard, the author of *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (1989) and several journal articles, who is undoubtedly the foremost author on the history of tuberculosis in South Africa.⁸⁰

⁷⁸ Ibid., 191-192. The remark must have hit a nerve, for it was referred to by the Tuberculosis Research Committee in their 1932 Report who admitted that, over two decades later, the Witbank black coal miners were still not given a lunch break. Their rather sarcastic remark that "whether any man, healthy or infected [with tuberculosis] can continue for long to do effective work for eight or nine consecutive hours, without intervals for meals, is an economic question as to which scientific tests must supply the answer; but it can hardly be doubted that, for the man whose health depends upon a delicate balance between larval tuberculous lesions and tissue resistance, a day's work of this length, without food, is calculated to swing the balance in the wrong way". South African Institute for Medical Research, *Tuberculosis in South African Natives with Special Reference to the Disease amongst the Mine Labourers of the Witwatersrand* Report Number XXX (Volume V) (Johannesburg: The South African Institute for Medical Research, 1932), 272.

⁷⁹ Ibid., 194.

⁸⁰ See the Source list for full details.

One of the most striking aspects of the Tuberculosis Commission Report was that it demonstrated how quickly the centre of economic power in South Africa had shifted to the Transvaal, and how much of this power rested in the hands of the mining magnates. The mining houses were recruiting their labour force from within South Africa and its neighbouring countries.

By the time the Tuberculosis Commission was set up, the migrant labour system was securely entrenched and had become an essential element, the very backbone of the labour force on the mines. Black workers retained their traditional rural base but for the duration of their contract they were housed in squalid compounds and paid meagre wages.⁸¹ In this way the cheap labour force maximised profits and workers could simply be repatriated back to their rural homes should they be injured, become ill or grow too old to continue working. They could also be returned to their places of origin in cases where they had been recruited from outside South Africa's boundaries.

Of particular concern was the high death rate occurring at the mines among black workers from the 'tropical' areas, who were singled out for special attention.⁸² The commission strongly recommended that recruiting of black workers from these areas should be stopped. By the time the commission's work was done this advice was heeded, with the government issuing official orders that all recruitment from these regions should be discontinued.⁸³

The table below indicates the number of deaths and repatriations which took place between 1910 and 1912 as a result of disease. While the mining houses were able to provide statistics on the number of deaths, they had very little information on

⁸¹ Packard, *White Plague, Black Labor*, 11. It was also for this reason that the mining industry came out in support of the 1913 *Natives Land Act*.

⁸² NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 1.

⁸³ *Ibid.*, 199-200.

repatriations.⁸⁴ To counter this hurdle the commission turned to the records of the WNLA and the government's Native Labour Bureau to fill in most of the gaps.⁸⁵

Table 7.1: Annual mortality and repatriation rates from all diseases per thousand of average number of labourers employed on the Witwatersrand gold mines.⁸⁶

Year	Death rate	Repatriation rate	Total rate
1910	26,72	27,66	54,38
1911	28,51	36,67	65,18
1912	22,50	48,47	70,97

Turner was quick to make light of the high repatriation numbers, remarking that at the time labourers were repatriated for the slightest ailment or injury, such as amputated toes. The miners were repatriated not only in South Africa, but also to the neighbouring areas.

The investigations conducted at the Witwatersrand gold mines put the commissioners at loggerheads with one another. Turner and Porter took a different view to that expressed by Gregory. Many of their disagreements amounted to little more than nit-picking. When Gregory commented that he believed the improvement of living conditions in the mine compounds would lead to a corresponding decrease in the death rate from both pneumonia and tuberculosis, and cited the example of improvements in the Kimberley diamond mines to support his view, Porter and Turner disagreed with him. Although they concurred that overcrowding and bad compound conditions impacted negatively on the incidence and mortality of those suffering from pneumonia, tuberculosis and disease in general, they objected to the

⁸⁴ Ibid., 196-197.

⁸⁵ Ibid., 197. The WNLA was a recruitment agency set up by the mining houses on the Witwatersrand. It maintained records of the number of labourers recruited and their whereabouts on the different mines. The Government Native Labour Bureau had records of all black labourers, but the information was less detailed than those kept by the WNLA.

⁸⁶ Ibid., 204.

comparison with the Kimberley diamond mines, arguing that the available facts on the diamond mines were inconclusive. They went further, disagreeing with Gregory's conclusion that 'a fall in the incidence of pneumonia and tuberculosis among underground workers [was] ... synchronous with improved compound conditions'.⁸⁷

With regard to housing, the suggestion was made that black mineworkers should be accommodated in living quarters with their families, rather than in compounds. The gist of the opposition to this recommendation was that if the labourers were 'too comfortable', they would be 'disinclined' to return to their rural base at regular intervals and over time would be likely have no home to go to. It was argued they would then lose the recuperative benefit of the long rests at home, which were believed to be invaluable.⁸⁸ In essence, the denial of decent family oriented living conditions was made in the interests of the mining industry to justify the migrant labour policy.

It would be simplistic to attribute the differences of opinion between Turner and Porter on the one hand and Gregory on the other merely to animosity between them. Turner and Porter had underlying allegiances to the mining industry. Porter worked with inspectors from the department of mines and was jointly responsible for overseeing sanitary and safety measures, while Turner was the WNLA's medical adviser. The powerful status of the mining industry gave rise to a situation whereby medical authorities on the Witwatersrand were either unwilling or unable to oppose the interests of the mining houses and therefore unlikely to maintain medical opinions that conflicted with their interests. The same held true for medical officers employed by the major recruiting agents. It was inevitable that when Gregory drew attention to the lack of critical oversight at the mines, it would cause considerable acrimony between the commissioners.⁸⁹ As discussed later in this chapter, the situation reached a tipping-point after the report had been finalised. In the

⁸⁷ Ibid., 176.

⁸⁸ Ibid., 212. This is discussed in more detail later in this chapter.

⁸⁹ Packard, *White Plague, Black Labor*, 202.

meantime, it was imperative that if mining interests were to be protected, there had to be medical justification in support of the migrant labour system.

This support was provided in the form of Dr Maynard's opinion. He maintained that tuberculosis was not an infectious disease; in his view it was hereditary. He added that any decrease in the death rate from the disease was not due to sanitary improvements; it was simply an evolutionary process.⁹⁰ Maynard's beliefs received a great deal of attention from the press under headlines such as "Doctors Differ". For members of the Cape medical profession, who had worked tirelessly to have the Tuberculosis Commission appointed in the first place, this was a severe blow which threatened to undermine their efforts to persuade the government to embark on an active campaign against the spread of tuberculosis.⁹¹ A flurry of articles appeared in the *SAMR* in which Maynard's views were called into question, but the damage had already been done.

A valid question would be: Why did Maynard's views receive such prominence? After all, he was not one of the commissioners. He was, however, a man of considerable stature in medical circles and at the time he was the assistant medical officer of the WNLA. He had also acted as assistant MOH for Johannesburg and for the outlying parts of Pretoria. Furthermore, he had been the secretary to, and a member of, the Miners' Phthisis Commission and was the editor of the *Transvaal Medical Journal*. With this list of credentials, it was hardly surprising that his views received a great deal of attention.⁹²

Maynard's findings were published in a paper entitled 'The Relative Importance of Infection and Heredity in the Spread of Tuberculosis'.⁹³ His article was heavily influenced by the work of the eugenicist, Karl Pearson.⁹⁴ Maynard felt that there was

⁹⁰ B.J. Guillemard, 'The Infectivity of Tuberculosis', *SAMR* (28 September 1912), 391.

⁹¹ 'Dr. Maynard's Views on Tuberculosis', *SAMR* (28 September 1912), 385.

⁹² *Ibid.*, 385-386.

⁹³ G.D. Maynard, 'The Relative Importance of Infection and Heredity in the Spread of Tuberculosis', *SAMR* (26 October 1912), 433-450.

⁹⁴ S. Dubow, 'Biological Determinism and the Development of Eugenics' in *Illicit Union Scientific Racism and Modern South Africa* (Cambridge: Cambridge University Press, 1995), 142.

sufficient scientific evidence to support Pearson's views and decried the fact that health legislation and education had focused attention on the assumption that the disease was infectious and in trying to improve sanitary conditions. He also believed that money could have been better spent on research.⁹⁵

The Cape medical profession, fearing that the progress it made in the education of the public would be negated, and that parliament would use the controversy to shelve the tuberculosis issue yet again, immediately responded by calling for a public debate on the matter.⁹⁶ Dr Marais, who by this time was a well-known expert in the field of tuberculosis, immediately published an article in which he responded, in great detail, to each and every comment and statistic Maynard had put forward. He also made the valid point that Maynard, by his own admission, had only taken a passing interest in the tuberculosis question until he came across the eugenics literature. According to Marais, Maynard's views were based on a very narrow statistical analysis and did not take into account anything that could not be mathematically proven and had not considered the wider issues on the spread of the disease. For example, he refused to acknowledge that tuberculosis was spreading among the Coloured population. Marais criticised this, saying it displayed complete ignorance of the situation in the Cape Province; he felt it was 'a pity' that Maynard chose not to have his views debated in medical circles, and added that the harm caused by venting them in the public domain would cause damage that would take years to undo.⁹⁷

What was clear was that there was division between the points of view held in the Cape and those on the Witwatersrand. Despite this, it cannot be said that Maynard's views came completely out of the blue. Packard, in his 1987 article 'Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932',

⁹⁵ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 323. For full details on Maynard's views see his 'The Relative Importance of Infection and Heredity in the Spread of Tuberculosis', Annexure 'E' in the Tuberculosis Commission Report, 323-343; it was also published in the *SAMR*.

⁹⁶ See 'Dr Maynard's Views on Tuberculosis', *SAMR* (28 September 1912), 385-387; and Marais, 'Dr Maynard's Views on Tuberculosis', *SAMR* (28 September 1912), 387.

⁹⁷ Marais, 'Dr Maynard's Views on Tuberculosis', *SAMR* (28 September 1912), 387-390.

traces the background and relative popularity of Maynard's views.⁹⁸ The main question revolves around perceived notions of black susceptibility to disease. Physiological explanations were voiced by medical men working in South Africa in the first decade of the century, but they represented a minority viewpoint. Beginning in 1912, these explanations became increasingly prominent in the thinking of medical authorities on the Rand and subsequently within the wider, admittedly Eurocentric, South African medical community.⁹⁹

Maynard's much publicised report led to further division among the commissioners, with Turner and Porter insisting that it should be incorporated into the Tuberculosis Commission Report, while Gregory opposed its inclusion. Finally, Maynard's report was indeed included, but it was accompanied by an explanation from each commissioner justifying his own particular opinion on this controversial issue.

Gregory's opinions have already been discussed above, and Te Water concurred with his views.¹⁰⁰ In the main, Porter and Turner agreed with Gregory, but believed that the heredity factor could not be summarily dismissed in the sense that people of European descent appeared to have some degree of natural resistance to tuberculosis and other diseases. They believed that heredity had little to do with the incidence of tuberculosis among blacks in the South African context because they had had little prior exposure to the disease. Like Gregory, they felt that expenditure on improving the housing, feeding and well-being of the community was both justifiable and necessary.¹⁰¹

Finalisation of the Report

By March 1914 parliament was raising concerns about the fact that the Tuberculosis Commission had been sitting for more than two years, and the costs had already escalated to over £4,000. General Smuts immediately went on the defensive, stating

⁹⁸ R.M. Packard, 'Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, 13, 2 (1987), 209.

⁹⁹ *Ibid.*, 196. Also see Chapter 6 on the influence of eugenics on immigration policy.

¹⁰⁰ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 120.

¹⁰¹ *Ibid.*, 121.

that he had only appointed the commission under considerable pressure. He added that he had tried repeatedly to expedite its proceedings and it was unfair to criticise the government.¹⁰² An ultimatum was issued to the commission – its operations had gone on for long enough, and any costs incurred after 31 March 1914 would not be paid. By this stage the costs had risen to the sum of £6,700. Accusations were flying fast and furious, with parliamentarians labelling the cost as ‘scandalous’. The *SAMR* also weighed in on the matter, stating that in its experience of medical journalism, it had never felt so ashamed of the profession. It felt that the scandal surrounding the report would set the profession back for many years to come.¹⁰³ In their efforts to finalise the report, the commissioners continued their work even after being informed that no further payment would be forthcoming.¹⁰⁴

Once the report was complete, even more drama unfolded, with both Turner and Porter making a last-ditch attempt to prevent Gregory’s criticism of the mining industry being published. In a letter addressed to the *SAMR*, Gregory described how his fellow commissioners had refused to present the draft report to the government until such time as certain clauses – which had subsequently been prepared by them, championing the existing system of mine health control – had been added as a rejoinder.¹⁰⁵ This led to the inclusion of a ‘minority report’ authored by Gregory.¹⁰⁶ Turner and Porter promptly responded with a supplementary statement criticising Gregory’s views and maintaining that ‘Gregory’s idiosyncrasies and methods’ had made working with him ‘extremely difficult if not impracticable’.¹⁰⁷

The Report of the Tuberculosis Commission was finally published in November 1914.¹⁰⁸ The entire process had taken a huge toll on Gregory. In a letter addressed to the *SAMR*, he put forward his side of the story, accusing Porter and Turner of having

¹⁰² ‘Medical Matters in Parliament. The Tuberculosis Commission’, *SAMR* (28 March 1914), 102.

¹⁰³ ‘Medical Matters in Parliament. The Tuberculosis Commission’, *SAMR* (11 July 1914), 213.

¹⁰⁴ *Ibid.*

¹⁰⁵ A.J. Gregory, ‘The Tuberculosis Commission’, *SAMR* (12 September 1914), 312.

¹⁰⁶ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, minority report by Dr Gregory, ‘Future Control of the Health of Mine Workers and Mine Sanitation on the Witwatersrand’, 258-280.

¹⁰⁷ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 280-282.

¹⁰⁸ ‘The Tuberculosis Commission Report’, *SAMR* (28 November 1914), 391.

their own agenda on the issue of mine labourers' health. He claimed that Porter did not assist in drafting the report but had criticised each and every statement made by Gregory. He added that he had tendered his resignation from the commission on two occasions, and had only remained when requested to do so by the minister of the interior. In a frank admission, he reported that he had faced bitter opposition and vilification throughout the proceedings. The attack by parliament was the last straw, leading him to conclude that his 'long and honourable professional career had been irrevocably damaged in the eyes of the public'. It was clear from the tone of his letter, that he was deeply saddened by the way things had turned out, especially as he had been obliged to neglect his private and family affairs. By the time Gregory wrote this letter he had left South Africa and returned to England.¹⁰⁹

Recommendations on the Measures to be Taken for the Prevention of Tuberculosis

One of the main findings of the Tuberculosis Commission was that exposure to an unhealthy environment predisposed individuals to contract the disease because such conditions lowered the body's resistance. The report went on to explain:

... it is not sufficient for the spread of this disease that infection in the shape of the tubercle bacillus should be present, but ... it is also necessary that the powers of resistance, natural or acquired, which we all possess, should at the same time be so depressed in the person exposed to the infection that they cease to protect. Just as fresh air, sunlight, dryness, good food, rest and healthy living ... will increase the powers of resistance in the consumptive, and go far to effect the cure of tuberculosis, so conversely, will overcrowding into ill-ventilated, dark, damp, dirty, sunless dwellings, want of sufficient food, over indulgence in alcohol, overwork, and unhealthy living lower the vitality and conduce to an attack of the disease.¹¹⁰

In these circumstances, it was felt that, in order to prevent tuberculosis and halt its spread, the message was clear: attention had to be paid to the improvement of general living conditions.

Other recommendations recognised the need for uniformity throughout South Africa with regard to registration of births and deaths, the collection and compilation of

¹⁰⁹ Gregory, 'The Tuberculosis Commission', 312.

¹¹⁰ NLSA, UG34-1914, *Tuberculosis Commission Report, 1914*, 236.

statistics on the prevalence of the disease and the imposition of a compulsory notification system.¹¹¹ Recommendations were also made in respect of living and working conditions in the mining industry. Another was that the teaching of hygiene should be undertaken at schools.¹¹² The commissioners also conducted a detailed investigation of the extent of bovine tuberculosis, and made recommendations in that regard.¹¹³

In conclusion, an evaluation was presented of the state of public health in the various provinces. In the light of the vast area to be covered and the relatively sparse population, the commissioners found it difficult to come up with recommendations. Many areas lacked municipal bodies and officials to deal with local affairs, and there were different systems in place in the various provinces. The deficiency of the *South Africa Act of 1909* in so far as public health was concerned was also evaluated.¹¹⁴

Despite the many challenges, the Tuberculosis Commission did come up with a proposed scheme for dealing with the disease, including steps to identify cases and the provision of information and support for patients who remained in their homes. Also recommended was the use of a sanatorium for short-term treatment of whites and 'better class Coloured persons'; a farm colony where the treatment of suitable cases could be continued; and an institution for the care and isolation of advanced cases. The establishment of tuberculosis dispensaries was seen as essential. These dispensaries would not only diagnose cases, but assist patients with the provision of information and referral to sanatoria or chronic-sick facilities where necessary. Detailed information on how these recommendations would work in practical terms was also included.¹¹⁵

Also recommended was to the medical examination of blacks who were proceeding to labour centres, and for those about to return home from the mines. Institutional

¹¹¹ Ibid., 37-46.

¹¹² Ibid., 237-240.

¹¹³ Ibid., 217-236.

¹¹⁴ Ibid., 242.

¹¹⁵ Ibid., 243-250.

and hospital treatment for blacks was also discussed.¹¹⁶ The employment of district nurses and health visitors, as well as local medical officers of health, was also recommended.¹¹⁷ A further suggestion was putting a total prohibition on spitting in public places throughout the Union.¹¹⁸ It also emphasised that tuberculosis was a national problem and should be controlled by the state.¹¹⁹ After careful consideration, it came to the conclusion that the financial burden should be shared by government and the local authorities. It was proposed that the government contribution should only apply to approved expenditure and then only if the local authorities had taken the prescribed steps to prevent the spread of the disease.¹²⁰

The commissioners stressed that the focus should fall on the *prevention* of tuberculosis and that the best way to achieve this was by the improvement of living conditions.¹²¹

Recommendations on Public Health Legislation

In addition to its recommendations on tuberculosis and the intricacies of whether or not to allow consumptive immigrants into the country, the commission provided an evaluation of the current state of public health. It made recommendations on the future legislative framework for public health in general and tuberculosis in particular.¹²² Financial arrangements were always a thorny issue, and while the commission believed that the Union government should be largely responsible for footing the bill, it felt that extravagance would prevail if the local authorities were given free reign. Possibly anticipating that the government would not sanction total liability in respect of the costs, they offered a compromise whereby the state would pay for the establishment of sanatoria, farm colonies and chronic-sick institutions and provide poor relief and medical treatment for paupers. Other costs, such as

¹¹⁶ Ibid., 250-253.

¹¹⁷ Ibid., 253.

¹¹⁸ Ibid., 253.

¹¹⁹ Ibid., 254.

¹²⁰ Ibid., 256.

¹²¹ Ibid., 256-257.

¹²² Ibid., 242.

those for setting up tuberculosis dispensaries, should be carried on a 50/50 basis between the local authorities and the government. But as mentioned above, if it was found that the local authority had allowed conditions to deteriorate and was partially responsible for the spread of the disease, the government could decline to pay its contribution.¹²³

Conclusion

It was inevitable that the proceedings of the Tuberculosis Commission, and its subsequent report, would be fraught with controversy. Three of the commissioners, namely Gregory, Turner and Porter, were powerful personalities in their own right. Smuts had initiated the commission under pressure from the medical profession, rather than out of concern about tuberculosis. The terms of reference were so wide that it was impossible for the work to be completed within the allocated time frame. Furthermore, investigations took place shortly after political Union had been established, at a time when political and professional hierarchies were still being established. Added to the mix was the vested interest of the mining industry.

Perhaps the biggest lesson from the findings of the Tuberculosis Commission is that tuberculosis is experienced differently in industrial and social settings. Packard has approached tuberculosis as a disease of industrialisation in his *White Plague, Black Labor*. In the Cape Colony tuberculosis is experienced as disease with deep links to living conditions, overcrowding and poverty.

Ultimately the report did not lead to any immediate legislative changes although some of its recommendations made their way into *Public Health Act, Act No. 36 of 1919*. These are discussed in the next chapter.

¹²³ Ibid., 256.

Chapter 8

From the Tuberculosis Commission to the Public Health Act, 1914-1919

By the time the Tuberculosis Commission submitted its report in 1914, the First World War had broken out. The war itself had a deleterious effect on the public health of the country. The Union government took the decision that no further medical appointments would be made, except on a temporary basis, until hostilities were over.¹ The existing district surgeons were hard hit by the austerity measures. Drug and witness fees were reduced, and no fees were paid for post-mortem examinations.² Post-mortems were an essential component in the discovery of tuberculosis cases so this may well have affected the reliability of statistics during the war period. The impact of the salary reductions for district surgeons meant that their focus of attention was on their own personal circumstances. As a result, very little attention was paid to the inadequacy of health legislation and providing public health guidance during the war years.

Little information is available on public health and tuberculosis during this period. The annual public health reports, which had been a feature for several years prior to Union, all but ceased to exist. Some information was made available in the reports submitted by the Department of the Interior for the year 1913,³ and again in 1916.⁴ The detailed reports of the pre-war period, which had been carefully compiled and analysed by Gregory during his tenure as medical officer of health of the Cape Colony were a thing of the past.

¹ 'Passing Events', *South African Medical Record* (hereafter *SAMR*), (27 March 1915), 86.

² 'Passing Events', *SAMR*, (22 May 1915), 149.

³ National Library of South Africa, Cape Town (hereafter *NLSA*), Union of South Africa Govt. Reports (hereafter *UG*), *NLSA, UG24-1914, Department of the Interior, Annual Report for the Calendar Year 1913 including Public Health, Leper and Lunatic Asylums, Naturalisation, Passports, Newspaper Registrations, Aided Immigration, Archives, Statistical Department, Asiatic and Chinese Registrations, Indian Immigrants, Repatriation, etc.* (Pretoria: Government Printer, 1914).

⁴ *NLSA, UG50-1917, Department of the Interior. Annual Report for the Calendar year 1916, including Public Health, Births and Deaths etc.* (Cape Town: Government Printer, 1918).

The Cape Town Corporation continued to produce their own internal annual reports, but information from the smaller local authorities was in short supply. There were a number of reasons for this. Without leadership from a public health department, there was no pressure to produce the reports of former years. The position of district surgeons has already been mentioned. After 1914 the added pressure of wartime conditions was also an important factor.

The war itself had further implications. It ushered in a new phase of industrial development in South Africa. Stimulated by wartime shortages of consumer goods, manufacturing industries began to emerge in the nation's major urban centres. The result was an influx of work-seekers of all racial groups into the towns. In Cape Town the black population grew from 1 569 in 1911 to 7 466 in 1921, while in East London it increased from 8 000 to 12 000. In Port Elizabeth and Durban it doubled in size.⁵

The rapid rate of urbanisation and the wartime shortages had at least two consequences which were of importance in the spread of tuberculosis. Towns battled to deal with the development of slum areas and overcrowding made conditions even worse as the population grew. This in turn gave rise to what was commonly known as the 'poor white' problem.⁶ Faced with these new challenges, Union officials looked to town planning and public health as tools of a new wave of social engineering that was targeted at preventing the mixing of the black and white population in whichever form it took place.⁷ State manipulation of planning regulations to protect white working class residential conditions in the new industrial centres were an early mechanism by which South Africa cities were racially

⁵ R.M. Packard, *White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989), 127.

⁶ The 'Poor whites' were impoverished white South Africans from the rural areas. Their plight was the subject of an official investigation and its findings published in the Carnegie Commission Report. See NLSA, Government Report, *The Poor White Problem in South Africa, Part 4, Health Report: Health Factors in the Poor White Problem* (Stellenbosch: Pro Ecclesia-Drukkery, 1932), v.

⁷ L. Lange, *White, Poor and Angry: White Working Class Families in Johannesburg* (Abingdon: Ashgate, 2003), 81.

segregated and the living standards of impoverished whites and whites in general, were thereby protected.⁸

It was in this regard that Dr Charles Porter played a crucial role. His attitude to town planning was shaped by his British experience and training. He was profoundly influenced by the new international ideas of urban reform and state responsibility for securing satisfactory housing and health of the urban working class and he spared no effort in pressing for effective legislative powers to secure his objective of orderly, low-density garden city development. Within two years of his appointment he was effectively implementing fairly extensive anti-slum control.⁹

Porter's influence was not limited to the Transvaal. The war years saw housing shortages increase everywhere. Towards the end of the war there was an urgency for civic reconstruction and innovative urban planning was seen as an integral component of that task. Disclosures of slum life in Cape Town by Canon Lavis led to demands for 'some plan upon which the city [should] develop both residentially and industrially', and in November 1917 a committee was formed to address the housing question. Not long thereafter, Cape Town played host to the introduction of the so-called 'Garden City Movement' of South Africa. The prime participant was Richard Stuttaford, a merchant and member of the Union cabinet, who was disturbed by the housing shortage and rent racketeering that was taking place. Stuttaford made use of his personal financial resources and his access to others in government circles to launch the Garden Cities Association and to initiate Pinelands, South Africa's first garden city, on the fringe of Cape Town in the 1920s. This project influenced suburban layout in upmarket white residential areas in the country for decades to follow.¹⁰ Similar initiatives were also taking place in other parts of the Union. In Durban the Town Planning Advisory Committee was reconstituted in September

⁸ S. Parnell, 'Creating Racial Privilege: The Origins of the South African Public Health and Town Planning Legislation', *Journal of Southern African Studies*, 19, 3 (September 1993), 471.

⁹ *Ibid.*, 476-477.

¹⁰ A. Mabin, and D. Smit, 'Reconstructing South Africa's Cities? The Making of Urban Planning 1900-2000', *Planning Perspectives*, 12 (1997), 197.

1918.¹¹ The effort to improve the quality of life and housing of white people had important implications for the incidence of tuberculosis and was reflected in lower mortality rates for this sector of the population.

Planning a Brave New World: The 1918 Kimberley Municipal Conference

In 1918, with the end of the war approaching, there was already a sense of optimism in countries such as Britain as they began to plan for a return to peace-time conditions. South Africa, too, began to look to the future. It was with a heightened sense of expectation of what could be achieved once peace prevailed that municipal officials gathered in Kimberley in March 1918.

Tuberculosis was high on the agenda for a number of reasons. This was the first meeting held since the Tuberculosis Commission had finalised its report. In addition, an important public health conference, which included government, medical and municipal officials, was due to take place in Bloemfontein in September 1918 to discuss the proposed Public Health Act. It was widely anticipated that tuberculosis would feature prominently in the act, so the Kimberley conference was the last opportunity for municipal officials to gain consensus on their priorities before the meeting. During the discussions the delegates reaffirmed their belief that tuberculosis was infectious and that there was an urgent need for local authorities to take steps to prevent overcrowding and to ensure that there was sufficient ventilation and sunlight in dwellings.¹² This was important because Maynard's view that tuberculosis was a hereditary disease had been expressed most vocally in the Tuberculosis Commission proceedings, and had received a great deal of publicity.¹³ At the heart of the difference of opinion between the Transvaal and the Cape on the causes of tuberculosis was the fact that the disease was experienced differently in these two provinces. In the Cape it was a social disease at its most prevalent in the

¹¹ Ibid., 197.

¹² 'Kimberley Congress', *The Municipal Journal of South Africa*, First Quarter, (September 1918), 2.

¹³ This is discussed in detail in the Tuberculosis Commission Report. Another excellent source of information is Packard, *White Plague, Black Labor*.

townships and in the lives of the poor, predominately Coloured, population. In the Transvaal, on the other hand, it was seen as an industrial disease, of particular relevance to the mining industry.¹⁴

As far as dealing with tuberculosis was concerned, two main ideas were discussed at the Kimberley conference. Dr David Marais of Cape Town proposed a three-level approach in line with what was used by the Cape Town health department. This was influenced by the so-called 'Edinburgh System'. At the entry level was a dispensary which diagnosed the seriousness of the disease and distributed the sufferers accordingly. The home remained the key location for treatment but suitable cases could also be sent either to a sanatorium or to a farm colony. Both these institutions were intended to be educational as well as places where treatment was provided.¹⁵

The second idea involved the segregation of consumptives. By 1918 the concept of segregation had gained popularity, especially for impoverished blacks and Coloured people living in the townships on the outskirts of the towns. Ideally, from the point of view of the local authorities, they wanted central government to recognise the disease as a national problem and take responsibility for treating the sufferers. This could be achieved if removal of the sufferers was made compulsory and the government was granted the power to place them in hospitals or take them to a large farm where they could do some work.¹⁶ This would, in fact, be an 'out of sight, out of mind', solution.

In reality there was very little hospital accommodation available and no suitable farm where sufferers could be placed.¹⁷ Some years previously John Garlick had made a donation of £25 000 towards the provision of a sanatorium on condition that

¹⁴ See Packard, *White Plague, Black Labor* on the challenges faced by mine workers who contracted tuberculosis.

¹⁵ D.P. Marais, 'Our Tuberculosis Problem and the Proposed Village Scheme', *The Municipal Journal of South Africa* (September 1918), 7-8.

¹⁶ 'Kimberley Congress', 18.

¹⁷ The only hospital accommodation specifically for tuberculosis sufferers in the Cape Province was limited to 20 beds in Cape Town. See above in Chapter 4.

at least £75 000 should be contributed by other donors.¹⁸ Dr Jasper Anderson, representing the Cape Town city council, attempted to solicit additional contributions at the Kimberley conference. Ultimately this initiative bore fruit and led to the opening of the Nelspoort Sanatorium in 1924.

While the separation of tuberculosis sufferers might have been a wise solution, it was costly and the local authorities looked to central government to provide the funding. Even when the establishment of a tuberculosis village and farm colony were in sight, finances were still the most troubling consideration. One difficulty was the allocation of costs when the sufferer was resident in a particular district but was diagnosed in another.¹⁹ In any case, the tuberculosis village was only designed to cater for patients in the early stages of the disease, where there was some chance of recovery, and not for advanced cases.²⁰

As the conference drew to a close, a number of key resolutions were passed. The delegates decided that the responsibility for tuberculosis should rest with government rather than the local authorities. They recommended that government be granted the power to remove paupers suffering from tuberculosis and take them either to hospitals or a large farm where they could do a little work, and that government should assume the responsibility for the provision of suitable hospitals.²¹

The Aftermath of the Conference

Armed with these resolutions a delegation consulted with the minister of the interior (Sir Thomas Watt) on 5 May 1918. Members of the delegation included the administrator of the Cape Province (Sir Frederic de Waal), the mayor and councillors of Cape Town, representatives of charity organisations as well as the Child Life

¹⁸ 'Kimberley Congress', 10.

¹⁹ Ibid., 3. The constant bickering between local authorities on the place of residence of sufferers denied patients the opportunity to go to the Tuberculosis Village, resulting in its failure.

²⁰ A. Jasper Anderson, 'Hospital Provision for Cases of Tuberculosis', *The Municipal Journal of South Africa* (September 1918), 10.

²¹ 'Kimberley Congress', 18.

Protection Agency, the Association for the Prevention of Consumption, and the Returned Soldiers Committee. Also present were representatives of the municipal associations, the secretary for the interior (Colonel Shawe) and Dr Wilmot, the assistant medical officer of health for the Union.²² That so many different organisations were represented pointed to the wide social impact that tuberculosis was having. The meeting set forth the current position as well as the steps which the local authorities believed should be taken to prevent the spread of the disease, and what government should do to secure their cooperation.²³ The debate that followed left no doubt that tuberculosis was not receiving the required attention. What it boiled down to was a lack of finances. In his statement, Frederic de Waal said that:

... the primary difficulty was a question of money, and once this was given a scheme could be evolved for effectively combating the disease. That alone was possible by the government undertaking the whole financial burden, because if left to the municipalities the desire to keep down rates would paralyze action. ... It was clearly a matter for the government to take up and meet the expense. This done, they would be glad to give the authorities the benefit of their local knowledge. *Unless this could be done he feared they could do nothing* (emphasis added).²⁴

This was tantamount to giving the government an ultimatum. De Waal went further and stated that the conference did not feel that the local authorities should have to make any contribution towards the costs of combating the disease.

While these various meetings and discussions were under way very little was happening on the ground to stem the tide of tuberculosis. All the talk of the disease being a 'national problem' had led some local authorities to believe that this was indeed the case despite the fact that the government had thus far not committed itself. In practical terms this meant that very few local authorities (other than Cape Town) were taking any proactive steps to combat the disease.²⁵

There was a myriad of other reasons why tuberculosis was not receiving any grassroots attention. For a start, the law itself was unduly complicated. Taking

²² *Municipal Journal of South Africa*, First Quarter, (September 1918), 18.

²³ *Ibid.*, 18-19.

²⁴ *Ibid.*, 20.

²⁵ *Ibid.*, 11.

hospitals as an example, the Union government was responsible for hospitals treating leprosy, lunacy, syphilis and scurvy.²⁶ The local authorities had the power to erect infectious diseases hospitals and it had become customary for the government to contribute towards the costs of building these hospitals. Since Union, however, the contributions from government had fallen away.²⁷ Tubercular patients could not be admitted into general hospitals, because the law did not allow the provincial authorities to deal with them. There was only one place – Cape Town – where chalets had been erected for use by tubercular patients, and there were a total of 20 beds available for them at the City Hospital.²⁸ Here the burden of the cost of treatment fell on the shoulders of the Cape Town ratepayers, which was unfair to them, especially because many patients from outlying districts tended to come to Cape Town to make use of hospital facilities.²⁹

Similarly, provincial authorities were not prepared to contribute towards the cost of maintaining tubercular patients as they believed the matter was a national one. The provincial auditor was highly unlikely to agree to expenditure under this head.³⁰ Given the lack of hospital facilities for tubercular patients, the provincial administrator had, on a number of occasions, authorised their admission into general hospitals but this was done reluctantly because he felt it was unfair to the hospitals concerned and the fellow patients.³¹ In other parts of the country, the local authorities were either trying to use general hospitals, which were not built for the purpose, or they were doing nothing at all.³²

The biggest challenge was the large number of paupers suffering from tuberculosis; in other words, the poorest of the poor, those who had no resources to cope with the illness. It was this group that was particularly vulnerable. Without government help, the Cape Province provided food parcels for tubercular paupers on purely

²⁶ Ibid., 19.

²⁷ Ibid. The erection of infectious disease hospitals was governed by Section 43 of Act 4 of 1883 (the *Infectious Diseases Act*).

²⁸ Anderson, 'Hospital Provision for Cases of Tuberculosis' (September 1918), 10.

²⁹ *Municipal Journal of South Africa*, First Quarter (September 1918), 20.

³⁰ Ibid., 20.

³¹ Ibid.

³² Ibid.

humanitarian grounds but the numbers of sufferers continued to grow to the point that the local authorities could no longer cope. Nor could they increase their rates to deal with the problem, not only because many of their residents were also poor, but because they felt that tuberculosis was a national, rather than a local, problem.³³

Even as early as 1908 the situation in the Cape Colony had become so serious, particularly among the Coloured population, that for every white resident who perished from tuberculosis, six black or Coloured persons died, and the annual loss to the Cape Colony worked out at an average of six deaths for every day of the year.³⁴

Central Government Intervenes at Last: The Public Health Conference, September 1918

It was not long after the meeting in Kimberley that a further conference was called to discuss the proposed Public Health Act. This conference differed from the others in that it was initiated by government, with the intention of soliciting opinions on public health issues in preparation for revised public health legislation. The conference met in Bloemfontein in September 1918, only weeks before the outbreak of the influenza epidemic that killed a staggering 300 000 people in South Africa.³⁵

The conference was attended by a range of officials but proceedings were dominated by Sir Thomas Watt, the minister of the interior, who acted as chairman, as well as Sir Fredrik de Waal, the administrator of the Cape Province, and Dr J. Alexander Mitchell, the assistant medical officer of health for the Union. There were representatives from the department of native affairs, and the provincial departments of education, from various provincial councils, local authorities, municipal associations, and divisional councils. Woman's organisations, such as the

³³ Ibid., 19.

³⁴ D.P. Marais, 'Our Tuberculosis Problem and the Proposed Village Scheme', *The Municipal Journal of South Africa* (September 1918), 7.

³⁵ H. Phillips, *Plague, Pox and Pandemics: A Jacana Pocket History of Epidemics in South Africa*. (Johannesburg: Jacana Media, 2012), 68.

South Africa Women's Enfranchisement League and the Council of Women in South Africa were also present.³⁶

One of the major objectives of the proposed new legislation on public health was to unite the disparate pre-Union provincial laws. At the same time the existing law could be refined and expanded.³⁷ At the top of the agenda was the concept of a central authority in charge of public health. Other topics related to the appointment of medical officers of health, contributions by government towards the cost of health expenditure incurred by local authorities, and the responsibility for the costs of treatment in cases of infectious diseases that were discovered and treated in an area outside that of the patient's general residence.³⁸

There were two other important matters on the agenda. One was venereal disease, and the other was what should be done about tuberculosis, particularly housing and other preventative measures; dispensaries; sanatoria, farm colonies and hospital accommodation for chronic patients.³⁹

At the start of the conference the chairman pointed out that one of the lessons from the war was the need for a fit and healthy population, not only from the point of view of national defence but for the years of industrial and economic struggle that lay ahead. He believed that the passing of a Public Health Act could no longer be delayed. The conference, he said, had been called because the previous two attempts to pass a composite Public Health Act had failed due to a lack of cooperation, especially by local authorities in the Cape, because they felt that their powers were being eroded.⁴⁰ To overcome such difficulties, he felt that a

³⁶ Natal Archives, Pietermaritzburg (hereafter NA), Archives of the Municipality of Durban, 3/DBN, 4/1/2/848, Vol. 1, Report of the Proceedings of the Bloemfontein Public Health Conference, 16 to 18 September 1918, 1-3.

³⁷ Parnell, 'Creating Racial Privilege' 483.

³⁸ NA, 3/DBN, 4/1/2/848, Bloemfontein Public Health Conference, 16 September, 1918, 1.

³⁹ Ibid.

⁴⁰ Ibid., 3; and H. Phillips, 'History of Medicine: The Origin of the Public Health Act of 1919', *South African Medical Journal* (hereafter *SAMJ*), 77 (19 May 1990), 531.

representative conference should be used to iron out any potential problems and to secure the cooperation of all the affected parties.⁴¹

The view expressed on the part of government was that it should retain responsibility for epidemic outbreaks because 'epidemics know no provincial boundaries' and could be dealt with more effectively by 'one central authority where the local authority is unable to do so'.⁴² It was also acknowledged that public opinion, both in South Africa and other countries, was in favour of the government playing a more active role in combating tuberculosis and venereal disease. Government also wanted to retain control of the purse-strings, especially if it was going to be responsible for the prevention of these diseases.⁴³

During the discussions on the steps to prevent the spread of tuberculosis, the link between inadequate housing and tuberculosis was recognised. Housing, and in particular slum clearance, had become a popular topic of discussion because overcrowding had increased in urban centres, primarily as a result of the war and burgeoning urbanisation. Dr Mitchell believed that the root of the tuberculosis problem lay in poor housing. He stressed that he knew of places where tuberculosis was rampant – dependent, in the main, on housing conditions in the insanitary areas.⁴⁴ The different provinces had varying mechanisms in place to deal with slum conditions and centralised Union legislation would achieve conformity and make such measures applicable to the entire country.⁴⁵

In addition to the recommendations on housing and clearance of slum areas, the Union government proposed certain financial provisions relating to those suffering from tuberculosis. It was proposed that the government would contribute an amount of not exceeding half the cost of the building of institutions for the treatment of sufferers, provided that the plans were approved by the relevant

⁴¹ NA, 3/DBN, 4/1/2/848, Bloemfontein Public Health Conference, 16 September, 1918, 4-5.

⁴² Ibid., 5.

⁴³ Ibid., 6.

⁴⁴ Ibid., 11.

⁴⁵ Additional laws to deal with housing and slums which were passed after the Public Health Act included *The Housing Act, Act No. 35 of 1920*; and *The Slums Act, Act No. 53 of 1934*.

government officials before the building began. Government was also prepared to contribute fifty per cent of the cost of treatment incurred by the local authorities in cases where the patients were not in a position to pay for their own treatment; and to cover the cost of bacteriological testing in government laboratories. This provision was limited to those cases where the patient was indigent and unable to pay for the costs himself. 'Indigent' was defined as a person who was absolutely destitute and had no immediate relatives who were able to support the patient or contribute towards his/her support.⁴⁶ It was clear that the treatment envisioned was for whites, Coloureds, and for those who were generally referred to as 'the better class of Natives', in other words, those living in towns and urban areas, even though it was known that the majority of sufferers were in the rural areas.⁴⁷

A point that was raised in the Report of Tuberculosis Commission was also reiterated by Mitchell, namely that the government would only contribute towards the costs of the prevention of tuberculosis in cases where the local authority had taken every precaution to prevent the conditions which favoured its spread. He stressed that the battle against tuberculosis could not be won simply by perfecting hospital arrangements, and that the real challenge was to prevent new cases.⁴⁸

After making the abovementioned proposals, he cautioned the delegates that the suggestions on the financial contributions to the spread and alleviation of tuberculosis had not been accepted by the minister. Even if the minister's approval was forthcoming, the measures still had to be accepted by the treasury.⁴⁹

It appears, based on a newspaper report at the time, that the delegates were 'thoroughly disappointed' with the government proposals, saying they had been led to believe five years earlier by Generals Botha and Smuts, that something would be done about tuberculosis and venereal disease. They had understood that this would entail government covering all expenses. Cluver stressed that he felt it was

⁴⁶ NA, 3/DBN, 4/1/2/848, Bloemfontein Public Health Conference, Appendix to Agenda of Report.

⁴⁷ *Ibid.*, 37.

⁴⁸ *Ibid.*, 35.

⁴⁹ *Ibid.*, 32.

impossible for the local authorities to pay half the costs, especially as it was a national disease. He appealed to the government to meet its obligations and provide substantial financial assistance, failing which it might well 'wreck the bill'.⁵⁰ There could be no disguising the intention to derail the entire Public Health Act on the question of finances, and had it not been for the Spanish influenza epidemic outbreak immediately after the conference, it is doubtful whether the bill would ever have seen the light of day.

Despite the delegates' gloomy outlook on what had been achieved at the conference, by the end of the meeting there was agreement on certain key issues. They all agreed that the government should be the supreme authority on public health, and that it should be the sole authority when it came to the rural areas that did not fall under the control of any local authority. They also agreed that the local authorities should maintain the powers they already held but that final control should be in the hands of either the provincial council or the government. This 'last word' would be restricted to situations where a clear case could be made for interference, such as when conditions were a really grave menace to public health.⁵¹

Despite these agreements, it was clear that tough negotiations still lay ahead. When the conference drew to a close Mitchell was asked to summarise its conclusions in the form of a new draft bill to be circulated among the delegates before being presented to parliament in 1919. Mitchell estimated that he could achieve this in one month if he was left undisturbed.⁵²

The Outbreak of the Spanish Flu Epidemic Brings Everything to a Halt

Mitchell did not make much progress before the Spanish influenza epidemic broke out. It had first made its appearance in South Africa just as the public health conference was beginning in Bloemfontein, and had incubated for a fortnight before

⁵⁰ *The Friend, Bloemfontein*, 17 September 1918.

⁵¹ NA, 3/DBN, 4/1/2/848, Bloemfontein Public Health Conference, 18 September 1918, no page number.

⁵² Phillips, 'Origin of the Public Health Act of 1919', 531.

breaking out in a virulent form in September 1918.⁵³ The epidemic took a heavy toll on South Africans. Within six weeks 300 000 people (6 per cent of the total population) were dead. In the words of Howard Phillips, it turned

... tens of thousands of wives and husbands into widows or widowers virtually overnight, hundreds of thousands of orphans [were] created at a stroke. These stark statistics sum up the grim impact of the devastating epidemic of so-called Spanish Flu, which raged through South Africa in October-November 1918, and again, less virulently, in August 1919. Short, sharp and savage, 'Black October' (as contemporaries called it) became a synonym for the country's worst epidemic ever, for it outdid in intensity, range and lethality every other epidemic in the subcontinent before or since.⁵⁴

The Spanish Flu of 1918 was part of a global pandemic of highly infectious influenza. The first wave was not as serious as the second wave, which rapidly spread across the country.⁵⁵ It occurred at a time when the war was coming to an end. The severity of the outbreak in South Africa probably owed much to the country's well-developed railway system, which facilitated the transmission of the disease across the country, and the high number of adult men using the railways (especially migrant workers and soldiers who were returning home).⁵⁶ In Cape Town alone deaths amounted to more than 400 per day and at the height of the epidemic in the city it was estimated that if the deaths continued at that rate the entire population would be wiped out in 16 months.⁵⁷

What was interesting about the influenza epidemic is that it struck the same demographic as tuberculosis. Of the approximately 300 000 deaths, 78 per cent were black, 12 per cent Coloureds, 8 per cent whites and 2 per cent were Indians. The majority of those who died were in the 18 to 40 years age bracket, and of these more were male than female, perhaps because in the towns men were often the breadwinners and unlikely to stay at home if they caught the 'flu'. The relative percentage of black and Coloured deaths per composition of the total population was markedly higher than the percentage of the overall population, suggesting that among them, living conditions were particularly conducive to the spread of the

⁵³ Ibid., 531.

⁵⁴ Phillips, *Plague, Pox and Pandemics*, 68.

⁵⁵ Ibid., 70.

⁵⁶ Ibid., 80-81.

⁵⁷ Ibid., 70.

disease and that in many cases the ability to stop an infection from turning fatal was seriously compromised by the poor physical condition of the individual and a lack of effective nursing.⁵⁸

Just days after the Union government had made the statement that it should retain responsibility for epidemic outbreaks it was put to the test.⁵⁹ It was found to be seriously wanting, both in terms of capacity and capability. The health department was limited to three men, who acted in an advisory capacity to the government, as well as a few clerks and administrative officials. In the absence of national legislation on public health, its functions remained undefined, its powers unspecified and its establishment small.⁶⁰ At best, all the government could do was to circulate medical advice, call for volunteers and leave it for the local authorities to deal with the devastating outbreak. The government received heavy criticism for its failure to take the lead. Speaking in its defence, Durban's medical officer of health pointed out that Durban employed the same number of medical men as did the Union health department, and that the government officials had done all that was humanly possible. He went on to compare the relative positions 'as between a small rowing boat that can be effectively manned efficiently by three men, and demanding that these three men ... take out to sea a transatlantic liner!'⁶¹

The influenza epidemic was so catastrophic that the government had only one answer: the health department had to be reconstituted as a fully-fledged department of public health. 'We are very anxious to have an efficient health department (not an apology for one, as at present)' stated the chairman of the Influenza Epidemic Commission. The commission's report spelt this out in no uncertain terms: 'It should be the urgent concern of the government to immediately

⁵⁸ Ibid., 81.

⁵⁹ NA, 3/DBN, 4/1/2/848, Bloemfontein Public Health Conference, 16 September, 1918, 5.

⁶⁰ H. Phillips, *'Black October': The Impact of the Spanish Influenza Epidemic of 1918 on South Africa*, Archives Year Book for South African History, Vol. 1 (Pretoria: Government Printer, 1990), 101.

⁶¹ Phillips, 'The Origin of the Public Health Act of 1919', 531-532.

establish a thoroughly autonomous and efficient health department on modern lines ... directly responsible to a minister'.⁶²

It was with the memory of the influenza epidemic in mind that Mitchell was offered every opportunity draft the new bill as quickly as possible. It was finalised by late December 1918, and published in the *Government Gazette* on 6 January 1919.⁶³

The Public Health Act, Act No. 36 of 1919

Although robust debate had taken place in 1918 between government, various community leaders and local authorities on the proposed public health regulations, the task of consolidation was extremely difficult owing to the multiplicity of competing interests. Government, provincial and local authorities alike, not to mention rural concerns, all had to be catered for; they all wanted untrammelled powers of control and expenditure, combined with the right of calling upon someone else to foot the bill. A further complication lay in the fact that in the Cape Province there was already a fully developed system of local government, whereas in the other provinces local government only existed in a limited number of urban centres.⁶⁴

Despite all the input, the information gathered at the 1918 Bloemfontein conference was not the final word on the matter. In fact, the bill that was presented to parliament bore little resemblance to what had been discussed. The decision was taken in parliament to refer the proposed bill to a select committee that was given the power to take evidence.

There was very little evidence provided to the select committee on tuberculosis in humans. This was in sharp contrast to the amount of evidence placed before it on bovine tuberculosis.

⁶² Phillips, *'Black October'*, 124.

⁶³ Phillips, 'The Origin of the Public Health Act of 1919', 532.

⁶⁴ 'New Public Health Bill', *SAMR* (11 January 1919), 1.

Other than that, for the most part the evidence focused on the question of costs. Mr Finch (the town clerk of Cape Town) pointed out that the Cape local authorities were unanimous in asking the government to pay four-fifths of the costs incurred in combating formidable infectious diseases. He added that the same contribution should be made to fight tuberculosis, stating that only two municipalities (Cape Town and Durban) had tackled the problem of tuberculosis and that as a result these towns had become 'dumping grounds' for tuberculosis cases from other parts of those provinces. He believed that unless a specific financial contribution was agreed upon, the smaller municipalities would simply not tackle the problem.⁶⁵

Dr Anderson (Cape Town) was firmly convinced that local authorities should not be required to pay half of the costs associated with tuberculosis. Although he conceded that there was something in the argument that tuberculosis was a disease that often arose in squalid conditions such as bad housing and overcrowding, he believed that the most significant causes were economic in origin, conditions that went hand in hand with low wages and poor nutrition.⁶⁶

Dr Abdurahman, also of the Cape Town city council, spoke of the tuberculosis patients that he was treating in Cape Town for whom no facilities existed. He was against the local authorities being charged half the costs for the patients from their areas, claiming that the smaller local authorities, who had meagre resources, would simply not send the sufferers for treatment. He saw the solution in government taking over control of tuberculosis, and paying four-fifths of the cost for the upkeep of the hospitals.⁶⁷ This view was reiterated on a number of occasions.⁶⁸

It was Mitchell who was adamantly opposed to the government paying more than half the expenses incurred in the fight against tuberculosis. The reason he advanced

⁶⁵ NA, S.C. 3-1919, Union of South Africa, Report of the Select Committee on the Public Health Bill. (Cape Town: Government Printer, 1919), Evidence by Mr J.R. Finch, 20 February 1919, 61.

⁶⁶ Ibid., Evidence of Dr A.J. Anderson, MOH, Cape Town, 20 February 1919, 63.

⁶⁷ Ibid., Evidence of Dr Abdurahman, Cape Town, 20 February 1919, 63.

⁶⁸ Ibid., Evidence of Dr A.H. Watt, Cape Town, 26 February 1919; and Evidence of J.W. O'Hara, Cape Town, 4 March 1919, 195.

for his point of view was that in his experience the payment of four-fifths of the cost was unsatisfactory; he believed that local authorities would not 'exercise economy and proper efficiency' if they only had to pay 20 per cent of the costs. He was prepared to concede that on special occasions a reason might be advanced for a greater contribution, but said that in such cases it should be up to parliament to decide whether an additional payment was warranted.⁶⁹

At the end of the debates held in the select committee, three recommendations were made, all relating to financial provisions. The amount proposed to combat tuberculosis was believed to be inadequate, with the suggestion that it should be set at least two-thirds of the cost incurred by local authorities.⁷⁰ It was ultimately Mitchell who won the day, with the act only obliging the government to refund local authorities half of the costs, and then only if these costs were necessary for the maintenance and management of institutions tasked with the care and treatment of persons suffering from tuberculosis, and for their treatment in general.⁷¹ In addition there was a catch to the payment of the state's contribution. If the government felt that a local authority was not doing everything in its power to prevent or limit the spread of the disease, the contribution could be withheld until such time as the breach had been remedied.⁷² This was in line with the recommendation that had been made by the Tuberculosis Commission.⁷³

Although it is not the intention to deal with all the provisions of the *Public Health Act, No 36, 1919*, there are some aspects which require special mention. The establishment of a public health department was one such provision. The bill presented to parliament proposed the establishment of a separate department of public health under its own minister; this was accepted by parliamentarians. Furthermore, the state was tasked with the responsibility of guarding against the introduction of infectious diseases from outside the country's borders and with

⁶⁹ Ibid., Evidence of J.A. Mitchell, Cape Town, 7 March 1919, 221-222.

⁷⁰ Ibid., iii-iv.

⁷¹ Section 50, *Public Health Act, Act No 36 of 1919*.

⁷² Ibid.

⁷³ NLSA, UG34-1914, *Union of South Africa, Report of the Tuberculosis Commission, 1914* (Cape Town: Government Printer, 1914), 256.

preventing, limiting and suppressing infectious, communicable and preventable diseases within the Union.⁷⁴

The bill also stipulated that local authorities should appoint medical officers of health for their areas, and that several smaller local authorities could combine and appoint a person who was responsible for more than one municipal area. These appointments were subject to the approval of the minister, and incumbents could not be dismissed without the minister's approval.⁷⁵ This latter provision gave them some security of tenure as disagreements between health officials and the local authorities could be referred to the minister, whose decision was final.⁷⁶ This was a considerable improvement on the previous situation in the Cape Colony, where for example the local authority of Cradock had arbitrarily attempted to terminate the services of its medical officer of health.⁷⁷

Although medical officers of health were afforded some measure of protection, they were also required to perform their duties with due attention to detail. It was no longer optional or up to the whim of the local authority whether or not they would receive infectious disease notifications or provide reports on the state of public health and sanitation in its specific area. The medical officers were obliged to provide monthly and annual reports to the local authorities.⁷⁸ In addition, local authorities were required to appoint sanitary inspectors.⁷⁹ Failure to make these appointments within three months enabled the minister to make the appointment on behalf of the local authority.⁸⁰ In cases where a full-time medical officer of health or sanitary inspector was appointed, the government would contribute a third of the costs, up to a certain limit.⁸¹

⁷⁴ Sections 2 and 3, *Public Health Act, 1919*.

⁷⁵ Section 12, *Public Health Act, 1919*.

⁷⁶ *Ibid.*

⁷⁷ *Midland News*, 23 November 1905. See also Chapter 3.

⁷⁸ Section 13, *Public Health Act, 1919*.

⁷⁹ Section 14, *Public Health Act, 1919*.

⁸⁰ Section 15, *Public Health Act, 1919*.

⁸¹ Section 16, *Public Health Act, 1919*.

The local authorities, who had always been vocal about any attempts to remove any of their powers, had these powers extended but at the same time they were put on a tight leash in that systems of accountability were put in place. And importantly, tuberculosis was added to the list of infectious diseases for which they were accountable. They could no longer ignore notifications of the occurrence of tuberculosis in their areas of control; this was now an offence which could result in prosecution.⁸²

Chapter III of the *Public Health Act* was particularly far-reaching. It related to the prevention and suppression of infectious diseases and gave local authorities and medical officers of health unprecedented powers of investigation and removal in cases where persons were found to be suffering from an infectious disease. This was provided by Section 23 which gave the local authority the power to instruct the medical officer of health to enter into any premises in which persons who were believed to suffer from infectious diseases were residing or were employed, so that they could be examined.⁸³ If such a person was found and was not receiving adequate medical care or was living in conditions which posed a threat of infection to other members of the household, the medical officer of health could order that he/she be removed and admitted into a hospital or other suitable place of care.⁸⁴ Prior to the act, this type of intervention was only possible by police on instructions from the resident magistrate. The lack of powers of the medical officer of health had proved to be an obstacle in cases where the patient was clearly infecting other members of the household but was refusing hospital care.⁸⁵

The local authority also had the power to order disinfection, not only of place of residence but of an individual's personal belongings. If a person was unable to pay for the cost incurred, the disinfection was carried out free of charge. The act clearly set out what steps were to be followed in the event of the unintentional destruction

⁸² Sections 10, 18, 19, 20, *Public Health Act, 1919*.

⁸³ Section 23, *Public Health Act, 1919*.

⁸⁴ Section 25, *Public Health Act, 1919*.

⁸⁵ See Chapter 4 above for examples.

of personal property, as well as the circumstances under which articles could be deliberately destroyed.⁸⁶

A number of sections of the act regulated the behaviour of persons who were suffering from infectious disease, and were extremely onerous. The overall effect of stipulations in these sections was to impose a duty on the person to isolate themselves from the public at large. They were not allowed to enter into public buildings, including shops, churches and hotels.⁸⁷ In cases where an infected person made use of public transport or public or private facilities, the owner was obliged to have the facilities disinfected.⁸⁸

This chapter of the *Public Health Act* was a typical example of the body of interventionist social legislation and administrative law that was developing in Europe and the United States of America at the time.⁸⁹ The practice of intruding into the lives of citizens, particularly when there was an outbreak of infectious disease, became increasingly prevalent from as early as 1883 in the Cape Colony during the outbreak of the smallpox epidemic. It took on its own uniquely South African complexion when blacks were removed from Cape Town and Johannesburg during the plague epidemics in 1903 and 1906 respectively.

Part IV of the *Public Health Act* made special provisions for tuberculosis. It laid down that government should bear the cost of bacteriological examinations, as well providing half the cost of establishing institutions for the care of sufferers, providing that prior consent had been granted before building commenced. Once institutions were established, government undertook to refund half of the maintenance and management costs. All payments to local authorities were conditional upon them doing everything in their power to prevent the disease from occurring in the first place. The provinces remained responsible for the provision of hospitals. In a boost for organisations such as the Association for the Prevention of Consumption,

⁸⁶ Section 27, *Public Health Act, 1919*.

⁸⁷ Sections 30–32, *Public Health Act, 1919*.

⁸⁸ Section 32, *Public Health Act, 1919*.

⁸⁹ Phillips, 'The Origin of the Public Health Act of 1919', 532.

government also undertook to make grants-in-aid available to them and similar organisations involved with the prevention and treatment of persons suffering from tuberculosis.⁹⁰

Chapter VIII of the act related to sanitation and housing. Because of the close correlation between housing conditions and the spread of tuberculosis, it was of particular importance to local authorities who were attempting to prevent the spread of the disease. Local authorities were given the power to prevent nuisances and conditions which could be dangerous to public health. The act contained a list of what constituted a 'nuisance', and included dwellings which were overcrowded and without sufficient air-space, ventilation and lighting.⁹¹ One of the strengths of the act was that it gave local authorities the power to demolish dwellings in cases where a court was satisfied that it was so dilapidated or badly constructed that repairs were unlikely to lead to improvement. In these cases no compensation was payable by the local authority to the owner or the occupier of the property.⁹² This was of particular benefit in cases where land owners would charge exorbitant rentals for unsuitable premises, and then make claims against the local authorities for loss of income. The act also prohibited the building of back-to-back dwellings, and rooms without through ventilation.⁹³

There were a number of positive aspects of the act that dealt with the control of tuberculosis. For a start, it recognised that tuberculosis was different from other infectious diseases and therefore needed to be treated differently. Notification was no longer voluntary; it was now compulsory for local authorities to act on them. Financial assistance towards the costs of institutions tasked with the care of sufferers was a step in the right direction, and so too was the contribution of half the costs incurred in their treatment.

⁹⁰ Sections 50-52, *Public Health Act, 1919*.

⁹¹ Section 122(f), *Public Health Act, 1919*.

⁹² Section 129, *Public Health Act, 1919*.

⁹³ Section 130, *Public Health Act, 1919*.

A major weakness was in the act's failure to treat tuberculosis as a *national* problem. Instead the prevention of the disease was still in the hands of the local authorities. This had already proved to be a failure in the Cape Colony, where it was clear that the local authorities had neither the expertise nor the financial resources to make a meaningful difference. The onerous stipulations on access to funding, in terms of which local authorities had to prove that they had not contributed to the conditions favouring the spread of the disease, created a barrier to securing the necessary finance. Furthermore, local authorities could deny that the patient was a resident in their area and thereby avoid paying for treatment, leaving the sufferer with no access to health care.

Apart from the procedures put in place on the necessity of notifications and the financial aspects, tuberculosis was classified along with the other infectious diseases. Two things explained the reason for this. On the one hand the centre of political power had shifted to the Transvaal, and secondly, the principal author of the act, Mitchell, had made it clear that because, in his view, tuberculosis (and venereal disease) were diseases which primarily affected black people, and sufferers were resident mainly in rural areas, treatment was of 'little concern to local authorities'.⁹⁴ The attitude of the Transvaal to tuberculosis had been made very clear during the proceedings of the Tuberculosis Commission, when there was a shift in medical opinion away from the cultural explanations of the previous decade and towards the physiological or racial model of black susceptibility to tuberculosis as proposed by Maynard, Traill and others.⁹⁵

Mitchell's close association with tuberculosis and its occurrence in the mining sector simply glossed over the way the disease was experienced in other parts of South Africa, especially the blacks and Coloureds who lived in the insanitary townships in places such as the Cape Province. The bottom line was that the 1919 *Public Health Act* was fundamentally about safeguarding the health of white South Africans and they were the least affected by tuberculosis. Although the racial dimensions of

⁹⁴ Parnell, 'Creating Racial Privilege', 483.

⁹⁵ Packard, *White Plague, Black Labor*, 200.

disease were not discussed at the Bloemfontein conference or in the new health legislation of 1919, there was an unspoken consensus that territorial segregation provided the solution to the growing problem of disease control in 'white' urban areas.⁹⁶ Mitchell did, however, recognise that territorial segregation was incomplete and that a sizeable percentage of infected blacks and Coloured people lived in so-called white towns. It was no accident that by providing a skeleton budget for the treatment of tuberculosis, the local authorities were actively discouraged from treating the disease.⁹⁷

Reaction to the Act

The act itself was not enthusiastically received at the time. It was criticised for its reliance on the British and New Zealand public health acts. It was also considered 'un-South African', autocratic and a threat to local initiative.⁹⁸ Despite this, the government's law adviser noted that during the debates on the bill, the experience of the Spanish influenza epidemic had 'induced a spirit of compromise both in and out of parliament, a spirit which it is doubtful would have existed except for the remembrance of what the public suffered in the epidemic'.⁹⁹

Although the local authorities were not enthusiastic about the act, it did survive the test of time. Some 25 years later the National Health Services Commission made the comment that the act was 'an excellent legislative code for the control of infectious diseases and environmental sanitation ... [and] placed specific *primary* responsibility for public health upon the local authority of that area'. Its creation of a central ministry of health was, in the opinion of the commission's chairman, 'indeed a "revolutionary" measure in its day'. The act itself, although amended on no less than 21 occasions, remained South Africa's basic Public Health Act until 1977.¹⁰⁰

⁹⁶ Parnell, 'Creating Racial Privilege', 483.

⁹⁷ Ibid., 482-483.

⁹⁸ Phillips, 'The Origin of the Public Health Act of 1919', 532.

⁹⁹ Phillips, *Plague, Pox and Pandemics*, 87-88.

¹⁰⁰ Phillips, 'The Origin of the Public Health Act of 1919', 532.

Conclusion

Linda Bryder, the author of *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (1988) made the observation that 'the historian investigating epidemiology often discovers more about the assumptions and prejudices of the inquirers than about disease patterns themselves'.¹⁰¹ The same holds true for this study.

On one level, this research project recounts the 'story' of tuberculosis in the Cape Colony as seen from the perspective of the white population. As a popular destination for tuberculosis sufferers from Britain and Europe it was the subject of a vast array of literature in which the climate and the disease were discussed. The journey of these sufferers and their experience in Cradock form an interesting glimpse of the social history of the time and also opens the door to investigate the attitudes of small town officials towards public health in general and tuberculosis in particular. For the most part this has escaped the history books because the focus has been on the larger towns, such as Cape Town.

Although the town officials of Cradock and Cape Town could never be accused of welcoming the consumptive immigrants with open arms, there was a major change in attitude once it became clear that tuberculosis had spread to the local population. From the outset it was clear that the Coloured population was particularly vulnerable to the disease. Many of them lived in overcrowded conditions where poverty and its associated ills, such as poor nutrition, were the order of the day. By contrast, the death rate among the whites was low in comparison. Had it not been for the fear that it would spread to this sector of the population it is doubtful whether the disease would have received any attention at all.

¹⁰¹ L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford: Clarendon Press, 1988), 4.

It was Macvicar who had the insight to explain why the change in attitude had taken place. In his article 'Tuberculosis amongst the Coloured Population of South Africa' he explains that white people feared that the disease would spread to them because some of them employed Coloured servants. Macvicar immediately went on to debunk this belief by explaining that the majority of whites lived in conditions in which tuberculosis was very unlikely to spread.¹⁰² Notwithstanding this, little that was done to curb the spread of the disease. Macvicar attributes this to the fact that the disease was not, 'in the main, a white man's problem' and that 'this happy experience explains in great measure the apathy with which most white people regard the tuberculosis problem'.¹⁰³

A further reason for the failure to tackle tuberculosis was the attitude towards the black population. A visitor to the country, writing in 1910, described the 'intense hostility of the whites to the semi-civilised blacks who live among them. Racial feeling as regards the latter is extraordinary and ... unnecessarily bitter ... reveals itself in an attitude of overwhelming contempt'.¹⁰⁴

This found expression in blaming the victims for the creation of the circumstances under which they lived and looking to segregation as a means of disease control. While this could be achieved following outbreaks of epidemic disease such as the plague, it could not be the solution to the control of an endemic disease such as tuberculosis.

As medical understanding of tuberculosis grew and the association between the prevalence of the disease and poverty became apparent, this did not translate to any policies of social upliftment or attempts to improve living conditions. What happened instead was that the government's health department used this as a

¹⁰² N. Macvicar, 'Tuberculosis amongst the Coloured Population of South Africa', *SAMR* (26 February 1910), 39.

¹⁰³ *Ibid.*

¹⁰⁴ V.R. Markham, *South Africa: Past and Present: An Account of its History, Politics and Native Affairs Followed by some Personal Reminiscences of African Travel during the Crisis preceding the War* (London: Smith, Elder & Co, 1900), 243.

means to shift the responsibility for the improvement of living conditions onto the shoulders of the local authorities. They, in turn, spent their energy trying to promote the establishment of a Commission of Enquiry in the hope that it would suggest that the government take control of the disease and be responsible for the cost involved. This fraught interaction between government and the local authorities persisted for several decades, during which, apart from the efforts of the Cape Town health department, the disease continued to spread unabated.

Matters did not improve after Union in 1910. The attitude towards tuberculosis and its spread among people of colour did not suddenly change; it became more entrenched. There was also the added dimension of the mining houses wishing to absolve themselves of the responsibility of taking care of black workers who had contracted tuberculosis.

By this time, it was clear that society was deeply divided along racial lines and that the drafters of what later became the *Public Health Act of 1919* saw themselves as catering for the needs of the white population. As discussed earlier in this chapter, Mitchell had made this point clear when he declared that tuberculosis was a disease which primarily affected black people in the rural areas and was therefore of 'little concern to local authorities'¹⁰⁵ – and on this basis he saw fit to provide a skeleton budget for local authorities to deal with the disease.

The attitude of the Union government towards tuberculosis sufferers was not only directed towards indigenous black people and Coloureds. As described in Chapter 6, it also sought to exclude sufferers who wished to enter the country as immigrants. *The Immigration Regulation Act of 1913* ensured that only 'those who could pay, could stay'.

In both these cases the attitudes which prevailed at the time were translated into policy, and thereafter became formalised in legislation. The longevity of the *Public*

¹⁰⁵ Parnell, 'Creating Racial Privilege', 483.

Health Act of 1919, which remained the basis of public health well into the apartheid era, underlies the need for a study which investigates the background leading up to and including the passing of this act.

It was only in the 1940s that the full realisation of the failure of early efforts to control tuberculosis became apparent. Urbanisation escalated and thousands of South Africans of all racial groups, including impoverished 'poor whites', flooded into the major urban centres of the country as a response to the demands of the wartime economy and the collapsing economy of the rural reserves. The limited medical resources available to local authorities, combined with a continued unwillingness on the part of the government to provide for the welfare of the growing population of black and Coloured workers and their families and the high rates of inflation, produced a major upsurge in urban tuberculosis mortality. Although these circumstances contributed to an increased awareness of the need for urban environmental reform, this was short-lived because the discovery of streptomycin and other anti-tuberculosis drugs gave rise to the promise that tuberculosis could be eradicated through purely medical means.¹⁰⁶

However this vain hope has not materialised, even to the present day. Although drugs are now available, tuberculosis has developed a stubborn resistance to drugs. There is also an added complication in that many of those suffering from the disease are also HIV-positive. In 2014 South Africa lost nearly 100 000 of its people to tuberculosis, three-quarters of whom were found to be HIV-positive. Tuberculosis is now curable, but too often effective care does not reach the people who need it most. The current minister of health, Dr Aaron Motsoaledi, launched a campaign in 2015 to help 5 million people in high-risk communities learn whether they have tuberculosis or not. This was seen as an essential first-step towards providing those who are infected with the care that they need.¹⁰⁷

¹⁰⁶ H.M. Coovadia and S.R. Benatar (eds.), *A Century of Tuberculosis: South African Perspectives* (Cape Town: Oxford University Press, 1991), 47.

¹⁰⁷ *Mail and Guardian*, 3 December 2015.

In addition to medical intervention, however, serious attention still needs to be paid to the living standards, nutrition, poverty and general wellbeing of the majority of South Africa's impoverished people. Until economic imbalances have been addressed, the fight against tuberculosis will continue.

APPENDIX 1

(TO CHAPTER 3 'THE MECCA OF CONSUMPTIVES' – CRADOCK – 1872-1910)

MEMORANDUM ON THE PREVENTION OF THE SPREAD OF TUBERCULOSIS OR CONSUMPTION

To accompany Circular Letter No 12 of the 9 June 1909 to all Local Authorities in the Colony.

Tuberculosis or consumption kills more people than any other single disease. In many places in the Colony it is the cause of from a quarter to a third of all deaths that occur among Coloured persons and Natives. It is most dangerous to children and young adults.

It is an entirely preventable disease. It is caused by a minute living organism getting into the body and multiplying there. It may attack any part of the body – the skin, the joints, the bowels, the brain, the glands (especially those in the neck), but most frequently of all it attacks the lungs.

Persons suffering from the disease usually give off large numbers of the organism in the discharges from the affected parts of the body, especially in the phlegm or spit when the lungs are affected. When a milch cow is affected the organisms may be in its milk.

The disease can only be got by infection from some other person or animal suffering from it, and, therefore, if means be taken to kill the organisms coming from those so suffering, the spread of the disease will be prevented.

The organism is easily killed by heat (such as boiling water) by drying in fresh air and sunlight, or by the application of disinfectants.

On the other hand, it is kept alive and multiplies under conditions of bad ventilation, darkness, dampness and dirt. Also, persons are much more likely to be attacked by the disease and have their strength or vitality lowered by ill-health, by chill, as may be caused by sleeping in wet clothing, by excessive indulgence in alcohol, or by living in damp, dirty unhealthy or overcrowded dwellings.

Bearing these facts in mind, it is easy to understand that in order to prevent the disease the following simple precautions will usually be effective.

Thus, every dwelling should be properly constructed so as to be dry, well ventilated and well lighted. The floor should be well raised above the surrounding ground and should not be of earth but made of some hard and easily cleansed material.

Plenty of sunlight should be allowed to enter every habitable room, and every room should be thoroughly aired for some hours every day.

Especially should every sleeping room be well ventilated throughout the night. A window should always be left open. The closing of all windows, doors and other openings of sleeping rooms at night is a most injurious practice and one which, of itself, leads to chronic ill-health.

Overcrowding of sleeping apartments must be avoided. Every adult and child over twelve years of age should have an allowance of at least 400 cubic feet of floor space and of forty square feet of floor space, and every child under 12 years of age half these amounts. [To ascertain the floor space of a room multiply the length in feet by the width in feet, and to ascertain the cubic capacity, multiply the result thus obtained by the height of the room in feet. If the roof or ceiling be on the slant, take the height at the highest point and the lowest point, add them together and divide by two, which will give you the average height. For example, a room 12 feet long by 10 feet wide and an average height of 10 feet contains 120 square feet of floor space and 1200 cubic feet of air-space, and will accommodate three adults].

Scrupulous cleanliness should be maintained throughout the dwelling and of all things in it, especially the bedding, which should be well aired every day and whenever possible out of doors. Walls and woodwork should be periodically cleaned, lime-washing of walls is good and cheap.

The head should not be covered up in the blanket when sleeping.

The hands should always be washed before taking food.

All milk should be boiled and all meat thoroughly cooked before it is consumed.

IN THE CASE OF A PERSON SUFFERING FROM TUBERCULOSIS OR CONSUMPTION:

A consumptive must never spit about the place, but must always use a spit-cup, or a piece of rag or paper. The rag or paper should be burnt after use. If a cup is employed, a small quantity of disinfectant should be put into it before use, and from time to time its contents should be emptied out into a good fire and burned, and the cup should then be placed in boiling water.

All handkerchiefs, pillow slips, sheets, serviettes and house or body linen liable to be fouled by the patient's spit or other discharge, and all spoons, forks, and drinking

vessels used by him, should be placed in a strong disinfectant and thereafter cleansed in boiling water.

The patient should be careful not to cough in anyone's face.

He should not kiss others, more especially on the lips, nor should he use anyone else's pipes.

If the patient is a child, it should not be allowed to use the same pencils, slates or toys as are used by other children.

Every consumptive patient should whenever possible, sleep in a room by himself and never in the same bed as anyone else, and he should keep the windows always open. If the weather permit, he should sleep out of doors. His own cure depends on getting as much fresh air, sunlight and simple nourishing food as possible, together with the avoidance of excessive fatigue and alcoholic or other excesses.

However, cleanliness and destruction of all infection is as important to the patient as to the other inmates of the dwelling, inasmuch as the patient can re-infect himself. In the event of the patient removing from the residence or dying, thorough disinfection of the dwelling, or at the very least the apartments occupied by the patient, with the whole of their contents, should be carried out. No landlord should re-let premises which have been occupied by a consumptive without thorough disinfection having been first effected.

The law requires that every medical man attending on a person suffering from tuberculosis or consumption, and everyone having the charge of such person, shall at once notify the fact to the local authority of the district in which the person resides. Upon the receipt of this notification, the local authority should enquire into the conditions surrounding the case, in order to ascertain whether any steps can be taken for preventing the spread of infection, and will be responsible for the proper carrying out of any necessary disinfection of the dwelling and contents. It is, therefore, in the interests of the patient and his friends to at once notify the local authority and obtain its assistance.

Department of Public Health.

Cape Town. 8 June 1909

Source: 3/KWT 4/1/199

SOURCES

The sources are arranged under the following heads:

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 - Cape of Good Hope
 - a Government Reports
 - b Acts and Ordinances
 - c House of Assembly: Debates
 - d House of Assembly: Reports of Select Committees
 - e House of Assembly: Bills
 - f Legislative Council: Reports of Select Committees
 - g Government Gazettes
 - h Cape Blue Books and Statistical Registers, 1880-1910
 - Union of South Africa
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 - a Newspapers
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- 3 CONTEMPORARY SOURCES
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C Secondary Sources

- 1 BOOKS AND JOURNAL ARTICLES
 - a Books
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- 2 UNPUBLISHED THESES and DISSERTATIONS
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- 4 INTERNET DOWNLOADS

A MANUSCRIPT SOURCES

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3/CT 1/1/5/66b – 1/1/5/75b, Council Minutes, 1910-1921

3/CT 1/1/5/176 – 1/1/5/255, Appendices and reports, 1880-1893

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3/CT 1/1/5/198, Health Report, 1883

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3/CDK 1/1/1/4, Town Council of Cradock, Minutes of meetings of Town Council, 1873 Jan – Oct 1879.

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