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Consumptive Cape Town: The Chapel Street TB Clinic, 1941-1964

By

Fiona Kilpatrick

(KLPFIO001)

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University of Cape Town

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Date: 30 August 2002

Abstract

This thesis focuses on the history of the Chapel Street TB Clinic and Administration Centre in Cape Town from 1941 to 1964. The author set out to evaluate the Cape Town City Council's attempts to control the TB epidemic, through the lens of the Chapel Street TB Clinic, in order to provide a local perspective on the history of TB in South Africa. A number of questions informed the direction of this study. Firstly, what initiated and shaped the response of the Cape Town City Council's Health Department to TB? Secondly, what were the underlying assumptions and attitudes of the City's public health administrators and medical officers to a TB epidemic that predominantly affected blacks? Lastly, why did the City's TB campaign take the form that it did, with the establishment of a medically focussed anti-TB scheme guided by the concept of the "*direct attack*" on TB.

Due to the local perspective of this study, the primary sources are dominated by the official records of the Cape Town City Health Department and the annual reports of the Medical Officer of Health. These public health administration sources are problematic because they are influenced by official policy direction and dominated by a white, predominantly male, western medical viewpoint. However, if approached critically, these sources can give some insight into the influences that shaped the response of Cape Town's Public Health Department to TB. In addition, these records also expose the underlying assumptions and approach of public health administrators and medical officers to TB sufferers and the disease.

Another primary source is found in the records of the voluntary TB Care Committee, based at the Chapel Street TB Clinic in order to cater for the welfare needs of TB patients. These records provide a rich seam of information in the form of Committee meeting minutes and annual Committee reports. Although these records are also biased and are informed by the aims of the Committee members and the City Health Department, they do provide some insight into the dire situation in which many TB patients found themselves.

Articles in contemporary medical journals, specifically the South African Medical Record and the South African Medical Journal, and local press articles have also been utilised in this study in order to gain some insight into current debates, concerns and attitudes to TB management, TB sufferers and the disease itself.

In conclusion, this study finds that local conditions provided a spur to the establishment of the city's TB scheme. However, at the same time, the response of the Cape Town City Council's Public Health Department to TB was shaped and informed by medical trends overseas, specifically Dr R. Philip's "Edinburgh Plan". Yet, although Cape Town's Public Health Department and its medical officers showed commitment to controlling TB in the city, their efforts were not successful in curbing the disease. This was due to the gap between their rhetoric of social reform and the medically-focussed curative campaign that was implemented (evidenced in the concept of the "*direct attack*" on TB).

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I dedicate this thesis in memory of my grandmother, Mrs J. H. S. Kilpatrick (1911-1998) and my brother, Duncan Kilpatrick (1978-1997).

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Note on 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 Africans during the period of white colonisation and settlement.

The Population Registration Act of 1950 formalised racial classification and divided South Africans into "White", "Coloured", "Asian" and "Native" or "Bantu". In this thesis, I have used the term "non-European" sparingly in original quotations. Rather, I preferred to use the term "black" in place of "non-European", and, I have used the term "white" in place of the older terminology, "European". Where necessary, I have made the distinction between black South Africans as either, African, coloured or Asian.

List of Abbreviations

The following abbreviations are used in this thesis:

APT	Artificial Pneumothorax
CA	Cape Archives
BCG	Bacillus Calmette-Guerin vaccine
INH	Isoniazid
UCT	University of Cape Town
AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
MOH	Medical Officer of Health
SAMJ	South African Medical Journal
SAMR	South African Medical Record
SANTA	South African National Tuberculosis Association
TB	Tuberculosis
PAS	Para-amino Salicylic acid
MDR	Multi-drug Resistant
MRS	Mass Radiography Service

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University of Cape Town

Introduction

“The history of the infectious diseases in modern times remains inextricably intertwined with the history of the cities that spawned them”.¹

This thesis will discuss the history of the Cape Town City Council’s efforts to manage TB within its boundaries through the lens of the Chapel Street TB Clinic and Administration Centre from 1941 to 1964. The City Council’s health department emphasised a western medical approach to control TB, which is evident in the creation of a TB sub-department under the direction of a medically trained TB Officer. Yet, the history of TB in Cape Town is bound up in the history of the city itself, with the patterns of disease changing over time due to the varying roles played by social, political and economic factors that influenced, and were influenced by, the disease. In order to gain some insight into the foundations of the current TB epidemic that has a vice grip on the city, this thesis will focus on the medically-based administrative response of the City Council to the disease in the context of the prevailing socio-economic and political conditions in the city. The first part of this chapter will briefly discuss the aetiology of TB in order to gain some understanding of the significant ways in which this mercurial disease spreads and interacts with the host and environment. Secondly, the international historiography of TB and local perspectives on the disease are outlined so that this thesis can be placed within a broader theoretical framework. Lastly, a synopsis is given of the most salient themes and issues that occur in the chapters that follow.

¹ A. Hardy, The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900. (Oxford, 1993), p.293.

i) The Changing Aetiology of TB:

Current Knowledge and a Brief History of Biomedical Discoveries

In 1997 the World Health Forum (WHO) reported that the global estimate for tuberculosis (TB) mortality for that year ranged between two to three million.² Yet, in many respects this disease ought to be under control because it is both preventable and curable. There are various forms of TB but only two have been found to cause active TB in humans. The causative organism for the communicable form of TB between humans is the *Mycobacterium tuberculosis*, which is generally transmitted through coughing and sneezing. The inhalation of TB bacilli is by far the most common mode of transmission. However, *M. tuberculosis* can also be ingested through the swallowing of TB sputum-laden dust, (expectorated bacilli may remain virulent for up to six months if not exposed to direct sunlight), and by licking, sucking or swallowing infected particles (this applies mainly to children who might play on TB infected ground).³ The second form of TB that can infect humans is the *bacterium bovis*, or bovine TB, which can be found in cattle and to a lesser extent in pigs.⁴ Thus, TB can also be transmitted through the ingestion of infected meat and more commonly through unpasteurised, infected milk supplies, often accounting for the cases of non-communicable TB of the bones and joints in humans.

This thesis will focus on the communicable form of TB in humans, generally known as pulmonary or respiratory TB. Pulmonary TB is spread by droplet infection from an infectious case to an uninfected individual. Once inhaled, the bacilli generally lodge in the

² A. Kochi, "Tuberculosis Control- Is DOTS the Health Breakthrough of the 1990s?", World Health Forum, vol. 18 (1997), p.226.

³ E. Glatthaar, Tuberculosis: A Guide for the Primary Health Care Worker (Pretoria, 1991), pp.12-13.

⁴ *Ibid*, p.12.

mid-lung region and form a primary lesion or site of infection. The incubation period varies between four and twelve weeks from an initial infection with *M. tuberculosis* to the first signs of a primary lesion or for a significant reaction to a tuberculin skin test to occur.⁵ Not all people infected with *M. tuberculosis* will develop active TB as many develop a cellular immunity and the disease is curbed. If, however, an individual is exposed to repeated infections, a very heavy bacillary load in the sputum coughed by an infected person, or is immuno-compromised due to poor nutrition or other cross-infections, they may develop active TB. According to current knowledge, active TB develops in two ways. The first type of infection is known as endogenous reactivation, when a dormant primary lesion from an old infection breaks down and develops into active TB as a result of stress or when the patient has a lowered resistance.⁶ The second type is known as exogenous infection, which occurs when a person's natural resistance is overwhelmed by a reinfection of the TB bacillus.⁷ According to Dr E. Glatthaar, approximately 10-15 % of those cases with dormant TB infection will eventually develop active TB during their lifetime.⁸ Thus one can speak of two pools of individuals, those who are *infected* and those who are *infectious*.⁹

TB is well known as a sensitive index for a particular population's health status. The causes of TB are varied because the disease interacts with the host and the host's environment on many overlapping levels. Anything that reduces an individual's cellular

⁵ P. M. Strebel and J. R. Seager, "Epidemiology of Tuberculosis in South Africa" in H. M. Coovadia and S. R. Benatar (eds.), *A Century of Tuberculosis. South African Perspectives* (Cape Town, 1991), pp.58-59. There are a number of methods for tuberculin skin testing, but most involve the use of an intradermal administration of Purified Protein Derivative (PPD), an extract of *M. tuberculosis*. This is done in order to measure any resistance to *M. tuberculosis*. If a reaction occurs on the skin, it indicates that the individual has at some stage been exposed to *M. tuberculosis* and has developed a cellular resistance to the TB bacilli.

⁶ *Ibid*, p.59.

⁷ *Ibid*.

⁸ E. Glatthaar, *Tuberculosis: A Guide for the Primary Health Care Worker*, p.22.

immunity plays an important role in predisposing an individual to the development of an active case of TB. An infected individual's cellular immunity might be compromised by a number of factors, such as physical or emotional stress, malnutrition, diseases such as diabetes and AIDS which suppress or adversely affect cellular immunity, alcoholism or a continuous bombardment by bacilli in situations of overcrowding.¹⁰ Age is also a determining factor. TB affects the very young, who have not yet developed an adequate immune response, those between the ages of 20 to 50 years, when the demands of work combined with lack of sleep compromise immune responses, and in the aged, where the immune system has deteriorated.¹¹ Although there are many debates surrounding McKeown's findings on the role of nutrition in the decline of TB rates, which will be discussed later on in this section, it is clear that malnutrition and under-nutrition do affect cellular immunity adversely.¹² Thus, it is as a result of these environmental factors that TB has become labelled as one of the "social diseases".¹³

Although TB is notorious for its 'silent' onset due to its variable incubation period, a number of symptoms and signs can be observed once active pulmonary TB has developed. The most significant is the development of a cough, after which a loss of weight, a loss of appetite, lethargy, haemoptysis (coughing up blood in the sputum), night-sweats, dyspnoea (a shortness of breath), chest pains, amenorrhoea, and a hoarse

⁹ E. Glatthaar, "Tuberculosis Control in South Africa", *SAMI* (17 November 1982), p.36.

¹⁰ *Ibid*, pp.17-19.

¹¹ *Ibid*, p.18.

¹² *Ibid*.

¹³ It is important to note that, although TB provides a sensitive index to a particular population's health status and its socio-political position within a given context, there are many other diseases that are similarly important markers, such as the diseases of malnutrition, measles, gastro-enteritis, cholera, and industrial accidents. Unfortunately, due to the narrow focus of this study it is not possible to incorporate a broader comparative perspective, which would be preferable. C. De Beer, *The South African Disease: Apartheid Health and Health Services* (London, 1986), p.12.

voice might indicate advanced disease.¹⁴ For current diagnostic purposes it is suggested that South African health workers use the index that most TB patients have a cough and one or two of the other symptoms.¹⁵ The disease is difficult to diagnose accurately without the aid of x-rays and a bacteriological examination of the sputum because none of these external symptoms are specific to TB alone. This knowledge of current difficulties throws the reliability of historical statistics into question, where the lack of technical aids and the contemporary medical understanding of TB would have led to misdiagnoses. Cultural responses to TB are also very significant and the stigma attached to the disease might have influenced doctors to refrain from diagnosing TB if the symptoms were unclear. The statistics for TB are therefore notoriously unreliable because they are contingent on various factors that could interfere with their accuracy and, as such, the figures for TB mortality and TB morbidity should be viewed with some circumspection. Furthermore, these figures are even less likely to be accurate in the South African context where population statistics were influenced by political factors, evidenced in the removal of Africans from urban statistics under the guise of the 'homelands' policy (which will be discussed in Chapter Three).

As TB has continued to spread amongst populations throughout history, political and cultural systems and the current state of knowledge about the disease mediated responses to this disease. This is seen in changing and often conflicting ideas about the aetiology of TB over space and time. Robert Koch's discovery of *M. Tuberculosis* (then termed the *tubercle bacillus*) in 1882 marks the beginning of the bacteriological era, which allowed for a better understanding of TB and its spread. Although this meant that public health

¹⁴ E. Glatthaar, "Tuberculosis Control in South Africa", *SAMJ* (17 November 1982), pp.24-26.

¹⁵ *Ibid*, p.26.

reformers knew that TB was communicable and thus preventable, the debate between those who emphasised the relative importance of the environment over the influence of hereditary factors continued on a new level. This debate can be found in the 'seed and soil' metaphors, where the TB bacillus represented the 'seed' and the human host the 'soil'. This understanding of the action of the disease is compounded by the debates that raged about the role of an inherited susceptibility or vulnerability to TB (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 TB was acquired and passed on to future generations, and the Darwinian theory of natural selection, where those susceptible to TB were 'weeded out' from the population over time. These metaphors were especially resonant in the colonial context with regard to the concept of race, which was determined by changing contemporary political and cultural ideas.¹⁶

Yet, despite the new bacteriological knowledge about TB, medical counter-measures remained modest during the pre-antibiotic era (up to 1944). According to contemporary knowledge, the isolation of infectious TB patients continued to be the most effective means of prevention and control and the provision of Sanatoria and supervised bed rest along with nutritious food, the best available means of treating the disease. During the 1920s invasive surgical interventions gained some acceptance internationally. Artificial pneumothorax (APT) came into vogue in Europe and America and it was believed that the collapse of part or the whole of the affected lung would lead to a reduction in the volume

¹⁶ For an analysis of changing ideas about acquired or inherited TB immunity and the concept of race see M. Worboys, "Tuberculosis and Race in Britain and its Empire, 1900-1950", in W. Ernst and B. Harris (eds.),

of the lung area and ultimately to an arrest of pulmonary TB.¹⁷ South African doctors proved fairly conservative in their response to this surgical procedure, and, because it was expensive and required an aseptic hospital environment with specialised medical expertise, it was never undertaken on a wide scale.¹⁸ In the field of TB prevention, the Bacille Calmette Guerin (BCG) vaccine was developed during the 1920s but was not accepted until much later (from the 1950s onwards) internationally and in South Africa. This will be discussed in Chapter Three.

It was only in 1944 that the first active antibiotic treatment, streptomycin, was developed and this led to the advent of the antibiotic era in TB treatment. Streptomycin was found to inhibit the development of *M. Tuberculosis* in humans and had a relatively low level of toxicity. However, there were some drawbacks, and streptomycin had unpleasant side effects, especially on the inner ear, as it could cause hearing and balance problems for some patients.¹⁹ There were also signs that the TB bacillus could become drug resistant if streptomycin was administered on its own. Following streptomycin, the addition of para-amino-salicylic (PAS) in 1946,²⁰ and isoniazid (INH) in 1952,²¹ to the TB drug armoury led to a more effective combination of these drugs in order to avoid the danger of drug resistance developing. The availability of these medical “magic bullets” allowed for the sidelining of socio-economic factors that form part of the many-sided problem of TB and

Race, Science and Medicine, 1700-1960 (London, 1999), pp.144-166.

¹⁷ D. P. Marais, “Therapeutic Artificial Pneumothorax: Its Indications, Scope, and Results”, SAMR (28 January 1922), pp.28-33.

¹⁸ P. Allan, “The Tuberculosis Problem in the Union of South Africa”, SAMJ (11 November 1939), p.741.

¹⁹ F. Ryan, Tuberculosis: The Greatest Story Never Told (Bromsgrove, 1992), pp.279-280.

²⁰ F. Ryan, Tuberculosis: The Greatest Story Never Told, p.261; R. M. Burke, A Historical Chronology of Tuberculosis (Springfield, 1955), p.74. Although Jorgen Lehmann had worked on PAS for a long time, this denotes the preliminary publishing of results from administering PAS.

²¹ F. Ryan, Tuberculosis: The Greatest Story Never Told, pp.350-357. During the 1960s these drugs were complimented by the discovery of pyrazinamide, cycloserine, ethambutol and rifampicin, which were all found to have an inhibitory effect on *M. Tuberculosis*. F. Ryan, Tuberculosis: The Greatest Story Never

enabled the idea of the narrow medical “direct attack” on the disease to become a reality. However, even though the antibiotic era is commemorated by some writers as a watershed in the medical management of TB, this would only provide one facet of the history of TB because the streptomycin era introduced a fresh set of problems alongside the apparent solutions that it offered.

ii) The Historiography of TB:

A Brief Review of Themes in the Twentieth Century

Roughly fifty years after the discovery of the first successful TB drugs, tuberculosis remains a serious, and in fact expanding, public health problem in many developing, and some developed countries. An analysis of the available historical literature on TB (written in or translated into the English language) reveals a number of broad themes in a rapidly changing historiography from the streptomycin era in the late-1940s to the present. These themes are at times difficult to tease out in a coherent fashion because they overlap and are often subtly changed by varying concerns and debates over time. On the one hand, historical writing about TB can be discussed in terms of a chronological scheme charting the uneven amount of attention that TB has received from British, European and American scholars during the twentieth century. This is illustrated by what Nancy J. Tones describes as the “remarkable renaissance of interest” in TB and the increased historical writing about this disease from the 1970s to the present.²² On the other hand, historical writing about TB can be discussed in terms of the tension between different approaches to the epidemiology of TB, where the central concerns and questions asked

Told, p.384; S.R. Benatar, “The Evolution of Anti-Tuberculosis Chemotherapy”, in H. M. Coovadia and S. R. Benatar (eds.) A Century of Tuberculosis: South African Perspectives (Cape Town, 1991), pp.258-270.

vary and result in divergent interpretations of the historical data about TB. This section will highlight a few of the themes that are present in international historical writing on TB, which has on the whole been dominated by the history of TB in countries such as Britain and the United States.²³ The final part of this section will analyse the South African historical literature on TB and will locate this writing within international historiographical trends in the literature on TB.

Firstly, the broad distinction between competing schools of historical writing will be illustrated with reference to selected historical literature available on TB. As western medical advances were revolutionising the treatment of TB from mid-century, two histories of TB stand out as diametrically opposed in their approach to the disease and typify the response of these rival schools of thought. The first example, Tuberculosis in History: from the 17th Century to our own Times (1949) by Prof. S. Lyle Cummins, (a leading authority on TB in the first half of the twentieth century) is a medical history that focuses on the well-known, primarily European and British, medical figures who worked in the field of TB.²⁴ The introduction to this work by a fellow medical authority firmly equates scientific knowledge with a superior 'right' to write medical history. This is seen in the statement that Cummins's historical writing is all "the more authoritative and valuable" because of his "expert knowledge".²⁵ It is within this context that Cummins

²² N. J. Tomes, "The White Plague Revisited", Bulletin of the History of Medicine, Vol. 63 (1989), p.467.

²³ There are a few notable exceptions such as Randall Packard's White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa (Pietermaritzburg, 1990), and William Johnston's The Modern Epidemic: A History of Tuberculosis in Japan (Cambridge, 1995), which will be discussed later on in this section.

²⁴ Cummins does, however, discuss the life of the North American TB specialist and sanatorium pioneer, Edward Livingston Trudeau. S. L. Cummins, Tuberculosis in History: From the 17th Century to our own Times (London, 1949), pp.149-175. For a discussion of Cummins's changing views on TB and race see Michael Worboys, "Tuberculosis and Race in Britain and its Empire, 1900-1950", in W. Ernst and B. Harris (eds.), Race, Science and Medicine, 1700-1960 (London, 1999), pp.144-166.

²⁵ S. L. Cummins, Tuberculosis in History: From the 17th Century to our own Times, p.xi.

writes from a purely western biomedical perspective and heralds the triumphs of a list of medical pioneers in a manner that is suggestive of linear progress. Although this more traditional approach to medical history is echoed in selected contemporary historical accounts, it has been superseded by a different approach to TB that has in large measure been influenced by the work of social historians such as Rene Dubos and Jean Dubos.²⁶

In contrast to Cummins's history of TB, four years later Rene Dubos and Jean Dubos published their study of TB entitled: The White Plague. Tuberculosis, Man and Society (1953).²⁷ The White Plague is significant because it provides the first general history of TB that attempts to illustrate the wider picture of the disease without focussing on a purely medical perspective. Rene and Jean Dubos's introductory note states that "Tuberculosis is a social disease, and as such presents problems that transcend the conventional medical approach."²⁸ Unlike Cummins's historical account, the Dubos's discuss the changing social, political and economic factors that affected the spread of TB at the same time as they consider the more narrowly medical focus on the TB bacillus. This is seen in the central theme of the book, where Rene and Jean Dubos attempt to illustrate the "subtle interplay between the social body and the social disease".²⁹ Thus, the Dubos's work synthesises the dialectic between the contribution of biomedical interventions, the role of the environment in the social construction of disease and the influence of changing cultural perceptions of TB in their analysis of the decline of TB mortality in western industrialised nations.

²⁶ Frank Ryan's Tuberculosis, the Greatest Story Never Told (Bromsgrove, 1992) offers a contemporary example of the heroic positivist narrative that documents the search for a medical cure to TB, although he tempers this account with his final chapter about the resurgence of TB in developed nations where it was thought to be 'conquered'.

²⁷ R. Dubos and J. Dubos, The White Plague. Tuberculosis, Man and Society (London, 1953).

²⁸ R. Dubos and J. Dubos, The White Plague, p.vii.

²⁹ *Ibid*, p.viii.

Thomas McKeown's The Modern Rise of Population (1976) provides a narrower approach to the question of why mortality rates from infectious diseases declined during the 19th and 20th centuries.³⁰ In The Modern Rise of Population McKeown argues that the decline of the TB death rate in England and Wales occurred rapidly from 1838 onwards, thus taking place before the sanitary reform movement gained ground from the mid-nineteenth century.³¹ Current historians have disputed McKeown's claims and argue that the decline of TB mortality actually occurred during the second half of the nineteenth century, which would bring the phenomenon in line with the rise of public health interventions as the more traditional histories of TB have claimed.³² Through the elimination or exclusion of different possible causes McKeown argues that the reduction of TB mortality was not due to medical preventative measures or to interventions but rather due to an improvement in living standards, with nutrition playing a pivotal role.³³ Although McKeown acknowledges that the introduction of streptomycin and BCG vaccination resulted in a more rapid decline of TB mortality from 1950 onwards, he maintains that the fall in the number of TB deaths would have continued at a slower pace despite this medical intervention.³⁴ McKeown's work has been criticised by a number of scholars because he has marshalled evidence to support his belief in a very narrow manner, to the exclusion of important counter-evidence.³⁵ Yet, his work continues to

³⁰ T. McKeown, The Modern Rise of Population (London, 1977); see also McKeown's The Role of Medicine: Dream, Mirage or Nemesis? (Oxford, 1984), where he applies his beliefs to question the significance and success of public health services and to examine medical education and research.

³¹ T. McKeown, The Modern Rise of Population, p.68.

³² Anne Hardy suggests that the beginning of the decline in TB mortality might even be pushed closer to the 1880s. A. Hardy, The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine 1856-1900 (Oxford, 1993), p.214.

³³ T. McKeown, The Modern Rise of Population, pp.128-129.

³⁴ *Ibid.*, pp.92-93.

³⁵ For a critical discussion of McKeown's work, see N. J. Tomes, "The White Plague Revisited", Bulletin of the History of Medicine, vol. 63 (1989), pp.467-480; L. G. Wilson, "The Historical Decline of Tuberculosis

influence and inform many subsequent histories of TB because his controversial argument fuels an ongoing debate within TB historiography i.e. the assumed dichotomy between the value of a targeted anti-TB scheme that utilises medical “magic bullets” and direct social interventions in contrast to broad social reforms and concomitant beneficial effects from rising standards of living to combat the disease. This theme recurs throughout the historiography of TB in different guises and will be discussed in a few examples.

McKeown’s influence can be seen in the more recent work of historians such as Linda Bryder and Francis B. Smith. Both historians locate their work in the bacteriological age of Robert Koch and question the value of medically focussed public health interventions that foreground the sanatorium as an effective measure of TB control in Britain during this period. Francis B. Smith’s The Retreat of Tuberculosis 1850-1950 (1988), charts the history of TB management in Britain and provides a blistering critique of medical attempts to control the TB epidemic during this period.³⁶ Smith argues that it was unfortunate that a “coterie” of medical TB experts formed from the late 1880s and thereafter dominated the field of TB and protected their own interests at the expense of an effective anti-TB scheme.³⁷ Smith believes that these experts channelled the public’s money into largely futile curative schemes when that money could and should have been used for preventative measures and for helping severely impoverished TB cases and their families.³⁸ McKeown’s assessment of the efficacy and importance of medical

in Europe and America: Its Causes and Significance”, The Journal of the History of Medicine and Allied Sciences, vol. 45 (1990), pp.366-396.

³⁶ F. B. Smith, The Retreat of Tuberculosis 1850 to 1950 (London, 1988).

³⁷ *Ibid*, p.244.

³⁸ *Ibid*, p.245.

interventions in the decline of TB frame Smith's history of TB.³⁹ However, although Smith emphasises that improved living conditions and nutrition played a role in the retreat of TB in Britain, he does caution that the actual effect of these factors remains unclear.⁴⁰ In addition, while Smith is critical of the efficacy of TB sanatoria, he notes that the Poor Law institutions, which would have sheltered and isolated infectious, poverty-stricken TB cases from about the 1840s, could have played a major role in the decline of TB mortality.⁴¹ However, Anne Hardy contends that Smith has overemphasised the role that these institutions played. She notes that the stigma attached to the Poor Law Infirmaries meant that they only aided those TB cases who had failed to gain assistance from all other organisations, thereby making it unlikely that these institutions could have had much success in reducing the spread of TB.⁴²

Yet, Smith's historical narrative of various TB treatments is strongly suggestive of a linear path of progress from ineffective and expensive treatments, such as the building of sanatoria, to culminate in the successful discovery of effective TB drugs. Despite mentioning the initial problems of drug toxicity and the development of drug resistance, Smith places more emphasis on the success of the new TB drugs in dealing the final blow to TB mortality. Smith posits that: "The long-term effects of improved nutrition, shelter, employment and life chances since the War, particularly among younger cohorts probably helped, but the victory belonged to streptomycin. The slowly retreating white plague was at last routed."⁴³ He qualifies his account of progress by noting that, although TB has been

³⁹ For example, this is seen in Smith's uncritical reproduction of McKeown's TB mortality graph for England and Wales as part of his concluding chapter. F. B. Smith, The Retreat of Tuberculosis 1850 to 1950, p.236.

⁴⁰ *Ibid*, pp.173-175 and p.244.

⁴¹ *Ibid*, pp.238-239.

⁴² A. Hardy, The Epidemic Streets, p.244.

⁴³ F. B. Smith, The Retreat of Tuberculosis 1850 to 1950, p.247.

“conquered” in the British Isles and the rest of the industrialised world, it remains a major killer in poor nations despite expensive efforts to manage it.⁴⁴ This observation is particularly applicable to South Africa’s history of TB, which will be discussed in greater detail later on in this section, where the state spent millions on a curative TB scheme at the same time as TB figures continued to increase. In this respect Smith notes that, “set against this continuum of near inconceivable misery our story is a miniature- a miniature moreover, with a happy ending.”⁴⁵ Written in 1988, however, Smith’s application of a linear historical narrative of the “retreat of TB” has been undermined by the advent of HIV and the resurgence of TB in those very same industrialised nations that were expected to have a ‘*happy ending*’.

Linda Bryder’s Below the Magic Mountain (1988) focuses on the anti-TB campaign in Britain in the early twentieth century. Her account examines the political and social responses to TB from the beginning of the century up until the discovery of effective chemotherapy. Like Smith, she questions whether the extensive anti-TB campaign in the early twentieth century actually made an impact on the decline of TB in Britain and attempts to determine why the disease attracted widespread attention at the turn of the century.⁴⁶ At the same time, Bryder analyses the evolution of specific actions taken by the British medical profession and state in attempting to curb the incidence of TB through surgical intervention, sanatoria, public health measures and chemotherapy. The patient’s perspective is returned to throughout this study and Bryder states that “a history of tuberculosis is not complete without considering the experience of those who contracted

⁴⁴ *Ibid*, p.2.

⁴⁵ *Ibid*, p.2.

⁴⁶ L. Bryder, Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain (Oxford, 1988), p.2.

the disease, including the impact of the anti-tuberculosis campaign on their lives.”⁴⁷

Although Bryder’s study recognises the current concerns with the influx of tuberculous immigrants into Britain, it does not go further to question the effects of TB in the developing world, or the member countries of the Commonwealth, due to this falling outside of the study’s bounds.⁴⁸ In looking to the future of TB management, however, Bryder warns that TB will not be “wiped out within a generation”. Yet, she only briefly mentions the issue of early knowledge about TB drug resistance and, like Smith, she chooses to place greater emphasis on the success of chemotherapy in the ultimate curbing of TB in Britain.

British historian, Anne Hardy, also deals with the impact of infectious diseases in nineteenth century Britain in her book The Epidemic Streets. Infectious Disease and the Rise of Preventive Medicine 1856-1900 (1993).⁴⁹ Hardy situates her contribution directly within the debate fuelled by McKeown’s theory about the role that preventive medicine and social interventions played in the declining rates of mortality from infectious diseases. She adds to previous histories an investigation of the most important infectious diseases that were prevalent during the nineteenth century viz. whooping cough, measles, scarlet fever, diphtheria, smallpox, typhoid, typhus and tuberculosis. She analyses the preventative measures against these diseases that were taken by local authorities and assesses their relative effectiveness. In her analysis of TB she focuses on the response of London’s medical officers of health in order to illustrate the local variability of the disease. However, in contrast to McKeown, Bryder and Smith, Hardy emphasises

⁴⁷ *Ibid*, p.3.

⁴⁸ *Ibid*, p.263.

⁴⁹ A. Hardy, The Epidemic Streets. Infectious Disease and the Rise of Preventive Medicine 1856-1900 (Oxford, 1993).

evidence from the sanitary literature and the pattern of falling TB rates in London, which suggests that local sanitary measures did in fact play an important role in stimulating the decline of TB mortality rates.⁵⁰ This leads to a more balanced appraisal of the efficacy of the anti-TB movement and is not as dismissive of the role played by public health measures in contributing to the decline in TB mortality.

The decade of the 1990s saw a relative spate of historical literature on TB. This renewed interest during the late twentieth century coincides roughly with the resurgence of TB in the wealthy industrialised nations and with the increasing spread of HIV and the growing epidemic of AIDS. Marcia C. Inhorn and Peter J. Brown have found a similar pattern in the sub-discipline of medical anthropology, where a research boom occurred from the 1980s onwards in work on infectious disease.⁵¹ They cite the growing AIDS crisis as one of the reasons for this research boom and note that AIDS has generated interest in other emerging and re-emerging infections such as TB.⁵² Inhorn and Brown also mention two other unfortunate but practical aspects that are familiar to many academic scholars; the issue of funding that often dictates the scope of scholarly studies and the influence of topical academic trends.⁵³ It is in fact possible to discern a greater awareness of the relationship and parallels between the history of infectious diseases such TB and the current AIDS epidemic in the historical literature from the 1990s up to the present. This tends to encourage a more culturally cognisant perspective that is not as immediately

⁵⁰ *Ibid*, p.266.

⁵¹ M. C. Inhorn and P. J. Brown (eds.) The Anthropology of Infectious Disease: International Health Perspectives (Amsterdam, 2000), p.14.

⁵² *Ibid*, pp.15-16.

⁵³ *Ibid*, p.17.

evident in the historical writing mentioned above, which seems to shy away from the cultural analysis of the “disease as metaphor”.⁵⁴

On the other hand, a notable feature of the sudden spate of historical literature on TB from the 1990s up to the present is the North American focus and an interest in the cultural forces that shape perceptions of TB. A few histories stand out. The first is Barbara Bates’s Bargaining for Life (1992) which emphasises the interaction of the American physicians, their patients and TB institutions and draws on contemporary correspondence of physicians in order to illustrate the relationship between caregivers and the TB sick in the pre-antibiotic era.⁵⁵ Bates focuses on the eminent American physician, Dr Lawrence Francis Flick, in order to chart the growth of TB institutions and to explore the experiences of white middle class TB patients. This historical study began in the late 1970s and was propelled by an interest in the experiences of TB patients.⁵⁶ Bates, like Bryder and Smith, argues that TB sanatoria and therapeutic regimes in America were not successful in curbing the disease because they were unable to isolate infectious cases on a large or efficient enough scale.⁵⁷ Yet, she balances this conclusion by noting that there might have been other “less tangible advantages” for some of those TB patients who could have experienced the benefits of nursing care, good relationships with their

⁵⁴ The Dubos’s White Plague pioneers the analysis of changing cultural metaphors that shaped perceptions of TB, and is followed by Susan Sontag’s Illness as Metaphor, which explores the realm of disease as metaphor in greater detail. S. Sontag, Illness as Metaphor (New York, 1979). Written after Sontag’s contribution to a cultural history of TB and Cancer, both Bryder and Smith’s accounts of TB in Britain were more reticent in their use of this methodological tool and instead they focussed on the patient’s perspective within the framework of the development of medical policy and institutions.

⁵⁵ B. Bates, Bargaining for Life. A Social History of Tuberculosis, 1876-1938 (Philadelphia, 1992).

⁵⁶ *Ibid*, p.2.

⁵⁷ *Ibid*, pp.318-320.

physicians, a sense of camaraderie with other patients and an escape from poor home and work conditions.⁵⁸

Georgina D. Feldberg's Disease and Class: Tuberculosis and the Shaping of Modern North American Society (1995) adds to this North American focus.⁵⁹ As Feldberg's title implies, this historical account looks at the class differences and imbalance of power between the patient and the medical authorities. Feldberg notes that when she began this study in 1982, few people understood her interest in TB because they viewed it as a disease that had been conquered.⁶⁰ She notes that this is no longer the case and draws on the modern resurgence of interest in the TB epidemic as a rationale for exploring the "historical context of contemporary experiences with TB."⁶¹ As with Bryder and Smith's accounts of the management of TB in Britain, and Bates' history of TB in America, Feldberg illustrates the intersection between the shaping of the middle class order, the control of the disease and the protection of middle class interests.⁶² She notes that "TB offered a powerful rationale for the prescriptions that gave the middle class its shape and substance. During these years, rates of tubercular infection and disease seemed to substantiate fears about gender, ethnicity, and dependency."⁶³ Feldberg tackles the apparent dichotomy between the use of western biomedical methods targeting the TB bacillus and the argument of broad social reform and argues that there were many physicians who "turned to the laboratory but continued to acknowledge the importance of

⁵⁸ *Ibid*, p.321.

⁵⁹ G. D. Feldberg, Disease and Class: Tuberculosis and the Shaping of Modern North American Society (New Brunswick, 1995).

⁶⁰ *Ibid*, p.1.

⁶¹ *Ibid*, p.1. Feldberg is also concerned with providing a history of TB that serves the purpose of informing current policy directions in dealing with TB. p.6.

⁶² *Ibid*, p.7.

⁶³ *Ibid*, p.82.

social circumstances.”⁶⁴ Furthermore, Feldberg argues that “the failure of state policy and institutions to support materially the rhetoric of social reform, rather than a socially conscious medicine, limited the success of American TB control efforts.”⁶⁵ This central paradox can also be seen in the history of TB in Cape Town and is a prominent theme that runs through all the chapters that follow.

However, Feldberg claims that the response of American physicians to TB was unique and distinctive because they chose the “road less travelled” and emphasised that TB was part of a “sociological as well as a biological problem”.⁶⁶ To this end Feldberg notes that American physicians shifted their focus from anti-spitting legislation and the threat of infection (the ‘seed’ metaphor) to the building up of the host’s resistance (constituting the ‘soil’) as part of their ‘therapeutic of social reform’.⁶⁷ Feldberg discusses how this translated into combating overwork, alcoholism, worry, poor diet, and bad habits through education and the use of the TB sanatorium and dispensary as a means to “fight both the bacterial and behavioural causes of TB.”⁶⁸ Feldberg analyses the American responses of circumspection and hostility towards BCG as a means of proving her theory of the distinctiveness of the “therapeutic of social reform”. However, Bryder and Smith show that there were medical professionals in Britain who similarly continued to emphasise the importance of environmental factors and both reveal the British medical profession’s guardedly negative response to BCG and pasteurisation during the first half of the twentieth century. Similarly, Cape Town’s medical authorities also made room for social conditions in their understanding of the aetiology of TB and revealed a conservatism with

⁶⁴ *Ibid*, p.5.

⁶⁵ *Ibid*, pp. 5-6.

⁶⁶ *Ibid*, p.6.

⁶⁷ *Ibid*, p.89.

regard to BCG vaccination when it was first released. This calls Feldberg's claim for American 'uniqueness' into question.

Katherine Ott's Fevered Lives: Tuberculosis in American Culture since 1870 (1996) contributes further to this body of literature that foregrounds the social and cultural construction of TB.⁶⁹ Ott describes the renewed interest in TB as offering an opportunity to analyse the intersection of medicine, history and society.⁷⁰ However, she notes that there has been a distinct lack of an historical perspective in many of the contemporary reports and discussions about TB.⁷¹ In discussing the rhetoric of contemporary reports, Ott notes that they portray TB as a timeless illness that is couched in an outdated nineteenth century discourse. She argues that this leads to the assumption that "Tuberculosis is back" instead of what she believes to be the more appropriate, "TB is back in the news".⁷² Basing her work in a cultural analysis discourse she notes that it is not the return of TB that is so remarkable, but rather that the decline of TB was "to a great extent an artifact of socially constructed definitions."⁷³ Fevered Lives is therefore a history of TB that is concerned with the changing conceptualisations and realities contained in the terms of reference used for the disease from the 1870s up to the present, with the term 'phthisis' changing to become 'consumption', which in turn was superseded by 'tuberculosis'.⁷⁴ Ott shows how 'consumption' was accepted as an affliction during the nineteenth century and was framed in non-threatening and

⁶⁸ *Ibid*, pp.89-90.

⁶⁹ K. Ott, Fevered Lives. Tuberculosis in American Culture since 1870 (Cambridge, 1996).

⁷⁰ *Ibid*, p.156.

⁷¹ *Ibid*, p.156.

⁷² *Ibid*, p.157.

⁷³ *Ibid*, p.157. Ott draws on the methodology of cultural history, literary criticism and medical anthropology.

Footnote no. 2, p.173

⁷⁴ *Ibid*, pp.1-2.

commonplace turns of phrase such as, “everyone is sometime or another a little bit consumptive.”⁷⁵

However, Ott’s history reveals that America’s current TB epidemic has come to mean something different through the intersection of modern medical science, class and race, which have shaped perceptions of the disease. TB rates declined among the ruling and wealthier classes and the understanding of TB as an affliction was instead transformed into that of a dreaded threat that fell under the control of public health officials. Ott places the contemporary TB epidemic within a framework that exposes current concerns about the disease as bound up in racism and ethnocentrism, with immigrants being blamed for importing the disease, and the conflation of morality and science where drug-resistant strains of TB are blamed on non-compliant treatment interrupters.⁷⁶ Ott’s work is significant because it shows how TB is socially constructed and how disease, class and race become conflated and transform the meaning and common understanding of TB. This can be usefully applied to the South African context where the discourse of public health changed over time as the identity of TB patients shifted from including the white ruling classes to solely the poverty-stricken, migrant labourers and black people in general.

Barron H. Lerner’s Contagion and Confinement: Controlling Tuberculosis along the Skid Road (1998), gives a more closely defined account of the social control of TB, and TB patients physically, through the work of Seattle’s Firland Sanatorium.⁷⁷ Lerner’s account also focuses on the antibiotic era and is a re-examination of the debate over the role of

⁷⁵ *Ibid*, p.1.

⁷⁶ *Ibid*, pp.162-163.

medical and social interventions and the environment in the decline and control of TB. Lerner attempts to determine whether public health measures really took cognisance of the various social factors that would exert an impact on the efficacy of a medically-focused curative TB scheme. He asks, "Have efforts to prevent and treat tuberculosis truly taken seriously the notion that it is a social disease? Or has such a characterisation of tuberculosis served as window dressing for strategies that have basically stressed control of the bacillus?"⁷⁸ Lerner chooses to focus on the antibiotic era in order to illuminate the response of medical authorities to TB once they were faced with the tempting availability of antibiotics. This effectively exposes the point of intersection between the medical and social approaches to TB. In discussing the public health measures undertaken by health officials in Seattle in the post-World War Two period, Lerner analyses the fine balance between protecting the public health through quarantine and detention and the coercive control of TB patients. Lerner's study contains useful parallels to Cape Town's experience since he focuses on the city of Seattle which, like Cape Town, was characterised by a transient population of migrant male work seekers. This exerted a particular impact on the anti-TB efforts of the city and interfered with TB drug schemes. However, in contrast to Cape Town, Seattle's officials attempted to forcibly detain migrants from their notorious "Skid Road" in institutions, in order to complete their course of medication. As will be discussed in Chapter Three, Cape Town's medical authorities were not financially able or even willing to use coercive means to enforce patient compliance during TB drug treatment, although they were also faced with a transient population. Rather, they worked within the Apartheid context, which

⁷⁷ B. Lerner, Contagion and Confinement. Controlling Tuberculosis along the Skid Road (Baltimore, 1998).

⁷⁸ *Ibid.*, p.4.

conveniently repatriated redundant or sick African workers without reference to the municipal authority.

In reaction to the dominant current historical paradigm discussed above, which tends to favour a social history of medicine, Frank Ryan claims that the people central to the search for a cure for TB in the first half of the twentieth century have been sorely neglected by history. In his book, Tuberculosis: The Greatest Story Never Told (1992) Ryan follows the race to discover effective TB drugs and his narrative culminates in the advent of the streptomycin era.⁷⁹ The book focuses on the personalities involved in this search and celebrates the discovery of drugs such as streptomycin and PAS. By his own admission in the preface, when he began his book he had not been aware of the new threat that TB posed near the end of the twentieth century. This factor only came to his attention when he was close to completing the book and he hastily added the last chapter about the new multi-drug resistant (MDR) strains of TB and the question of AIDS as a complicating factor in the resurgence of TB in the developed world. Ryan foregrounds the current threat that TB poses in areas where it was thought conquered, giving examples of a resurgence of mini-epidemics complicated by MDR TB and HIV infection in modern western cities such as Paris and New York.⁸⁰ Yet, although this might be a critical evaluation of the successes and failures of medical TB management, this account nevertheless adds to the more traditional medical history which is written from a western biomedical perspective, specifically focusing on the “big names” and “big dates” involved.

⁷⁹ F. Ryan, Tuberculosis: The Greatest Story Never Told (Bromsgrove, 1992).

⁸⁰ *Ibid*, p.402.

William Johnston provides an alternative to the geographically western focus that dominates current TB historiography.⁸¹ His study of the course that the TB epidemic took over time in Japan and its cultural incorporation allows for a broad description of the impact that the disease had on Japanese life. The Modern Epidemic: A History of Tuberculosis in Japan (1995) shows how the very nature of the disease shaped ideas and cultural patterns and was woven into the social fabric of Japan, but also discusses the speed with which this was forgotten once the epidemic subsided after World War II.⁸² Johnston states that “because tuberculosis became increasingly uncommon after 1950, those born during the ensuing years know almost nothing of this disease or of the enormity of its presence during the first half of the century”.⁸³ However, Johnston’s history of TB in Japan is ultimately about the eventual decline of TB, whether due to the vagaries of the disease or the control methods adopted. This observation about the collective popular amnesia of TB is interesting to compare with South African responses to TB. Many whites remained ignorant of the toll that TB took because it affected blacks beyond the purview of white society during the Apartheid years. Thus, the apparent decline of TB amongst whites and the political and social dominance of this group aided the popular or public amnesia about TB.

Historical writing about medicine, whether it be the more traditional form of medical history writing, a social history of medicine or a focus on the political economy of health, has received relatively little attention within the wider scope of South African historiography. However, the recent contribution made by historians focussing on South

⁸¹ However, Johnston notes that Japan should be included in the broad conception of “western civilisation”, which can signify internationally shared modern practices and institutions that are not geographically confined to Europe. W. Johnston The Modern Epidemic: A History of Tuberculosis in Japan (Cambridge, 1995), p.3.

African medical history promises an exciting growth in this particular field.⁸⁴

International scholars have illustrated how colonial medicine acted as a cultural force and have shown an interest in the exposure of the underlying patterns of social and political control embedded in Imperial medicine.⁸⁵ Recent work on the TB epidemic in South Africa is surprisingly sparse considering its status as a 'social disease' and its accepted links to the socio-political context of a given society. Historical literature on TB in South Africa is necessarily different from American and British accounts of a disease conquered, a disease in retreat, or the medical history of the race to discover new "cures". Although similar trends can be observed, such as an interest in the social construction of disease and the patient's perspective, the questions asked differ to those asked by scholars of British and American history.

A review of the historical literature of TB in South Africa reveals a tendency to focus on the political economy of the disease.⁸⁶ Cedric De Beer's history of what he terms "the South African disease" remains sharply focussed on the history of TB and its relation to current socio-political dynamics. His book, The South African Disease: Apartheid Health and Health Services (1986), was written within a particular political context under the Apartheid government's white minority rule. De Beer critiques the direction of contemporary public health policies from the perspective of the late 1980s. He outlines the two principles that underpin his history of TB. Firstly, he notes that "people's health is

⁸² W. Johnston The Modern Epidemic: A History of Tuberculosis in Japan (Cambridge, 1995).

⁸³ *Ibid*, p.24.

⁸⁴ See for example recent contributions in the special issue of African Studies: AIDS in Context, vol. 61, no. 1 (July 2002) that offers social and historical perspectives relating to the AIDS epidemic.

⁸⁵ See S. Marks and N. Andersson, "Typhus and Social Control: South Africa, 1917-50" in R. Macleod and M. Lewis (eds.), Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion (London, 1988), pp.257-283.

⁸⁶ See the collection of Conference Papers entitled, Consumption in the Land of Plenty- TB in South Africa (Cape Town, 1982).

directly related to the environment in which they live and work. These conditions, in turn, are determined by the position that people hold in the political and economic structures of the society in which they live.” Secondly, he states “that health services should not be understood to be a rational response to ill health. Their development is governed by realities and policies that have almost nothing to do with the health needs of the people.”⁸⁷

De Beer outlines the pre-1980 history of TB in South Africa and concludes that the conditions for the South African TB epidemic rest with the country’s early industrial expansion, beginning with the mines.⁸⁸ He also emphasises that the spread of TB is not random and that it specifically strikes those who hold the lowest positions in the economy.⁸⁹ Lastly he argues, that TB is above all a ‘social disease’ and that medical science by itself has, and will, fail to control an epidemic that rests on “poverty, unemployment and social misery.”⁹⁰ For De Beer the history of TB is inextricably linked to political and social realities that govern the country and he emphasises the importance of viewing TB as part of a general picture of ill health and disease.⁹¹ Yet, it should be noted that this approach tends to sideline any form of success that committed local medical authorities might manage to achieve within the boundaries of their administrative public health positions.

The work of an American historian, Randall Packard, stands out as the most significant contribution to the history of TB in South Africa. Packard’s book, White Plague, Black Labor (1989) deals with the rise of TB primarily amongst black workers in the burgeoning gold mining industry during the first part of the twentieth century, and

⁸⁷ C. De Beer, The South African Disease. Apartheid Health and Health Services (London, 1986), p.31.

⁸⁸ *Ibid.*, p.12.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

continuing through to the present.⁹² In terms of the scope of his study, he argues that there are not many historical accounts “that have tried to relate the history of a specific disease to the broader patterns of political and economic development in Africa over an extended period of time”.⁹³ There have in fact been no other works dealing with TB in Southern Africa on the scale that Packard does. Packard gives an account of how the political economy of health in South Africa encouraged the spread of TB amongst black workers during the twentieth century.⁹⁴ Consequently, he offers a sophisticated analysis of the history of TB in South Africa, that allows for a better understanding of the disease and the political economy in South Africa. Packard shows that the South African experience of TB can be understood “in terms of the same set of political and economic factors that have shaped the history of the disease in the west”.⁹⁵ He notes that “the history of TB in South Africa and the west has been shaped by the changing alignment of political and economic interests within a rapidly expanding capitalist industrial economy.”⁹⁶ What makes South Africa’s experience of TB unique, he argues, “is the specific way in which these alignments have evolved”.⁹⁷ Packard shows that, unlike in England, where a convergence of class interests around health occurred,⁹⁸ South Africa’s experience of TB was different because “to begin with, the tuberculosis epidemic in South Africa did not fall evenly on the working class as a whole. Rather it fell most heavily on African workers.”⁹⁹ In South Africa the coalition of interests and organisation might have

⁹¹ *Ibid.*

⁹² R. Packard, White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa (Pietermaritzburg, 1990).

⁹³ *Ibid.*, p.20.

⁹⁴ *Ibid.*, p.252.

⁹⁵ *Ibid.*, p.5.

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*, p.9.

⁹⁹ *Ibid.*, p.3.

benefited white workers to some extent but it did not lead to significant improvements in living and working conditions for black workers.¹⁰⁰

Like De Beer, Packard illustrates how great public expenditure concentrated on curative methods of control failed dismally in South Africa. Packard states that, although “TB efforts in South Africa since the 1950s have been impressive in terms of the scale of attack mounted by both governmental and private voluntary organisations”, they resulted in failure from “the subordination of public health to the overriding political and economic designs of the Nationalist government.”¹⁰¹ The failure of the state and capital to address the root causes of the rising TB epidemic and black ill health have led to a TB epidemic that has grown unchecked. Yet, as Elizabeth van Heyningen has pointed out, Packard’s masterful history of TB in South Africa, tends to retain its Witwatersrand (Gauteng) mining complex focus.¹⁰² Although he does include some comparative examples from cities such as Durban, Port Elizabeth and Cape Town to support his study of the impact of Apartheid policies on TB incidence, this coverage is limited. As a result of this Gauteng focus, the experience of African migrant labourers is dominant over that of other population groups. This approach also foregrounds the response of central government over that of the various local authorities. The variations in the response of individual local public health departments is therefore lost beneath the national picture of central government initiatives and perspectives. However, Packard’s work provides an indispensable starting point for detailed studies of specific local responses to TB during the twentieth century.

¹⁰⁰ *Ibid*, pp.16-17.

¹⁰¹ *Ibid*, p.276.

¹⁰² E. van Heyningen, “Epidemics and Disease: Historical Writing on Health in South Africa”, South African Historical Journal, no. 23 (1990), p.131.

A Century of Tuberculosis: South African Perspectives (1991) is a textbook that consists of a collection of essays dealing with the historical, social, political, economic and biological aspects of this disease.¹⁰³ This interdisciplinary collection constitutes the sole work of its kind on TB in South Africa and is important because it shows the relationship between the growing incidence of TB, efforts to curb this disease, and South Africa's political past. The first four chapters of the collection consist of epidemiological and historical essays on TB written by medical professionals, among whom Randall Packard is a contributor. The rest of the book is devoted to the clinical aspects of TB, Occupational TB, and the diagnostic, immunologic and therapeutic considerations of the disease in the South African context. Themes such as the divergent experiences of the disease between different races, disparities in access to health care facilities, and wide economic gaps between the wealthy and the poor are highlighted.

In discussing the historical writing available on TB internationally and in South Africa, a number of trends can be identified. The most significant trend in the literature, is the move away from a purely medically dominated history of the disease, towards a wider view of the impact of TB on societies within specific time frames and contexts. The perspective of patients, and a history of the disease as experienced by them, is also seen to emerge within some of the studies. However, in the South African literature on TB the political economy of health is stressed in reaction to the political climate during the twentieth century, with a focus on the central Apartheid government's policies, often sidelining local experiences of the disease. In addition, the economic climate, which has

¹⁰³ H. Coovadia and S. Benatar (eds.), A Century of Tuberculosis. South African Perspectives (Cape Town, 1991), Preface.

been dominated by the mining industry, has led to the area of Gauteng taking precedence and the experience of African migrants being emphasised in the history of TB. This approach downplays the very significant experience of the Western Cape that is currently acknowledged as an international TB ‘hotspot’ due to the magnitude of the TB problem in this area. Although previous studies have contributed immeasurably to the body of medical history in South Africa, there is room for additional work on TB in areas outside of the mining industry that will compliment the broader national studies. Thus, this thesis provides some local insight into the history of TB in Cape Town and the specific administrative measures that have been taken in an attempt to manage the city’s TB epidemic over time.

iii) A Synopsis of Themes in the Chapters that follow

In South Africa, TB incidence and mortality rates have not followed the trends of countries such as Britain, the United States, Canada and Japan. Unlike these countries, South Africa never experienced the dramatic fall in TB rates by the middle of the twentieth century. Instead, South Africa’s TB incidence and mortality rates followed diametrically opposed patterns according to race, that were determined by the political economy of health. This can be seen during the 1950s when white TB rates declined, in contrast to the ever-growing numbers of black TB cases. Although TB has not been limited to any one region or group of people in specific urban environments, it has become possible to identify particularly vulnerable “TB hotspots”. According to Dr Judy Dick, “the Western Cape has the highest reported rate of TB in the world”, although she cautions that “the data set for all health regions of South Africa lacks uniformity which

may affect the validity of this assessment”.¹⁰⁴ Within South Africa, the history of TB in Cape Town stands out for a number of reasons. Firstly, it is the oldest city, with the longest documented history of the disease and it is the chief urban centre of the Western Cape, which today has the ignominious status of being a TB hotspot. Secondly, Cape Town’s City Council was often at the forefront of active TB management from the turn of the century, as compared to other urban centres in South Africa, such as Johannesburg, Port Elizabeth and Durban. Yet, it should be emphasised that despite the committed efforts of medical officials in Cape Town, the TB epidemic grew out of control during the twentieth century. This is a central theme that runs throughout the chapters that follow.

Prior to the passing of the 1919 Public Health Act, local authorities dealt with TB on an ad hoc basis. This legislation made the notification of TB compulsory. The TB campaign effectively took place at a local government level and the local authority was held responsible for the prevention and control of infectious diseases. Thus, the Medical Officer of Health (MOH) and his department were responsible for the prevention and control of TB in the city. This responsibility translated into varied responses between different local authorities according to their budgets, their personal or professional interests or the lobby groups within their area. Once developed, Cape Town’s municipal anti-TB scheme echoed the comprehensive Edinburgh Plan, with the TB dispensary acting as a central ‘hub’ that co-ordinated all anti-TB efforts. This study will focus on the history of TB management from the local authority’s perspective and will discuss Cape Town’s official public health response to TB in order to expand our understanding of the foundation of the city’s current TB epidemic.

¹⁰⁴ J. Dick, “Adherence to Anti-tuberculosis Therapy in Cape Town” (Unpublished Ph.D. Thesis, University of Cape Town, 1995), p.2.6.

Within the broader framework of TB management in Cape Town, this thesis will focus specifically on the creation and development of the municipal TB dispensary system for a number of reasons. Firstly, the central TB dispensary was important because it was intended as the “hub” of all anti-TB activities undertaken by the Cape Town City Council. The Cape Town TB branch operated from the central TB dispensary, which housed the TB Officer, his staff and the voluntary TB Care Committee. Secondly, the TB dispensary acted as the site where the anti-TB work of the City Council and the voluntary Care Committee intersected. Thus, the relationship between these agencies can be analysed through the work undertaken at the TB dispensary. Thirdly, the TB dispensary scheme was primarily intended for the TB poor and was available free of charge for those TB cases who had no recourse to private practitioners or sanatoria. Thus the manner in which the TB poor were accepted, diagnosed and treated by the municipal and voluntary agencies based at the TB dispensary exposes the underlying tensions and commitment of the local authority to the health of a particular group in society. Medical discourse and local press articles also reveal the extent to which the spectre of TB was conflated with race and class to foster the potent image of a threat to white society.

This study begins with an overview from c1900 to 1936 in order to chart the development of a local anti-TB lobby and the foundations of an official public health response to TB in Cape Town. Consequently, the first part of this study deals with the history of anti-TB measures during the bacteriological era and prior to the discovery of effective anti-TB drugs. Thus the Cape Town Public Health Department had to find a solution to the TB problem armed with the knowledge that TB was infectious and could be prevented, but

without the aid of a medical “magic bullet” in the form of effective TB drugs. The history of the Chapel Street TB Clinic from 1941 to the early 1960s is therefore illuminating because it offers an opportunity to analyse the ways in which official responses to TB changed, through the lens of a particular public health institution in the period covering the pre- and post antibiotic era. The time span covered by this study follows the development of the Cape Town TB branch and its TB clinic and administration centre under the direction of Dr Hoole as TB Officer from 1938 until his retirement in 1964. The discovery of effective TB drugs has often been described as a watershed in the management and treatment of TB but this study finds that this is only partly true. On the one hand, the role of the TB dispensary did change dramatically because it could offer treatment that promised to cure TB, in contrast to the cough medicines and cod liver oil that had previously been given to TB patients. Yet, at the same time that TB drugs made the domiciliary treatment of TB patients possible, it should be noted that this did not lead to a complete revolution in the actual framework of Cape Town’s anti-TB scheme.

The sources for this study are problematic on a number of levels. The diagnosis of TB was difficult before the advent of accurate technical aids. There was also the ever-present stigma attached to the diagnosis of TB, which dissuaded people from readily becoming known to public health officials. Thus, TB incidence and mortality figures are notoriously mercurial. In addition, contemporary literature about TB is dominated by white biomedical perspectives in the form of the annual MOH reports or articles written in medical journals. The MOH reports hold the danger of bias because public health officials were reporting on their progress and might have wished to affect future policy directions through the conclusions drawn in their reports. In addition, these reports were intended for

a specific official and medical audience. The information provided by these reports suggests as much about the author as it does about the 'rational' medical response to TB. Yet, despite these shortcomings, this written material can be illuminating because it exposes the assumptions and attitudes of the authors.

However, the problem remains that the TB patient's voice is often lost beneath the concerns and interests of the public health officials. The articles in the press are frequently based on information furnished by public health officials and the TB patient's voice is seldom glimpsed in letters to the press. The minutes of the voluntary TB Care Committee are a rich vein of information about the position in which many TB patients found themselves, but patients' voices are filtered through the narrative constructed by the volunteers and the medical men who served on the Care Committee. It should be noted that the TB Care Committee received financial backing and policy direction from the Cape Town City Health Department. The written material in the SANTA Journals is also biased and exposes more about the underlying beliefs and ideals of the organisers than it does the TB patient's experience. Regrettably, it is only through the silences in these varied sources that one might distinguish or extrapolate some idea of the patient's experience.

With these limitations in mind, this study focuses on the official public health response to the management of TB and approaches the local public health official's perspective of TB with caution. A number of themes run throughout this study and loom large at various points. One of the dominant themes is the effect of population movements and upheavals. Cape Town, as a port city, was particularly affected by demographic upheavals. The issue

of immigrants and migrants posing a threat to public health recurs throughout and is discussed in each chapter. With the advent of the bacteriological age and germ theory, popular perceptions about the threat of disease exchange between the infectious and the uninfected occur in various guises. The face of the TB threat changed over time, ranging from the issue of the immigrant consumptive to the threat that the black migrant worker, the black domestic worker, and the 'recalcitrant' and 'irresponsible' alcoholic TB case or treatment interrupter posed to white society. Contemporary historical writing on TB tends to focus on the role that the Witwatersrand gold mining industry played in the extension of TB from urban to rural areas through the system of migrant labour and the repatriation of sick miners. This study redresses the imbalance and shows that Cape Town's history of TB also includes the lethal link between urban and rural patterns of disease, and that this city played a substantial role in exporting TB to rural areas, particularly the Transkei, during this period.

Another recurrent theme present in the contemporary public health response to TB is the continued tension between the concept of a rational "direct-attack" on the TB bacillus and the rhetoric of broad socio-economic reforms. This tension became starkly apparent with the advent of TB drugs, which made the "direct-attack" a more viable and compelling option for public health officials at the same time as it threw the abject poverty of many TB patients into view. As will be discussed in Chapter Three, this was due to the Catch-22 situation where the "direct-attack" in the form of a curative domiciliary TB drug treatment programme was undermined by the poor conditions endured by the majority of black TB patients. The final theme that looms large throughout this study is the question of 'responsibility' for TB. The discourse of the responsibility for TB infection reveals the

dominant, underlying assumptions of contemporary public health officials and the medical establishment who reported on the epidemiology of TB. These assumptions and explanations changed subtly over time and will be returned to in each chapter.

In order to place these themes in a chronological context, what follows is a brief synopsis of each chapter. Chapter One provides a broad background to the development of an anti-TB lobby and specific public health interventions to cope with the TB epidemic in Cape Town between the turn of the century and 1936.

Chapter Two focuses on the establishment of the Chapel Street TB Clinic and Administration centre in 1941 in the context of Cape Town's broader anti-TB scheme. The Chapel Street TB Clinic, under the direction of the TB Officer, Dr Hoole, provides a lens through which to view the underlying perceptions and approach of Cape Town's public health department to TB patients.

Chapter Three discusses the work of the Chapel Street TB Clinic and Administration centre from 1950 to 1964 in the face of the rising TB epidemic among blacks and the advent of the antibiotic or streptomycin era. This period saw the creation of a medical "magic bullet" to deal with TB in terms of a "direct attack" and brought the debate between the role of environmental reform and purely curative management schemes into sharp focus.

The final chapter provides an overview of the TB Clinic scheme up until the early 1960s in order to offer an understanding of the foundation of our current TB problem in the city

and concludes with a brief evaluation of the course that Cape Town's TB management scheme took after this period.

University of Cape Town

Chapter One

'Apathy' to 'Action'?

The Foundations of Cape Town's TB Branch, c1880s to c1936

"...We have abundant evidence to prove that we have a very great deal of this disease [tuberculosis] in our midst and that it is a far greater scourge and produces a much greater mortality than any other single disease".

Dr E. Barnard Fuller, MOH for Cape Town, 1899¹

The Cape Colony, and the city of Cape Town in particular, were no strangers to tuberculosis (TB) by the beginning of the twentieth century. Yet, despite the long history and high mortality rates of TB in Cape Town, it was only then that this disease began to evoke an official medical and public reaction. The timing of this response will be discussed later on in this chapter in order to provide some understanding of why TB began to be viewed as a public health problem only then. Although there is a body of very important work concerning the history of TB in South Africa,² no specific attention has been paid to the work done by the Cape Town municipality's Public Health Department. The aim of this chapter is to illustrate the dimensions of the TB problem in Cape Town and to broadly discuss how the Cape Town Public Health Department attempted to deal with the TB epidemic prior to the establishment of a TB sub-department in 1938. To do this, the first part of this chapter will briefly discuss the early

¹ Annual Report of the Medical Officer of Health, Cape Town, for the year ending 30th June 1899 in City of Cape Town: Minute of the Mayor for year ending 30 June 1899, p.cviii [Henceforth: Report of the MOH, Cape Town].

² H. M. Coovadia, and S. R. Benatar (eds.), A Century of Tuberculosis. South African Perspectives (Cape Town, 1991); C. De Beer, The South African Disease. Apartheid Health and Health Services (London, 1986); R. M. Packard, White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa (Pietermaritzburg, 1990); University of Cape Town, Medical School, Consumption

prevalence of TB in South Africa and will show how European colonisation, the mineral revolution, industrialisation and rapid urbanisation contributed to the rise in TB.

Secondly, the growth of a British-influenced public health awareness and organisation at the Cape will be discussed as this provided a stimulus for the growth of a local anti-TB movement in Cape Town. Thirdly, this chapter will look at some of the key developments in the growth of a municipal TB scheme in Cape Town in order to contextualise the birth of the Chapel Street TB Clinic administration in Chapter Two.

i) The Growing Prevalence of TB in Cape Town

The dearth of information about the early prevalence of TB in the Cape Colony hampers any thorough discussion of the disease prior to the nineteenth century. Yet there is sufficient evidence to point to a close connection between the increased prevalence of TB and European colonisation. Prior to white settlement, Randall Packard notes, the impressionistic data available points to a low level of TB endemicity amongst indigenous populations, if the disease was present at all.³ Moreover, the data supporting this view of a low TB prevalence prior to European settlement in South Africa has been found to correspond with the experiences of other colonial populations in Africa.⁴ The city of Cape Town has the longest history of European settlement in South Africa, a history that also translates to the longest period of contact between TB-carrying white immigrants

in the Land of Plenty: TB in South Africa (Cape Town, 1982); E.B. van Heyningen, "Public Health and Society in Cape Town 1880-1910" (Ph.D. Thesis, UCT, 1989).

³ 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, 1992), p.109.

⁴ R. M. Packard, "Industrialization, Rural Poverty, and Tuberculosis in South Africa, 1850-1950", p.109; C. Metcalf, "A History of Tuberculosis", in H. M. Coovadia, and S. R. Benatar (eds.), A Century of Tuberculosis, pp.15-16.

and visitors and indigenous populations. It is this feature that makes a study of TB in Cape Town important in terms of the broader history of TB in South Africa.

The earliest references to TB in the Cape Colony focus on the disease as it affected white colonists or travellers from about the 1780s.⁵ Yet it was only in the 1830s that references to the prevalence of TB amongst the indigenous population began to be noted. These references were firmly placed in a colonial discourse that focussed on the 'bad habits' and degeneracy of African and coloured consumptives. J. W. D. Moodie commented, in his book *Ten Years in South Africa* (1820-1830), that pulmonary TB was uncommon among the Dutch and English, but that it was "very frequent among the Hottentots (sic) from a scrophulous (sic) taint and their habit of sleeping on the ground".⁶ He also noted that the habit of smoking "dacha" was known to "occasion consumption if the practice be continued for a long time".⁷ The tendency of colonial medical authorities to blame the victims of TB for their affliction occurs throughout the period under review and is often conflated with ideas about race in contemporary medical writing. This will be returned to in the chapters that follow.

If TB existed, but on a relatively unobtrusive level within Cape society up until the nineteenth century, this contrasted sharply with the rapid increase in TB from the 1870s onwards.⁸ By 1907 one medical observer noted that TB had existed for so long among the African and coloured people of the Cape Colony that it was very difficult to find out

⁵ Union of South Africa, *Report of the Tuberculosis Commission*, U.G. 34-1914 (Cape Town, Government Printers, 1914), p.25; Union of South Africa, *Report of Tuberculosis Survey of the Union of South Africa*, U.G. 18-1924 (Cape Town, Government Printers, 1924), p.3.

⁶ Quoted in *Report of the Tuberculosis Commission*, U.G. 34-1914, p.25; *Report of Tuberculosis Survey of the Union of South Africa*, U.G. 18-1924, p.3.

⁷ Quoted in *Report of the Tuberculosis Commission*, U.G. 34-1914, p.25.

⁸ R. M. Packard, "Industrialization, Rural Poverty, and Tuberculosis in South Africa, 1850-1950", p.108.

whether or not it had been originally absent.⁹ However, the presence of the TB bacillus was not the sole cause of Cape Town's TB epidemic. Rather, the TB epidemic resulted from a complex interplay between the TB bacillus and various socio-economic factors that changed over time. It should be noted that the relative significance of different socio-economic factors, such as the immigrant effect, standards of living, and social upheavals, have been hotly contested within the historiography of TB. In contrast to histories that offer a single causality of TB, this section does not subscribe to a rigid hierarchy and will discuss the interconnected factors as they waxed and waned at different junctures in Cape Town's history. The purpose of this section is to explain the foundation of the TB epidemic in Cape Town and the response of the City's public health officials to TB during the first half of the twentieth century.

In 1899 Dr E. Barnard Fuller, the part-time MOH for Cape Town (1894-1899),¹⁰ lamented that Cape Town was "the first port of call" for consumptives.¹¹ He further noted that Cape Town was "usually the landing place of large numbers of consumptives who yearly [left] Great Britain and the Continent of Europe to seek the advantages of the South African climate".¹² The immigration of consumptives during the nineteenth century features prominently in the history of TB in South Africa. The belief that the sunny and dry South African climate was beneficial to the recovery of consumptives

⁹ N. McVicar, "Tuberculosis among the South African Natives", *South African Medical Record*, vol. 6, no. 13 (10 July 1908), p.200.

¹⁰ E. H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century* (Cape Town, 1958), p.335 and p.337.

¹¹ Report of the MOH, Cape Town, 1898/1899, p.cviii. Although, Dr E. B. Fuller believed that immigrant consumptives were harmful to the South African public health, it is noteworthy that many medical practitioners continued to consider the beneficial effects of the South African climate for the immigrant consumptives. This is seen in 1898 when his brother, Dr Arthur Fuller, wrote a treatise on the beneficial attributes of the South African climate as a health resort for consumptives. A. Fuller, *South Africa as a Health Resort* (London, 1898).

¹² Report of the MOH, Cape Town, 1898/1899, p.cviii.

gained ground from about the 1860s onwards.¹³ Initially the beneficial effects of South Africa's climate dominated local attitudes to consumptive immigrants, but these attitudes underwent a rapid change once it was determined that TB was both infectious and taking a heavy toll on public health.¹⁴ Yet, although the specific immigration of consumptives would have increased the pool of infectious individuals in South Africa, it cannot be considered as the primary source of infection because TB had become well established in the Cape prior to the 1880s due to colonial settlement.¹⁵ Neil McVicar of the Lovedale mission station noted that if one considered how common TB was in Europe during the period of early colonisation at the Cape, it stood to reason that the soldiers, missionaries and white settlers arriving from Europe would have harboured amongst their numbers numerous cases of TB.¹⁶

In 1903 Dr A. Jasper Anderson, the first full-time MOH for Cape Town (1901-1923)¹⁷ dispelled the misconception that the high death rates from TB at the beginning of the twentieth century continued to be caused by the importation of people already ill with TB. Dr Anderson noted that, although the importation of TB might have been the cause of high death rates "*many years ago*", it was well established within the Cape Town community, especially amongst the coloured population by 1903.¹⁸ This meant that,

¹³ Dr E. F. B. Wilson cites the immigration of consumptives in search of climatic cures from the 1860s. Dr E. F. B. Wilson, "The Treatment of Pulmonary Tuberculosis", South African Medical Journal (March 1899), p.241; C. Metcalf gives dates from c.1875 to 1900 in C. Metcalf, "A History of Tuberculosis", p.24; and P. Allan gives an approximate figure of 1880 in Report of Tuberculosis Survey of the Union of South Africa, U.G. 18-1924, p.3.

¹⁴ For an example of contemporary discussion at the turn of the century about the merits of the South African climate in TB treatment and the perceived negative effects of consumptive immigrants on the public health see, Dr E. F. B. Wilson, "The Treatment of Pulmonary Tuberculosis", SAMJ (March 1899), pp.241-251.

¹⁵ N. McVicar, "Tuberculosis among the South African Natives", SAMR, vol. 6, no.13 (10 July 1908), p.205; C. Metcalf, "A History of Tuberculosis", p.24.

¹⁶ N. McVicar, "Tuberculosis among the South African Natives", SAMR, vol. 6, no.13 (10 July 1908), p.205.

¹⁷ E. H. Burrows, A History of Medicine in South Africa, p.337.

¹⁸ Report of the MOH, Cape Town, 1902/1903, p.vii.

although some deaths might be attributed to the importation of sick TB carriers from abroad seeking medical relief, these people no longer made up the bulk of the TB deaths, or source of TB infection, in Cape Town or the Cape Colony. The question of tubercular immigrants from abroad was superseded at the beginning of the twentieth century by the more pressing problem of tubercular immigrants from within, with the growth of the migrant labour system and accelerating urbanisation and overcrowding.¹⁹ The migrant TB problem in South Africa, and the Cape Colony in particular, was therefore one of local origin by the turn of the century and demanded action from local authorities and the various governments of South Africa prior to Union in 1910.

Furthermore, from the turn of the century, conditions in Cape Town offered the ideal environment for the spread of TB. The South African War from 1899 to 1902, led to increased traffic passing through Cape Town. In addition, the city was subject to an expanded military presence and a flood of refugees from the Transvaal who settled in the city for the duration of the war. The wartime boom, with promises of employment, attracted people from rural areas and further swelled numbers within the city. A serious shortage of housing for these upcountry work-seekers and for African migrant labourers led to the growth of the number of unregulated shacks on the periphery of the municipal boundaries. Moreover, as Swanson and others have shown, the removal of Africans from the centre of Cape Town to the new location area of Ndabeni under the banner of 'sanitary reform' in 1901 did not ameliorate their living conditions.²⁰ The 1904 Depression made these conditions worse, and consequently unemployment,

¹⁹ Although the TB Commission submitted an interim report in 1912 that focussed on the negative effects wrought on the local population by tubercular immigrants entering South Africa during the nineteenth century. Report of the Tuberculosis Commission, U.G. 42-1912.

overcrowding and poverty spiralled the city into a social crisis. This situation was echoed on a larger scale following the First World War, when it was found that the rising cost of living and shortage of houses left Capetonians with a poorer standard of living than they had had in 1901.²¹ In 1925 the Cape Town MOH, Dr Tom Shadick Higgins (1923-1944) lamented that the provision of housing had not kept up with the increased urbanisation in the city.²²

The discovery of diamonds in 1867, and more importantly, gold in 1886, heralded an era of marked change in the history of TB in South Africa. Mining facilitated the spread of TB in South Africa, because it brought many miners from different areas into close contact with each other under conditions that were conducive to the transmission of TB. However, the mineral revolution not only affected the mining areas, such as the Witwatersrand and Kimberley with regard to the spread of TB. The repatriation of sick African migrant mine workers led to the spread of TB to rural areas where the disease had not previously been widespread. Apart from mine workers from the African continent, the mines also drew labour from overseas during this period. The immigration of a cosmopolitan group of skilled miners and others seeking work at the diamond and gold fields meant that a large amount of traffic occurred between the ports of South Africa, such as Cape Town, and the interior.²³

²⁰ M. W. Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909", in *Journal of African History*, vol. 18, no. 3 (1977), pp.387-410; V. Bickford-Smith, E. van Heyningen and N. Worden, *Cape Town in the Twentieth Century* (Cape Town, 1999), pp.44-46.

²¹ V. Bickford-Smith, E. van Heyningen and N. Worden, *Cape Town in the Twentieth Century*, p.101.

²² Report of the MOH, Cape Town, 1924/1925, p.ii.

²³ E. Katz, *The White Death. Silicosis on the Witwatersrand Gold Mines 1886-1910* (Johannesburg, 1994), pp.64-66.

Indirectly, the mining industry in the Transvaal also impacted on the spread of TB in Cape Town during the first half of the twentieth century. The growth of its port and the railway link to the Rand increased the volume of traffic passing through the city to the interior. The construction of a “*special fast-train service*” to the interior in the early 1890’s meant that Cape Town became the main point of entry for the new volume of passengers from overseas.²⁴ This increased volume of immigrants and travellers through Cape Town also meant that the city and its hinterland were more exposed to possible carriers of TB. Contemporary observers noted the important connection between routes of transport and the spread of TB and pointed to the apparent spread of TB following the main lines of traffic.²⁵ This is seen in McVicar’s contention in 1908 that native-born white and black people had the highest TB prevalence in areas traversed by the railway or in close proximity to it, in contrast to districts that were some distance from the railway line and had no reported cases of TB.²⁶

Apart from the actual opening up of the interior and the greater intermingling of tuberculous travellers and Capetonians, the railways and ports were also employers of labour. The hazards of close contact with tuberculous passengers while working for the railways were exposed when it was found that there was a high TB rate among white railway officials and among African workers who worked as carriage sweepers.²⁷

Similarly, the growth of the port drew work-seekers to Cape Town and the least skilled of these lived in conditions congenial to TB. As it grew at the turn of the century, Cape

²⁴ V. Bickford-Smith, Ethnic Pride and Racial Prejudice in Victorian Cape Town (Johannesburg, 1995), pp.12-13.

²⁵ N. McVicar, “Tuberculosis amongst the Coloured Population of South Africa”, SAMR (26 February 1910), p.39; N. McVicar, “Tuberculosis among the South African Natives”, SAMR, vol. 6, no. 11 (10 June 1908), p.176.

²⁶ N. McVicar, “Tuberculosis among the South African Natives”, SAMR vol. 6, no. 15 (10 August 1908), pp.234-235.

Town also offered other means of employment, particularly in the construction and manufacturing industries.²⁸ Consequently, many hopeful African workers flocked to Cape Town in search of work, some possibly believing it to be ‘easier’ and less dangerous than working on the mines.²⁹ The result was that a pattern of labour migrancy developed between rural areas and the city, that posed a perpetual problem for Cape Town’s municipal TB scheme. The issue of migrant labourers “importing” TB to the city was often raised by Cape Town’s medical officers and would eventually lead to the mass TB screening of incoming work seekers on arrival in the city during the 1950s. Nevertheless, some medical officers were also aware of Cape Town’s role in hastening the spread of TB to rural areas, particularly the Transkei, through the repatriation of sick workers to rural areas which were not able to provide adequate treatment and care for returning labourers.³⁰ A similar pattern of internal rural-urban migration is seen in late nineteenth century London, where young rural work-seekers who contracted TB in the city often returned home to die.³¹ However in contrast to Cape Town, there is no evidence that this pattern of TB infected people returning from London had any marked effect on rural TB rates.³²

It was not simply the importation of TB that caused Cape Town’s MOH concern but also the city’s permanent reservoir of TB. By 1930 Higgins stated that the TB situation in Cape Town remained “unsatisfactory”, acknowledging that the work done by the municipal health department had, had no direct effects on some of the fundamental

²⁷ N. McVicar, “Tuberculosis among the South African Natives”, *SAMR* vol. 6, no. 14 (25 July 1908), p.220.

²⁸ V. Bickford-Smith, E. van Heyningen and N. Worden, *Cape Town in the Twentieth Century*, p.26.

²⁹ N. McVicar, “Tuberculosis among the South African Natives”, *SAMR* (25 July 1908), p.220.

³⁰ *Ibid*, p.221.

³¹ A. Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventative Medicine 1856-1900* (Oxford, 1993), p.251.

³² *Ibid*.

causes of TB such as poverty, social degradation, and bad housing.³³ These factors became the bedrock of the next wave of the TB epidemic. The Depression of the 1930s further exacerbated socio-economic conditions in Cape Town. The TB mortality rates reflected this deterioration, peaking in 1931/1932 with a rate of 0.80 per 1000 for 'Europeans' and 5.32 per 1000 for 'Non Europeans'.³⁴ Once exposed to long working hours, inadequate nutrition, poor housing conditions and overcrowding in the cities, many succumbed to TB. The focus on white immigrants and African migrant labour tended to sideline the experience of the settled African and coloured community in Cape Town. Those medical officers who were well acquainted with the dimensions of the Cape's TB epidemic noted the established prevalence of TB in the city, particularly among the coloured community.³⁵ However, no practical socio-economic improvement occurred during the inter-war period from 1919 to 1939. The result was that the municipality attempted to deal with the growing TB epidemic through preventative measures such as the focus on sanitary improvements, the isolation of infectious TB cases in hospital and the maintenance of an out-patient TB clinic.

Thus, the growth of TB prevalence in Cape Town was produced by a number of inter-connected factors. European colonisation created the foundation of the TB reservoir and white immigration contributed to the rise of TB in the city. Yet, by the turn of the century these factors were not solely responsible for the city's TB problem. Internal migration, in the form of wartime upheavals, the mineral revolution and migrant work seekers, became

³³ Report of the MOH, Cape Town, 1929/1930, p.i.

³⁴ Report of the MOH, Cape Town, 1932/1933, p.34.

³⁵ Report of the MOH, Cape Town, 1902/1903, p.vii. "The Tuberculosis Question", SAMR (10 May 1907), p.140. See Dr D. P. Marais' response to Dr Maynard's assertion that TB had not become widely spread among coloured people. Marais countered that this comment "obviously show[ed] a complete ignorance of the situation in the Cape Province" (D. P. Marais, "Is Tuberculosis infectious? A Criticism", SAMR (28 September 1912), p.390).

a more pressing problem in the spread of TB. In addition, the city now had an established local reservoir of infectious TB sufferers who spread the disease among its settled communities. TB had become entrenched as a part of the cityscape. At the same time that TB was socially produced by conditions that were congenial to the spread of the disease, a gradual change occurred in medical and public apathy towards the disease. This changed attitude will be discussed in the following section in order to illuminate the climate in which the Cape Town Public Health Department responded to the TB epidemic.

ii) The Growth of Public Health Awareness and Organisation in Cape Town

“Out here in South Africa we have unhappily placed too much reliance on our sunny climate and pure air, and now are rudely awakened to find ourselves surrounded by the disease on all sides.”

Dr. D. P. Marais, 1912.³⁶

In 1912 Dr D. P. Marais, a well-known figure in Cape Town and in the South African anti-TB movement, claimed that a gradual change had occurred in public opinions about TB and that the previous “apathetic attitude” was slowly giving way to a “more enlightened interest”,³⁷ although in 1914 the TB Commission noted that the increased interest had taken the form of much agitation, with the idea that “the government ought to do something”, but little action.³⁸ South Africans had in fact been “apathetic” about TB in the nineteenth century compared to the medical and lay response to TB during the first

³⁶ D. P. Marais, “The Prevention of Consumption”, SAMR (10 February 1912), p.40.

³⁷ *Ibid.*

³⁸ Report of the Tuberculosis Commission, U.G. 34-1914, p.20.

decade of the twentieth century.³⁹ This section will discuss the combination of international and local factors that shaped the Cape Town City Council's response to TB around the turn of the century. The TB movement that developed at the Cape during this period was significantly influenced by the international TB movement; therefore this section will first discuss some of the international aspects of this phenomenon before exploring the local conditions that encouraged the growth of a public health awareness of TB in Cape Town.

Medical observers writing about the history of TB treatment from a traditional medical perspective have accorded much importance to Robert Koch's isolation of the causative agent of TB, *M. Tuberculosis* (or what was termed in contemporary medical writing as the *tubercle bacillus*), in 1882. The discovery of the TB bacillus heralded a new bacteriological era in TB control and allowed for a better understanding of the pathology of the disease. An example of the more traditional account that marks Koch's discovery as a scientific watershed is seen in Dr Robert Philip's assertion that the isolation of the TB bacillus brought the "advent of daylight".⁴⁰ Similarly, Rene and Jean Dubos believed that once the TB bacillus was isolated, the "vague terror" or fear of consumption was "personified" and that measures designed to prevent its spread "acquired the compelling strength of common sense".⁴¹ In South Africa, Dr D. P Marais lauded this discovery as the starting point in the campaign against TB.⁴² One South African medical observer felt that it was important because it forced people to recognise TB as a public health threat,

³⁹ This is seen in the March 1899 issue of the *SAMJ* (pp.237-251), which focussed on TB, with a number of articles discussing contemporary knowledge of the disease and the International TB movement.

⁴⁰ R. Philip, *Collected Papers on Tuberculosis* (London, 1937), p.96.

⁴¹ R. Dubos, and J. Dubos, *The White Plague Tuberculosis, Man and Society* (London, 1953), p.172.

⁴² D. P. Marais, "Whither Tuberculosis?", *SAMJ* (11 June 1960), p.509.

which he claimed had previously been “merely accepted”.⁴³ This recognition was a vital preventative factor in itself because people could take precautionary measures to avoid spreading or contracting the disease.⁴⁴

Yet, current historians have questioned these traditional accounts of the ‘bacteriological revolution’ that suggest a clear break between the pre- and post-bacillus periods. Francis B. Smith points out that medical and lay responses to TB in England and Wales did not change immediately after Koch’s discovery of the TB bacillus.⁴⁵ He notes that it took at least a decade before the germ theory of TB was gradually accepted and that the anti-TB movement took root only from the late 1890s. Linda Bryder, in looking at TB in Britain also questions the primacy of this discovery in the history of TB.⁴⁶ She suggests that the concern for ‘national efficiency’, which played an important role in the growth of health movements such as the infant and child health movement, at the beginning of the twentieth century might have been more influential.⁴⁷ From an American perspective, Georgina Feldberg questions the Dubos’s account that the isolation of the TB bacillus enabled a “rational attack on specific microbes”. She claims that American physicians did not always respond to infectious diseases in such a narrow medical fashion, rather they sought to include the effects of social conditions in their aetiological understanding of TB.⁴⁸

⁴³ D. Sinclair Smith, “Control of Tuberculosis”, *SAMJ* (14 October 1944), p331.

⁴⁴ *Ibid.*

⁴⁵ F. B. Smith, *The Retreat of Tuberculosis 1850-1950* (London, 1988), p.35 and p.37.

⁴⁶ L. Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth Century Britain* (Oxford, 1988), p.2.

⁴⁷ *Ibid.*, p.258. The concern for ‘national efficiency’ can be detected as shaping responses to TB in South Africa to some extent, but white fears about being infected by black TB seem to be more prominent and will be discussed in Chapter Two.

⁴⁸ G. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, 1995), p.4.

Despite current debates about the significance of Koch's isolation of the TB bacillus, medical literature around the turn of the century in South Africa does reveal a general awareness and acceptance of the communicability of TB. Medical consensus about the infectiousness of TB might have lagged between 1882 and the 1890s, but by the turn of the century at least one medical observer in South Africa noted that, "the profession ha[d] set back heredity, and advanced contagion to the front rank."⁴⁹ Thus, by the early twentieth century, most doctors in South Africa subscribed to the belief that TB was infectious, although there were some cases where individual doctors still argued in favour of the older theories of hereditary transmission of the disease.⁵⁰ In responding to the threat of TB, Cape Town's doctors were strongly influenced by the mid-Victorian British sanitation ethos and the public health legislation which flowed from this. Most Cape doctors were either immigrants from Britain or were locals who had received their training there, with Edinburgh in particular drawing a steady stream of students during this period up until the First World War.⁵¹ The Capetonian, Dr E. B. Fuller, was part of this phenomenon, and in March 1894, not long after his return from Edinburgh University, he was appointed as the part-time MOH for Cape Town.⁵² He associated Cape Town's municipal anti-TB effort directly with international health reforms, stating that "a great movement is now on foot throughout the whole civilised world to attempt to diminish the mortality from this disease, which is now universally acknowledged to be communicable from one person to another".⁵³ He was certain that the Council, which had shown "a disposition to have their Health Department in the van of sanitary

⁴⁹ D. Campbell Watt, "Prevention of Phthisis", *SAMI* (March 1899), p.237.

⁵⁰ See: "Dr Maynard's Views on Tuberculosis", *SAMR* (28 September 1912), pp.385-387.

⁵¹ E. H. Burrows, *A History of Medicine in South Africa*, pp.347-348.

⁵² *Ibid*, p.335.

⁵³ Report of the MOH, Cape Town, 1898/1899, p.cviii.

progress”, would be “anxious to take its full share in helping to reduce the large mortality from Tuberculosis”.⁵⁴

Britain’s influence is also seen in the case of Dr D. P Marais who explicitly stated that his personal association with Dr Robert W. Philip (the founder of the Victoria Dispensary in Edinburgh), had given constant direction to his life’s work in the TB field in South Africa.⁵⁵ The work of Philip and his “Edinburgh Plan” significantly influenced the approach of successive public health officials to the problem of TB in Cape Town and this scheme formed part of the medical “direct attack” on the disease. Dr Robert W. Philip’s Edinburgh scheme centred on the TB Dispensary as the “hub” of all anti-TB work.⁵⁶ TB cases were diagnosed and treated at the dispensary. TB cases were then either referred for in-patient treatment at TB hospitals and sanatoria or treated on an out-patient basis, with the TB patient’s domestic arrangements being overseen by the dispensary staff. TB patients would be educated about the necessary precautions to take to avoid spreading the disease, such as the use of spittoons (or sputum flasks) and the importance of well-ventilated indoor areas. The Edinburgh scheme was based on the new bacteriology, thus it offered a ‘modern’ medical approach based on knowledge about the TB bacillus and it offered a comprehensive public health programme for local authorities to attempt to control the disease. The influence of the Edinburgh scheme on Cape Town’s municipal anti-TB efforts will be discussed in greater detail in the following chapter. However, it should be noted that although Britain was certainly a strong influence on the Cape Town municipality, it was not the sole example that public health officials sought to

⁵⁴ Report of the MOH, Cape Town, 1898/1899, p.cviii.

⁵⁵ D. P. Marais, “Whither Tuberculosis?”, *SAMJ* (11 June 1960), p.509.

⁵⁶ See Appendix, Figure 4, for a diagrammatic representation of the “Edinburgh Plan”.

emulate.⁵⁷ The more energetic anti-TB work of public health officials in Europe, Canada, and the United States (more specifically New York City), were also referred to in comparison to Britain's otherwise tardy reaction to the TB problem.⁵⁸

Apart from these overseas influences, local conditions also acted as a spur to the growth of a public health awareness about TB and changed medical and lay attitudes to the disease. The Registration of Births and Deaths Act 1894 had a far more immediate impact on the growth of a local public health movement in Cape Town than the international TB movement did on its own. This legislation represented the first attempt to gain an accurate picture of birth and death statistics amongst the whole population in the Cape Colony, regardless of race, and, where implemented, provided alarming statistics not systematically collected or collated before. Dr A. J. Gregory, the assistant MOH for the Cape Colony (later MOH for the Cape Colony from 1900 to 1911), was quick to draw on the new statistics to point to the heavy toll that TB took on public health, especially among the African and coloured population in Cape Town.⁵⁹ The accuracy of these statistics was, however, flawed because it was not compulsory to register "non-Europeans" in rural areas, and this contributed to the initial impression that

⁵⁷ When the Cape Town City Health Department established a TB dispensary scheme, it looked to the examples set by the Glasgow municipal Health Department, Dr Philip's Edinburgh plan, and similar work undertaken in France. Report of the MOH, Cape Town, 1907/1908, pp.xxvi-xxvii.

⁵⁸ Dr E. B. Fuller suggested the adoption of the New York City Council's wording for a circular that requested the voluntary notification of pulmonary TB by doctors in Cape Town. (Report of the MOH, Cape Town, 1898/1899, p.cx.) This is also evident when the TB Commission reported on the immigration of consumptives to South Africa and recommended the immigration laws instituted in Canada and America as a blueprint for the Immigration Bill before parliament. (Interim Report of Tuberculosis Commission, "The Admission of Tuberculous Immigrants", *SAMR* (25 May 1912), p.215). The New York City Health Department's TB scheme was frequently referred to in medical articles on TB such as in N. McVicar, "Tuberculosis Among the Coloured Population in South Africa", *SAMR* (26 February 1910), p.41; "How Lancashire Fights Tuberculosis", *SAMJ* (13 June 1936), pp.424-425; C. C. P. Anning, "Recent Trends in Tuberculosis Control in the United States", *SAMJ* (10 April 1937), pp.223-228.

⁵⁹ E. H. Burrows, *A History of Medicine in South Africa*, p.334. Neil McVicar went as far as stating that the country was *indebted* to Dr Gregory for immediately drawing attention to the TB mortality figures (my emphasis). (N. McVicar, "Tuberculosis among the South African Natives", *SAMR*, vol. 6, no. 13 (10 July 1908), p.199).

TB was primarily an urban disease, and de-emphasised the spread of TB in rural and sparsely populated areas.⁶⁰ Even the urban TB death rates were somewhat misleading because sick migrant workers often returned to rural areas and their deaths from TB were not attributed to the towns or cities where they had first become ill.⁶¹

As MOH for Cape Town, Dr E. B. Fuller, played a substantial role in initiating the collection and collation of mortality statistics for Cape Town.⁶² This investigation yielded an alarming picture of an exceedingly high infant mortality rate of 34.4 percent amongst coloured infants, along with a high death rate from TB and gastro-enteritis.⁶³ The TB mortality figures revealed a bleak picture for Cape Town in the five years between 1893/4 and 1898/99. TB accounted for one in every eight white deaths and more alarmingly, for one in every six deaths for coloured people.⁶⁴ The mapping of deaths from TB in Cape Town revealed how wide the distribution of TB actually was throughout the city.⁶⁵ Together with the new bacteriological knowledge about the infectious nature of TB, the statistics yielded by the birth and death registrations were pivotal in provoking a response from public health officials and the general public.

Returning to Linda Bryder's suggestion that the growth of concern about TB might be rooted in the question of 'national efficiency', there is some evidence that Cape Town's

⁶⁰ In 1907, the SAMR agreed with Dr Gregory's view that the mortality statistics for rural districts in the Cape Colony were "fallacious" and that only those from sixty chief towns were "in any way reliable", whilst the SAMR believed that even these statistics lost "much of their value through the uncertainty as to the population factor in the equation". "Public Health Report. Cape Colony, 1906", SAMR (25 October 1907), p.311.

⁶¹ The medical profession were aware of the unreliability of the TB notification and death rates during the first decades of the twentieth century. See for example: D. P. Marais, "The Prevention of Consumption", SAMR (10 February 1912), pp.40-41.

⁶² E. H. Burrows, A History of Medicine in South Africa, p.336.

⁶³ *Ibid*, p.336.

⁶⁴ Report of the MOH, Cape Town, 1898/1899, p.cviii. (See Appendix, Figure 1, showing the map that depicted the distribution of TB mortality in the City of Capetown from 1895-1898).

medical authorities were aware of the economic implications of the TB epidemic. In 1903 the MOH noted that the heavy toll that TB took was “a matter of serious economic importance”.⁶⁶ Within the next few years medical authorities were making the connection between increasing TB rates among blacks and decreasing labour capacity, with the SAMR noting that TB was “decimating the Colony’s most valuable labour asset”.⁶⁷ Dr D. P. Marais noted that there was a need for a properly organised TB campaign (referring to the Edinburgh scheme) and directly related this to a matter of “national efficiency and of economics”.⁶⁸ In 1912 Marais estimated that the Cape Colony was losing well over £1,000,000 annually in wage-earning capacity and in the money spent on TB treatment.⁶⁹ Yet, it was primarily perceived as the ‘labour efficiency’ of African and coloured workers that was threatened by the ravages of TB. In 1910, one medical observer felt that this went a long way to explaining why most white people regarded the TB problem with the apathy that they did.⁷⁰ Contending that it would become a more serious matter for whites only if the ‘poor white’ group increased.⁷¹

This apathy, however, led to a situation of sharp crisis in the 1930s, where the dire situation in the black reserves could no longer be ignored due to ill-health seriously compromising the supply of a healthy African labour force.⁷² These observations continue throughout the medical writing about TB and reveal an awareness of the need for a healthy labour supply. The overwhelmingly high TB mortality rates for blacks was

⁶⁵ *Ibid.*

⁶⁶ Report of the MOH, Cape Town, 1902/1903, p.vii.

⁶⁷ “Public Health Report, Cape Colony, 1906”, SAMR (25 October 1907), p.311.

⁶⁸ D. P. Marais, “The Prevention of Consumption”, SAMR (10 February 1912), p.41.

⁶⁹ *Ibid.*

⁷⁰ N. McVicar, “Tuberculosis Amongst the Coloured Population of South Africa”, SAMR (26 February 1910), p.39.

⁷¹ *Ibid.*

often noted with alarm but the financial costs of providing what contemporary medical authorities believed to be the optimal treatment (the isolation and in-patient care of TB cases in sanatoria) were unattainable. The next section will discuss some of the actions taken by the Cape Town municipal Health Department in an attempt to control the city's TB epidemic.

iii) The Foundation of a Municipal anti-TB Scheme in Cape Town

This section will discuss the action taken by the Cape Colonial government and the Cape Town municipal Health Department in an attempt to manage TB. Firstly, this section will look at the problems posed by the lack of co-ordination among the various South African governments and their attempts to bridge this fragmentation in the interests of public health. The responsibility for the control of TB rested with the local authority, but it became clear that this placed an onerous burden on smaller local authorities who could not adequately deal with the TB problem. The legislative action taken by the Cape Colonial government will be discussed in order to show how this legislation both aided and hindered the TB management of cash strapped local authorities. Secondly, the drive to educate TB patients will be discussed in order to reveal the Cape Town City Health Department's approach and understanding of the TB epidemic and TB sufferers. Lastly, the foundations of the City Health Department's medically focussed anti-TB scheme will be discussed, with a particular focus on the creation of a municipal out-patient TB clinic system.

⁷² S. Marks and N. Andersson, "Industrialization, Rural Health, and the 1944 National Health Services Commission in South Africa", in S. Feierman and J. M. Janzen (eds.) The Social Basis of Health and Healing in Africa (Berkeley, 1992), p.146.

At the turn of the century, the lack of central co-ordination and organisation of an anti-TB movement undermined all separate anti-TB efforts. The absence of a unified health service until 1919 posed a formidable obstacle to local authorities that attempted to deal with a TB problem that was not contained by district boundaries.⁷³ The Cape Colony was reasonably progressive in its approach to TB because it had the longest history of TB in South Africa and the most advanced public health infrastructure compared to other South African governments. Yet, the Cape Colonial government was loath to institute far reaching socio-economic reforms or to cover the costs of a comprehensive curative scheme that included in-patient treatment in sanatoria to deal with the Cape's TB problem. This was seen in 1906 when the threat TB posed was highlighted at the inter-colonial conference held in Cape Town, which identified the disease as an urban problem and proposed sanitary reforms as the solution.⁷⁴ In May the following year a deputation of mayors and medical officers from the Cape Peninsula met with little support when they requested government assistance - the Cape Town MOH noted that this apathy revealed that Parliament had not sufficiently grasped the seriousness of the TB problem.⁷⁵ In 1910 a number of medical men noted the inability of smaller municipalities to cope with the financial strain of dealing with the TB problem in their districts.⁷⁶ Moreover, the 1914 TB Commission found that most local authorities held the view that TB was a "*national evil*" and as such the central government should take responsibility.⁷⁷ Neither Union in 1910 nor the 1919

⁷³ In 1907 the Cape Town MOH warned that it was only through the combined general management of TB, bridging all the various governments, that a decrease in TB mortality could be achieved. Report of the MOH, Cape Town, 1906/1907, p.xxii.

⁷⁴ Report of the Conference of the Principal Medical Officers of Health for the Different British South Africa Colonies, G48-1907 (Cape Town, 1907), p.8; E. van Heyningen, "Public Health and Society in Cape Town 1880-1910", p.474.

⁷⁵ Report of the MOH, Cape Town, 1906/1907, p.xxii.

⁷⁶ A. M. Gray, "The Modern Treatment of Tuberculosis", SAMR (12 November 1910), p.282.

⁷⁷ Report of the Tuberculosis Commission, U.G. 34-1914, p.21. It was noted in the SAMR that the state was "neglecting its duty" (A. M. Gray, "The Modern Treatment of Tuberculosis", SAMR (12 November 1910), p.282).

Public Health Act solved the problem of the fragmented nature of the TB work undertaken by various local authorities during this period.

However, the colonial administration did show a limited legislative commitment with regard to TB, when the notification of all forms of TB became compulsory in the Cape Colony in March 1904, under sections 28 and 29 of the Public Health Amendment Act, No. 23 of 1897.⁷⁸ Indeed, this proclamation was the first of its kind in South Africa, and predated the compulsory notification of TB in England by nine years because of the opposition of general practitioners there.⁷⁹ Yet, even though the co-operation of the Cape's medical practitioners had been gained, the notification of TB was not evenly applied throughout the Cape Colony because the costs devolved onto cash-strapped local authorities, and this meant that the operation of this legislation was parochial and often haphazard at best.⁸⁰ In addition to the compulsory notification of TB, the Cape Colonial Government passed an anti-expectoration regulation for Cape Town in 1905.⁸¹ The regulation applied to all public buildings, conveyances and public places including pavements and public footpaths and was widely advertised with placards throughout Cape Town.⁸² Cape Town's MOH, Dr Anderson, felt that this regulation had had a "*very great effect in diminishing*" the practice of expectorating within its first year, despite his reservations about the limitation of this regulation to adult males alone.⁸³ Yet the efficacy

⁷⁸ H. M. Coovadia, and S. R. Benatar (eds.), A Century of Tuberculosis. South African Perspectives, p.45; Report of the Tuberculosis Commission, U.G. 34-1914, p.42.

⁷⁹ L. Bryder, Below the Magic Mountain, p.41; Report of the Tuberculosis Commission, U.G. 34-1914, p.42 and p.44. Natal was the next South African province to follow the Cape's example of TB notification, near the end of 1904, although it required the compulsory notification of only pulmonary forms of TB.

⁸⁰ The TB Commission found that some local authorities actually discouraged TB notification because they had to bear the costs incurred through the payment for each notification. Report of the Tuberculosis Commission, U.G. 34-1914, p.21.

⁸¹ Cape of Good Hope Government Gazette, (31 March 1905), p.1313.

⁸² Cape of Good Hope Government Gazette, (31 March 1905), p.1313; Report of the MOH, Cape Town, 1904/1905, p.xxx.

⁸³ Report of the MOH, Cape Town, 1904/1905, p.xxx.

of the placards advertising the new regulation is questionable because the placards were limited to the literate.⁸⁴ Moreover, the practice of spitting seems to have continued in some public places.⁸⁵

As mentioned above, the first steps towards a TB control scheme in South Africa were fragmented and uncoordinated due to local authorities being responsible for the treatment of TB cases in their own area. Cape Town was one of the first local authorities which had the infrastructure and ability to act on the on the newly collated TB mortality statistics through the enforcement of sanitary measures and a propaganda campaign. As early as 1899 it instituted a system of home visitation by sanitary inspectors in order to disinfect the rooms of deceased TB cases and to distribute educational circulars on the prevention of TB. After compulsory notification in 1904, the role of the sanitary inspectors changed to include a careful surveillance of TB patients through fortnightly visits.⁸⁶ The 'education' campaign was, however, intrusive and dictated middle class conduct to those to be 'educated'. Moreover, if the sanitary inspectors were seen as invasive during the 1901 Plague epidemic in Cape Town,⁸⁷ their frequent and prolonged presence in the lives of TB patients must have been a burden for many TB patients during this period.

The form that the TB education campaign took changed over time. At the turn of the century the emphasis was one of prevention through education. The approach adopted by the City Health Department towards major health issues lays bare contemporary concerns

⁸⁴ N. McVicar, "Tuberculosis among the South African Natives", *SAMR*, vol. 6, no. 14 (25 July 1908), p.220.

⁸⁵ McVicar refers to a report of workers continuing the practice of spitting on the floor in a cigarette factory. N. McVicar, "Tuberculosis among the South African Natives", *SAMR*, vol. 6, no. 14 (25 July 1908), p.222.

⁸⁶ Report of the MOH, Cape Town, 1905/1906, p.xxx.

⁸⁷ V. Bickford-Smith, E. van Heyningen and N. Worden, *Cape Town in the Twentieth Century*, p.20.

and prejudices, which Elizabeth van Heyningen has shown, focussed on physiological and cultural explanations for disease rather than social conditions.⁸⁸ Through the use of physiological explanations such as racial susceptibility, and cultural explanations, such as the ignorance and moral ineptitude of the poor, responsibility was placed on the individual rather than the state. The gospel of self responsibility for TB can be seen throughout Cape Town's anti-TB scheme and is evidenced in the MOH reports too. The City Health Department aimed to educate people to attend the TB Bureau to be diagnosed at an early stage, as it was felt that the coloured TB cases would ignore their symptoms and continue to work until their condition was severe and they had spread the disease widely before they sought "expert advice".⁸⁹ The tendency to blame the victim for their condition occurs repeatedly in the medical literature throughout the twentieth century.

The dissemination of information about TB was broadened through the founding of the 'Association for the Prevention of Consumption' (APC) in 1904.⁹⁰ The APC created a forum for discussions about TB through organised public lectures, the distribution of leaflets, health demonstrations, and advertisements and cartoons being placed in public places.⁹¹ However, standing as it did on its own, this education campaign was not seen by contemporary observers as an effective anti-TB measure. Dr R. Philip stated in 1906 that:

"Most existing movements against tuberculosis fail in attaining all they might, because they are too partial. In many centres throughout the world anti-tuberculosis societies have been founded. The intentions of these have been good, but in practice less has been effected than

⁸⁸ E.B. van Heyningen "Public Health and Society in Cape Town 1880-1910", p.473.

⁸⁹ Report of the MOH, Cape Town, 1925/1926, p.lxxii.

⁹⁰ D. P. Marais, "The Co-ordination of Effort in Tuberculosis Control in South Africa", *SAMJ* (14 November 1936), p.738.

⁹¹ *Ibid.*

is to be desired, from insufficiency in the plan of operations. Excellent as much of the work has been, there is too generally lacking the element of efficient organisation.”⁹²

The acting MOH for Cape Town in 1907, Dr. A. S. Arenhold, held this opinion too, closely repeating Philip’s words as a comment on the fragmentary nature of the TB work done in the city.⁹³

These words of warning rang true for Cape Town’s anti-TB movement and, despite the efforts of the Cape Town municipality and the APC in educating the public, TB remained a public health problem in 1910. In that same year at least one medical practitioner still felt that “practically nothing” had been done to prevent TB in South Africa.⁹⁴ He also noted that, while the medical profession needed to be educated on the subject of TB, efforts to educate of the public had ended in the public “shunning the consumptive as a leper”.⁹⁵ Yet, he noted that *more* education was needed in order to remedy the situation, revealing a very narrow medical approach to resolving the problem.⁹⁶ The efforts of Dr Anderson in creating chalets for TB cases at the City Hospital and the work of the voluntary Cape Town Free Dispensary were described as only “a flea-bite” in the arena of TB prevention.⁹⁷

Contemporary thinking about the optimal response to TB went further than educational campaigns. The TB problem in Cape Town was dealt with in medical terms through TB cases either being hospitalised or being treated on an out-patient basis. From 1906 the

⁹² R. Philip, “Public Aspects of the Prevention of Consumption”, in Collected Papers on Tuberculosis (London, 1937), p.34.

⁹³ Report of the MOH, Cape Town, 1906/1907, p.xxii.

⁹⁴ Dr Guillemard in discussion following A. Murray Gray, “The Modern Treatment of Tuberculosis”, SAMR (12 November 1910), pp.280-281.

⁹⁵ *Ibid*, p.281.

⁹⁶ *Ibid*.

out-patient department of the New Somerset Hospital and the Cape Town Free Dispensary offered to diagnose and treat TB cases.⁹⁸ In 1909, the Free Dispensary went further and opened a special TB session one evening a week, where a medical officer examined and treated TB patients.⁹⁹ This service was subsidised by the Cape Town Council and the Government, and was open to all TB sufferers regardless of race or gender.¹⁰⁰ This system was broadened out in 1911 when a nurse was appointed by the City Health Department to visit TB cases at home in order to see that they received adequate food and treatment.¹⁰¹

In addition, the Medical Superintendent of the City Infectious Diseases Hospital near the harbour, Dr W. P. Cooney, held TB clinic sessions every weekday in “makeshift premises” at the hospital in order to deal with the many TB cases requiring treatment while waiting for hospital accommodation.¹⁰² These clinic sessions formed the core of what became known as the TB Bureau. The work undertaken at the TB Bureau was loosely based on Philip’s Edinburgh scheme where the TB dispensary acted as the central hub for anti-TB work. Thus, the TB Bureau’s work consisted of the diagnosis of TB cases, the selection of suitable cases to send to the Nelspoort Sanatorium, the admission of advanced TB cases to the City Infectious Diseases Hospital, and palliative out-patient treatment.¹⁰³ As with the Edinburgh scheme, the TB Bureau’s work was complemented by the aid of a TB health visitor who attended the TB clinic sessions and visited TB cases

⁹⁷ *Ibid.*

⁹⁸ Report of the MOH, Cape Town, 1905/1906, p.xxx. The Cape Town Free Dispensary was a philanthropic institution that offered medical assistance to the sick-poor in the City. See: M. Naude, “The Role of the Free Dispensary in Public Health Care in Cape Town, 1860-1910”, (BA Hons. Dissertation, University of Cape Town, 1987).

⁹⁹ Report of the MOH, Cape Town, 1905/1906, p.xxx. Report of the MOH, Cape Town, 1909/1910, p.xxix.

¹⁰⁰ Report of the Tuberculosis Commission, U.G. 34-1914, p.19.

¹⁰¹ Report of the MOH, Cape Town, 1910/1911, p.xxxii.

¹⁰² Report of the MOH, Cape Town, 1924/1925, p.lxvi.

¹⁰³ Report of the MOH, Cape Town, 1925/1926, p.lxxii.

at their homes. In 1925, however, Dr Shadick Higgins noted that TB had not declined and that increased efforts were required to deal with the problem.¹⁰⁴ In addition, Dr Cooney noted that the current premises for the TB Bureau were rendering work extremely difficult (due to their makeshift nature and a lack of space) and that new premises were urgently required.¹⁰⁵

Within his first few years as the MOH for Cape Town, Shadick Higgins, looked to the provision of a curative TB service that enabled a “*direct attack*” on the disease to be made.¹⁰⁶ Higgins described the “direct attack” as primarily consisting of the provision of TB treatment at Nelspoort Sanatorium,¹⁰⁷ the isolation of a limited number of advanced TB cases in the City Infectious Diseases Hospital and the maintenance of the Newmarket Street TB Dispensary.¹⁰⁸ Yet, despite this curative focus, Higgins emphasised that the “indirect” causes of TB should not be overlooked.¹⁰⁹ He listed socio-economic factors such as poverty, under-nourishment, overcrowding and bad housing generally, the lack of sunlight and fresh air, bad industrial conditions, and alcoholism as important indirect causes that needed to be addressed in order to eradicate TB and improve the public health generally.¹¹⁰ In 1926 Shadick Higgins noted that there were two directions in which the City’s TB campaign could be improved. Although he noted the importance of socio-economic conditions, his plan emphasised short-term curative measures. As part of the city’s “direct attack” on TB Shadick Higgins noted that the facilities for the isolation of advanced infectious TB cases in hospital had to be expanded, but he noted that this would

¹⁰⁴ Report of the MOH, Cape Town, 1924/1925, p.ii.

¹⁰⁵ *Ibid*, p.lxvi.

¹⁰⁶ Report of the MOH, Cape Town, 1925/1926, p.ii. The concept of the “direct attack” resurfaces in the MOH reports throughout the following decades and remains a central guiding force for the efforts of the City’s medical officers.

¹⁰⁷ Nelspoort TB Sanatorium was opened in 1924, and will be discussed later in this section.

¹⁰⁸ Report of the MOH, Cape Town, 1925/1926, p.ii.

¹⁰⁹ *Ibid*.

incur a considerable increase in expenditure.¹¹¹ The second area for improvement was the provision of a “properly equipped” TB clinic that was more centrally placed in the city, and the provision of other similar TB clinics.¹¹²

Consequently, in 1929, the TB Bureau was eventually moved to a building that was specially adapted for out-patient clinic sessions at 50 Newmarket Street, on the edge of the city, in order to operate more efficiently and effectively.¹¹³ With the move to the new premises the TB Bureau became known as the Newmarket Street TB *Clinic* as it had become physically removed from the City Hospital. At the Newmarket Street Clinic TB clinic sessions were divided according to race and gender, which had not been possible with the space constraints at the old premises.¹¹⁴ The Clinic’s position was also more accessible for those TB cases living in the city’s slum areas. In consequence, the total attendance of TB cases increased from 1820 in 1927/28 at the City Hospital, to a total of 3280 patients passing through the Newmarket Street clinic doors in 1928/29.¹¹⁵ Accordingly, before long the staff of the TB Clinic was increased, to three health visitors assisting the medical officer at TB Clinic sessions and visiting TB patients in their homes.¹¹⁶

¹¹⁰ *Ibid.*

¹¹¹ Report of the MOH, Cape Town, 1925/1926, p.ii.

¹¹² *Ibid.*

¹¹³ Report of the MOH, Cape Town, 1928/1929, p.79 (See: Appendix, Figure 3, showing the entrance to an unidentified TB Clinic. Taking the TB clinic times and the street number above the door into account, it is highly likely that this is a photograph of the TB Clinic in 50 Newmarket Street c1929-1941).

¹¹⁴ Report of the MOH, Cape Town, 1926/1927, p.lxvii.

¹¹⁵ Report of the MOH, Cape Town, 1928/1929, p.80. In contrast, the municipal Venereal Diseases Clinic moved from its central position in Keerom street to the City Infectious Diseases Hospital resulted in a drop in attendances because many patients could not afford the daily tram fare to and from the hospital. Report of the MOH, Cape Town, 1936/1937, p.lxviii.

¹¹⁶ Report of the MOH, Cape Town, 1928/1929, p.80.

Another feature of the Newmarket Street TB Clinic that echoed the Edinburgh scheme was the establishment of a TB Care Committee. Philip's Edinburgh scheme attempted to deal with the social welfare aspects of the TB problem through the encouragement of voluntary Care Committees that would work alongside municipal TB dispensaries in order to help the TB poor to cope financially and to avoid destitution. The issue of social welfare in South Africa was a thorny one because the state maintained a *laissez faire* attitude towards the conditions of the poor (especially if they were not white) and voluntary organisations were wary of giving hand-outs that might lead to dependency. At the same time, the poor were the most vulnerable to TB precisely because of their impoverished socio-economic conditions. The voluntary TB Care Committee (founded in Cape Town in 1928 as the "After-care Committee for TB Patients"),¹¹⁷ sought to bridge the welfare and medical needs of TB patients and their families. The TB Care Committee was funded by various organisations, particularly the Cape Town City Council and the Department of Social Welfare and it received grants from the Association for the Prevention of Consumption (a national organisation) and the Cape Peninsula Community Chest. The TB Care Committee was established with the aim of providing 'after-care' for TB patients returning from the Nelspoort Sanatorium, in order to see that the benefits they had derived from a period of rest and adequate nutrition at the sanatorium were maintained.¹¹⁸ The Committee therefore aimed to deal with the social, domestic and economic needs of TB patients, and to oversee the welfare of the family, and children in particular.¹¹⁹ Based at the Newmarket Street TB Clinic, the Committee supplied blankets and a certain amount of clothing and nourishing food on a weekly basis, and attempted to

¹¹⁷ Minutes of the TB Care Committee, Report for the year ended 31st December 1948, (lodged at the offices of "TB Care", Athlone).

¹¹⁸ Minutes of the TB Care Committee, Report for the year ended 31st December 1948.

¹¹⁹ *Ibid.*

find suitable employment for those TB patients who had recovered sufficiently.¹²⁰ The Committee showed a particular interest in rehabilitating TB patients and was cautious not to give “*mere poor relief*” which it felt could not achieve good results.¹²¹

That the Care Committee was founded in a spirit of close co-operation with the City Health Department, is seen in the presence of the MOH, Dr Shadick Higgins, and the Medical Superintendent of the City Infectious Diseases Hospital, Dr J. F. Wicht, at the Committee’s first meeting chaired by Mrs H. C. Horwood in April 1928.¹²² This co-operation would increase throughout the twentieth century, with successive Medical Officers of Health and TB Officers serving as Committee members or Committee chairmen. Although the TB Care Committee was the first voluntary agency founded to deal specifically with the social and economic aspects of Cape Town’s TB problem, other agencies soon became involved in the wider aspects of social welfare for TB patients.

Following the inclusion of Wynberg municipality into Cape Town in 1927, the Cape Town Health Department opened a second TB clinic in that area in order to cope with the growing number of TB cases accumulating in the surrounding Cape Flats area.¹²³ The Church Street TB clinic in Wynberg was the first specially designed TB clinic built along “*modern lines*” for the out-patient treatment of TB cases in Cape Town in 1935.¹²⁴ The Medical Superintendent of the City Hospital continued to oversee the TB clinic sessions that were held at these two premises until the appointment of a full-time TB Medical

¹²⁰ Minutes of the TB Care Committee, Report of the Case Committee, May to December 1929, p.63.

¹²¹ Minutes of the TB Care Committee, Report of the Case Committee, 7 February 1930, (p.2 of attached pages), on p.58.

¹²² Minutes of the TB Care Committee, Report for the year ended 31st December 1948.

¹²³ Report of the MOH, Cape Town, 1934/1935, p.95.

¹²⁴ *Ibid.*

Officer in 1938. The TB case worker would also travel to these clinic sessions in order to offer social relief to those TB patients in need of advice and material aid.

The provision of TB in-patient care, however, proved to be more obviously deficient, with an urgent need for dedicated, long term TB accommodation constantly being referred to in Cape Town's annual MOH reports from 1900 onwards. In 1907 accommodation was provided for twenty TB cases at the City Infectious Diseases Hospital in two buildings "*of a temporary nature*".¹²⁵ During that same period twelve beds were made available at the Old Somerset Hospital for the accommodation and isolation of advanced, incurable or indigent TB cases from the Peninsula.¹²⁶ Despite the dire need for TB accommodation in Cape Town, the 32 beds available in the city were the only form of long-term TB accommodation provided by a local authority in South Africa during the first two decades of the twentieth century.¹²⁷ Only when a Cape Town citizen, Mr J. Garlick, donated funds was the first TB Sanatorium at Nelspoort established in 1924.¹²⁸ Although this institution extended the TB accommodation available in the Cape Province, it did not solve the shortage of TB beds, which successive medical officers believed undermined the TB control efforts of the Cape Town City Council.

As discussed in the first section of this chapter, Cape Town was in deep crisis with regard to TB by the late 1930s. TB prevalence had increased from the 1870s onwards in Cape

¹²⁵ Report of the Tuberculosis Commission, U.G. 34-1914, p.19.

¹²⁶ Report of the Tuberculosis Commission, U.G. 34-1914, p.19. The Report of the MOH, Cape Town, 1906/1907, p.xxii.

¹²⁷ R. M. Packard, "Holding Back the Tide: TB Control Efforts in South Africa", in H. M. Coovadia, and S. R. Benatar (eds.), A Century of Tuberculosis. South African Perspectives, p.45.

¹²⁸ J. A. Mitchell, "The Nelspoort Tuberculosis Farm Sanatorium Scheme and Tuberculosis Clinics", SAMR (8 July 1922), p.242; D. P. Marais, "The Co-ordination of effort in Tuberculosis Control in South Africa", SAMJ (14 November 1936), p.736 and p.738.

Town due to the growth of the Cape Colony, the mineral revolution, industrialisation and urbanisation. The growth of Public Health awareness and organisation from the 1890s allowed for the creation of institutions responsible for the protection of Public Health. This in turn created an environment that was conducive to the changed social attitude towards TB from one of 'apathy' to some limited forms of 'action' (seen in the ad hoc education campaigns, the provision of some in-patient facilities and the establishment of a small TB Clinic along the lines of the Edinburgh scheme). The anti-TB movement in Cape Town consisted of the official work of the municipal Public Health Department and voluntary organisation. Yet, this work was undermined by a lack of adequate state funding and co-ordination and the seeds for the failure of future anti-TB efforts were already present in this early TB scheme. The gap between the rhetoric of socio-economic reform and the short term medical solutions, such as Shadick Higgins's "direct attack", was established. It was in this context that the Cape Town Health Department implemented the second phase of its "direct attack" on TB with the acceptance of Dr Shadick Higgins's TB report in 1937, which will be discussed in Chapter Two.

Chapter Two

Cape Town's "Direct Attack" on TB and the Chapel Street TB Clinic

During the Pre-Antibiotic Era, c1937-1950

"As things are at present, the diagnosis of pulmonary TB is invariably a death sentence, especially in a non-European".¹

"The death rate from tuberculosis among Europeans in the Union is the lowest in the world; but among the non-Europeans is the highest".²

The Depression years of the early 1930s left a legacy of poverty, overcrowding and malnutrition in Cape Town. This was exacerbated from the mid-1930s by the social consequences of increasing industrial growth and accelerating urbanisation in the city. The shanty towns that developed on the outskirts of the city were swollen even more by the influx of African workseekers during the Second World War. The consequence was a second epidemic wave of TB that clearly highlighted the failure of earlier efforts to control TB in Cape Town. This failure is a theme that runs throughout this dissertation, and this chapter takes a critical look at the Cape Town City Council's reorganisation of its TB control programme in an attempt to deal with the rising tide of the TB epidemic during the 1940s. Despite the MOH, Dr Shadick Higgins, emphasising the need for broad social reform to deal with TB in Cape Town, very little progress was in fact made due to a lack of funding and political will. Thus, while Higgins acknowledged the root causes of TB in Cape Town, financial and political expediency won the day and long-term plans to

¹ I. Hendler, "Tuberculosis", SAMJ (22 November 1941), pp.467-468.

² Cape Times, 19 July 1947, "How the Union is fighting Tuberculosis".

rectify socio-economic conditions were sidelined for the short-term, apparently cheaper, solution of the *direct attack* on TB.

The first section of this chapter will discuss Higgins's 1937 report on TB in Cape Town, which acted as a blueprint for the city's future TB scheme. The second section will show how the Cape Town City Health Department attempted to emulate the Edinburgh scheme more closely with the creation of a TB branch, the employment of a full-time TB Officer, and the expansion of the municipal TB Clinic scheme (with the construction of the new Chapel Street TB Clinic and Administration Centre in 1941) as a consequence of Higgins's TB report. However, this reorganisation did not appear to impact significantly on the TB epidemic in the city, and soon the TB Officer, Dr Hoole, was compelled to re-orientate the work undertaken by his TB branch. The final section will look at the introduction of new technological aids, such as Mass Radiography, and will discuss how this changed the scope and focus of the Chapel Street Clinic's work and how it affected the African and coloured workforce during the pre-antibiotic era.

i) The City of Cape Town's Response to the TB Epidemic from the late 1930s:

Dr Shadick Higgins's TB Report the Politics of the "Direct Attack"

By the close of the 1930s there was considerable discussion about the failure of previous anti-TB efforts in South Africa.³ Cape Town's MOH, Dr Shadick Higgins, was extremely concerned about the poor results that his department had achieved in attempting to

³ D. P. Marais, "The Co-ordination of Effort in Tuberculosis Control in South Africa", *SAMJ* (14 November 1936), pp.736-743; P. A. Allan, "The Tuberculosis Problem in the Union of South Africa", *SAMJ* (11 November 1939), pp.740-742; G. W. Gale, "The Prevention of Tuberculosis in the Union, with

control the disease. Therefore, in May 1937, he presented a report on TB to the Cape Town City Council that suggested the reorganisation and extension of the city's TB scheme.⁴ This report offered a medical solution to the city's TB epidemic that was based on the Edinburgh scheme and Higgins's idea of the 'modern' direct attack on TB. Moreover, it provided the blue print for the creation of a new TB branch with a central TB Clinic and Administration Centre that had satellite TB Clinics in the areas where they were most needed, close to poorer districts in the city. Higgins's response to TB was part of a more general movement among South African medical authorities who were discussing the increasing TB and syphilis epidemics in the 1930s and 1940s.⁵ The medical profession's concern about TB is evidenced in the SAMJ devoting a special issue to the topic of tuberculosis in November of the same year that he produced his report.⁶ This section will examine Higgins's report in order to show how this provided the basis for Cape Town's TB branch based at the Chapel Street TB Clinic.

Shula Marks and Neil Andersson note that, "by the 1940s South African medical health professionals and state health officials clearly recognised the social production of much disease" and that they "saw the connections between ill health and social change between industrial development and dislocation in the countryside."⁷ Moreover, studies such as Professor Edward Batson's social survey of Cape Town revealed that the city faced a serious social and health crisis, with one in four households falling below the poverty

Special Reference to Urbanized Natives", SAMJ (23 October 1943), pp.321-32; D. Sinclair Smith,

"Control of Tuberculosis", SAMJ (14 October 1944), pp.331-333.

⁴ Cape Archives, 3/CT, 1/4/7/1/1/47, 18 May 1937.

⁵ See: A. Jeeves, "Public Health in the Era of South Africa's Syphilis Epidemic of the 1930s and 1940s", South African Historical Journal, no. 45 (November 2001), pp79-102.

⁶ Special Tuberculosis Number, SAMJ, vol. 11, no. 22 (27 November 1937).

datum line during the years of 1938 to 1939.⁸ Yet, although Shadick Higgins emphasised the role of socio-economic factors and Cape Town's serious housing problem, he stated that the *immediate concern* of his TB report was the need for increased facilities to make a *direct attack* on TB (my italics).⁹ In the pre-antibiotic era, the term 'direct attack' did not refer so much to medical 'magic bullets', as it did to the idea of a 'modern' medical attack on TB, where the focus lay on eliminating the microscopic TB bacillus through an organised and carefully planned preventative scheme. In the absence of effective antibiotics to cure TB, this scheme focussed on medical knowledge about the infectivity of TB (as discussed in Chapter One), and the importance of educating and isolating TB patients employing a system of TB clinics and sanatoria.

Dr Shadick Higgins' 1937 Report was influenced by his recent tour of British and European cities where he had seen how TB was dealt with abroad.¹⁰ In many of these cities, he had found that the beds available for the treatment of pulmonary TB exceeded the annual number of deaths.¹¹ This was certainly not the case in Cape Town where there was still a serious shortage of TB beds. In light of this, Higgins focussed on the need to increase in-patient accommodation for TB cases in Cape Town, but he noted that the success of this programme also relied on the extension of the TB clinic facilities and the

⁷ S. Marks and N. Andersson, "Industrialization, Rural Health, and the 1944 National Health Services Commission in South Africa", pp.131-132. in S. Feierman and J. M. Janzen (eds), The Social Basis of Health and Healing in Africa (Berkeley, 1992).

⁸ Batson defined the Poverty Datum Line as the basic amount of money that was necessary to buy food, clothing, fuel, lighting and cleaning materials that were essential for health and survival. Those families whose income was less than this amount, fell below the Poverty Datum Line, and were classed as living in poverty. Official Report of the Social Survey Conference, Cape Town, February 1942 (Cape Town, 1942), p.33. (See: Appendix, Figures 5 and 6, for a depiction of Poverty, as defined by the Social Survey, according to race in Cape Town c1938/9).

⁹ CA, 3/CT, 1/4/7/1/1/47, 18 May 1937, p.10.

¹⁰ *Ibid.*, pp.10-15.

¹¹ *Ibid.*

expansion of the administrative and home visiting staff.¹² Even though Cape Town was the only South African city that had the rudiments of the Edinburgh scheme's framework in place by the late 1930s,¹³ it was nevertheless lacking in co-ordination and direction. It was this framework that Higgins proposed to strengthen. Higgins therefore recommended firstly the building of a new sanatorium-hospital of 200 beds in order to alleviate the dire shortage of accommodation for TB cases.¹⁴ In line with the Edinburgh scheme, he also suggested the creation of a municipal TB sub-department, the appointment of a full-time TB Officer, an increase of the existing staff of TB health visitors from 4 to 8, and the construction of a new TB clinic and administration office.¹⁵ He also emphasised the social welfare aspect of anti-TB work and suggested that an increase be made in the annual vote for assistance to TB patients.¹⁶ These proposals were instrumental in the growth of Cape Town's municipal TB scheme and the establishment of the Chapel Street TB Clinic and Administration Centre.

Although there was a very real need for these medical facilities in Cape Town, it is important to note that Higgins did not choose to follow through on his acknowledgement that the TB epidemic had its root causes in the widespread poverty in Cape Town.¹⁷ His 1937 Report offered a palatable plan of action for whites, with medical solutions for the TB epidemic that did not question the political, economic or social status quo in Cape Town. The scope of his actions were constrained by the financial abilities of his

¹² CA, 3/CT, 1/4/7/1/1/47, 18 May 1937, p.17; Report of the MOH, Cape Town, 1936/1937, p.58.

¹³ D. P. Marais, "The Co-ordination of Effort in Tuberculosis Control in South Africa", *SAMJ* (14 November 1936), p.737.

¹⁴ Report of the MOH, Cape Town, 1936/1937, p.59.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ For Shadick Higgins's views on the link between socio-economic conditions and ill-health see: T. Shadick Higgins, "The Public Health Aspect of Social Welfare", *SAMJ* (23 September 1939), pp.675-677.

municipal department, which were dictated by a majority white electorate who balked at providing funds for the African and coloured workforce. Comprehensive socio-economic reform was not a politically viable option. It should also be noted that Higgins was a western-trained medical man in charge of a municipal Public Health Department and, as such, he was most likely to look to western medical solutions to the TB problem within the context of his profession. Thus, even though Higgins emphasised that socio-economic conditions were an important cause of the TB epidemic, his actions remained solidly within the scientific biomedical context. As will be seen later in this chapter, these factors would continue to shape the future of the TB scheme in Cape Town.

However, views on the best strategy to deal with the TB epidemic were divided between the acknowledgement of social factors and the actual implementation of medical solutions. Dr Shadick Higgins was not alone in his views favouring a medically focussed “direct attack” on TB. In an article on the control of TB in South Africa in the *SAMJ*, for example, Dr. D. P. Marais criticised what he described as “single-track-minded reformers” who called for slum clearance or who insisted that underfeeding and alcoholism were prime factors in TB.¹⁸ His belief was that “a wide-angle view” was needed of the situation, that included all these “proximate causes”, but treated them as “accessories to the main fact- the presence of the tubercle bacillus”.¹⁹ He went so far as to state that the slogan “First eliminate slums and then you will end tuberculosis” actually held the TB effort back because the sheer immensity of that task would divert attention

¹⁸ D. P. Marais, “The Co-ordination of Effort in Tuberculosis Control in South Africa”, *SAMJ* (14 November 1936), p.739.

¹⁹ *Ibid.*

away from a *direct attack* on the disease.²⁰ The irony of his assertion was that the focus on a purely medical response to TB sidelined these environmental factors.

However, the implementation of Higgins' 1937 report did not follow the projected plan as thoroughly as he might have wished. Although the government accepted his proposals and the City Council acquired land near Durbanville for the proposed sanatorium-hospital, the considerably cheaper plans for a municipal TB sub-department and TB Clinic centre were more swiftly acted upon.²¹ The short-term financial expediency exhibited in this decision would be the repeated cause of the serious crisis in TB in-patient accommodation in the western Cape well into the 1940s and beyond. With the Cape Town City Council having opted for the cheaper initiative, a suitable site for a new central TB clinic and administration office was found near the border of central Cape Town and Woodstock, and was bought by the City Council in January 1938 for the sum of £2,100.²² The next section will discuss the establishment of the Chapel Street TB Clinic and Administration Centre.

iii) The Founding of the Chapel Street TB Clinic and Administration Centre

"It has often been emphasised that tuberculosis is a house disease, but it should be added that, while it is usually contracted in the home, it is seldom cured there."

Dr W. L. Hoole, TB Officer, Cape Town, 1947.²³

²⁰ *Ibid.*

²¹ Report of the MOH, Cape Town, 1937/1938, p.49.

²² *Ibid.*

²³ Cape Times, 20 August 1947, "400 Beds for TB Needed".

The City Council's commitment to establishing a solid anti-TB scheme is evident in Higgins's request for a medical officer who had "practical experience of the development and control of a large municipal anti-TB undertaking".²⁴ After interviewing a short-list of seven applicants, the Cape Town City Health Department appointed Dr W. L. Hoole as the first full-time TB Officer in charge of the new TB branch in June 1938,²⁵ for which his experience as an assistant TB Officer for Manchester prepared him well.²⁶ This section will look at the key role that the TB branch's TB clinic scheme played as part of the City Council's attempt to prevent and control the TB epidemic as part of the "direct attack" on the disease along international lines. However, with the TB crisis of the mid-1940s, the TB branch soon found that it was discovering many more TB cases than it could isolate in hospital. In response to this crisis, Hoole made a clamorous demand for more in-patient TB accommodation. The purely medical lens that he employed with regard to Cape Town's TB epidemic will be discussed in the context of this emphasis of his on in-patient isolation in official reports and in the press. Yet, he had to weigh his ideal against the reality of the continued lack of hospital accommodation which forced him to attempt to deal with the rising TB epidemic on out-patient lines through education, domiciliary isolation and treatment, even though his professed belief was that TB was "seldom cured" in the home.²⁷ What the consequences of this compromise were will be examined at the end of this section.

Dr Hoole took over the direction of the municipal TB clinics in Newmarket Street and Wynberg from the Medical Superintendent of the City Infectious Diseases Hospital, Dr J.

²⁴ CA, 3/CT, 1/4/7/5/1/1, Appendix 13 (3 December 1937).

²⁵ Report of the MOH, Cape Town, 1937/1938, p.49; Report of the MOH, Cape Town, 1938/1939, p.47.

²⁶ CA, 3/CT, 1/4/7/5/1/1, Appendix 13 (17 May 1938), p.3.

²⁷ Cape Times, 20 August 1947, "400 Beds for TB Needed".

F. Wicht.²⁸ While the Chapel Street Clinic was being constructed, Dr Hoole's office remained based at the Newmarket Street TB Clinic. Co-operation continued between the municipal TB clinic and the City Hospital, where TB patients from the clinics were sent for their X-ray examinations.²⁹ Dr Wicht retained his involvement with anti-TB work, offering TB clinic sessions four mornings a week at the City Hospital for special TB cases, particularly those who had undergone artificial pneumothorax surgery (a form of surgical intervention where part, or even the whole section, of the lung is collapsed).³⁰

Once the building was completed however, Dr Hoole and his staff relocated to their new premises and the Chapel Street TB Clinic was officially opened on 3 January 1941. The site selected for the Chapel Street Clinic was a significant factor in the City Health Department's attempt to deal with TB in Cape Town. It was situated near the borders of central Cape Town, the new industrial area of Woodstock and the working-class residential area of District Six. This seemed very practical when the connection between this district's overcrowded slum conditions and TB was emphasised in contemporary press articles, with a particular journalist boldly claiming that a family free from TB in District Six was indeed the exception.³¹ Apart from the Chapel Street TB Clinic's proximity to this highly publicised poverty-stricken area, the clinic was also conveniently close to the main arteries of public transport so that it was relatively easy for TB patients and clinic staff to access. Moreover, the clinic's proximity to the industrial area of Woodstock was to prove useful in the search for TB suspects among factory workers, especially after 1948, when mass X-ray screening was offered.

²⁸ Report of the MOH, Cape Town, 1938/1939, p.47.

²⁹ *Ibid.*

³⁰ Report of the MOH, Cape Town, 1938/1939, p.47. The TB Clinic could not offer the aseptic hospital environment that was required for this operation.

The specially-designed clinic building consisted of a waiting room, an interviewing room and a dispensary for TB patients.³² There was a clinical wing, which included three clinical rooms, a dental room, a recovery room and dressing cubicles.³³ This section also included dark rooms, an X-ray room, a developing room, a laboratory and other offices.³⁴ Provision was made for an administrative wing, which consisted of the TB Officer's office, a clerical and record office, an office for the health visitors, a staff room and a kitchen.³⁵ The close co-operation between the voluntary TB Care Committee and the municipal Newmarket Street TB Clinic (as discussed in Chapter One) was strengthened through the provision of a room at the new Chapel Street Clinic from which the Care Committee case worker could continue to do her work.³⁶ This was a considerable improvement from the previous arrangements at the Newmarket Street TB Clinic where two semi-detached cottages had been adapted to form the clinic building, affording cramped clinical and administrative office space.³⁷

Dr Hoole's direction of the municipal TB branch was influenced by the Edinburgh scheme and was based on curative principles from the outset.³⁸ Like Higgins and Marais, Hoole understood the roots of the TB epidemic to lie with the infectious nature of the TB bacillus. He noted that the infectivity of TB was "of paramount importance" as the *cause* of the spread of TB, compared to "abetting factors such as bad housing, malnutrition and

³¹ *The Cape Argus*, 1 August 1946, "How the Skollies are Reared".

³² Report of the MOH, Cape Town, 1944/1945, p.43.

³³ *Ibid.*

³⁴ *Ibid.*

³⁵ *Ibid.*

³⁶ *Ibid.*

³⁷ Report of the MOH, Cape Town, 1936/1937, p.102.

poverty".³⁹ He was also influenced by the idea that blacks were a "virgin population" when it came to TB. His understanding of Cape Town's TB epidemic is best seen in his official report on TB in 1940, where he stated that, "It is a profitable civic duty to demand that the "non-Europeans" should not be asked to make these immense annual sacrifices [high TB mortality rates] until such time as nature overcomes a racial susceptibility. It may be sure, but it is too slow, too distressing and too expensive".⁴⁰ Hoole offered a medical solution to cope with what he saw as the inherent problem of blacks' racial susceptibility to TB, stating that "non-Europeans" should at least be given a chance of hospital isolation and treatment.⁴¹

Yet, this ideal was not possible. Hoole pointed to the inequitable distribution of TB beds, where the available TB accommodation was divided equally between white and black TB patients, even though there were over four times as many black TB patients needing accommodation.⁴² Although he noted that other factors could influence the TB survival rate figures, (such as the emigration of black TB patients to rural areas), he noted that it was significant to compare the better hospitalisation for white TB patients and their TB survival rate of 43 per cent with the rate of 15 per cent for blacks.⁴³ Hoole's interpretation of these TB figures reveals his belief in the greater importance of medical and physiological factors over social and economic factors in TB patients' chances of survival.

³⁸ Dr Hoole graduated from Leeds University in 1927, and had gained experience in TB work in Manchester. CA, 3/CT, 1/4/7/5/1/1, Appendix 13 (17 May 1938), p.6.

³⁹ Report of the MOH, Cape Town, 1939/1940, p.53.

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

⁴² *Ibid.*, p.54.

The influence of the Edinburgh scheme is seen in Hoole's description of the TB clinic's work as consisting of seven aspects. The first was the examination of notified cases, contacts and suspects.⁴⁴ The second was the education of TB patients and the issuing of advice regarding treatment and isolation.⁴⁵ The third aspect was the referral of TB cases for hospitalisation and in-patient care which, Hoole felt, was advisable in some form for almost every new case, especially if home conditions were unsatisfactory.⁴⁶ The fourth aspect was the supervision of the domiciliary and ex-hospital TB patients, particularly if they had resumed work, but also while they were recovering from TB and provided that their condition was quiescent.⁴⁷ The fifth aspect of the clinic's work was described as palliative treatment, which was limited to the financially needy.⁴⁸ The sixth aspect called for co-operation with medical practitioners, other branches of the City Health Department, general hospitals, the Board of Aid and the Society for the Protection of Child Life.⁴⁹ TB propaganda and lectures were listed as the final aspect of the clinic's work.⁵⁰

Apart from the aspects listed above, Hoole also mentioned the work to be undertaken by the health visitors and the TB Care Committee's case worker. These two aspects had been an important part of the work done at the Newmarket Street Clinic and were run along the lines of the comprehensive Edinburgh scheme. Apart from their duties at the dispensary, the TB health visitors undertook to visit TB patients' homes in order to treat

⁴³ *Ibid.*

⁴⁴ Report of the MOH, Cape Town, 1938/1939, p.48.

⁴⁵ *Ibid.*

⁴⁶ Report of the MOH, Cape Town, 1938/1939, p.48. Nevertheless, domiciliary TB isolation was employed in appalling home conditions in the face of insufficient TB accommodation during this period.

⁴⁷ Report of the MOH, Cape Town, 1938/1939, p.48.

⁴⁸ The medical officer determined who was 'needy' during the clinic session and referred those patients to the Care Committee case worker.

bed-ridden patients and to investigate the home situation and the risk of infection posed to their surrounding community.⁵¹ Ultimately, what the domiciliary TB health visitor sought to achieve was the isolation of the infectious TB patient in order to prevent the spread of the disease. TB health visitors provided TB education to TB patients and their families too, and they checked that TB patients were adhering to basic preventative principles such as exposure to adequate ventilation, sleeping separately from their families and the careful disposal of TB-laden sputum. The health visitors also issued appliances such as sleeping shelters (where TB patients could sleep outdoors with maximum exposure to fresh air), pillows and nursing requisites on loan to TB patients.⁵² Dr R. Philip asserted that TB was a “house infection” and that the TB dispensary should therefore not merely treat the individual, but should, “through a careful system of domiciliary visitation and investigation”, unearth “tuberculous nests”.⁵³ This would mean that the TB dispensary could quickly and efficiently search for sources of infection within a community and help to prevent the further spread of TB from these infectious foci. Thus Cape Town’s health visitors made enquiries into the family history of TB cases and their home conditions, thereby collecting a considerable bank of valuable data.⁵⁴ They were then expected to investigate home contacts.⁵⁵

The TB health visitors worked in co-operation with the clinic’s administrative staff with regard to the running of TB clinic sessions and in the keeping of patient records.

⁴⁹ Report of the MOH, Cape Town, 1938/1939, p.48.

⁵⁰ *Ibid.*

⁵¹ R. Philip, “The Organization of the Home Treatment of Pulmonary Tuberculosis”, in Collected Papers on Tuberculosis (London, 1937), p.22.

⁵² Report of the MOH, Cape Town, 1938/1939, p.48.

⁵³ R. Philip, “The Anti-Tuberculosis Programme: Co-ordination of Preventive Measures”, in Collected Papers on Tuberculosis, p. 79.

⁵⁴ Report of the MOH, Cape Town, 1938/1939, p.48.

Although the Chapel Street Clinic staff were based at the central clinic, they all went out to help run the subsidiary clinics at Wynberg, Langa, and Windermere during the 1940s, taking supplies, patient cards and notification forms to and from these clinic sessions.

The TB Officer or his deputy went to these TB clinic sessions to examine the progress of current TB cases and to diagnose new cases, but the preparations for clinic sessions began with the Chapel Street clerical staff organising the patient cards and taking them to the clinic where the TB session would be held.⁵⁶ Every TB patient's card was therefore ready for the session and the patient's medical history could be quickly accessed. If the patient did not attend, the head administrative clerk would notify the health visitor responsible for that patient's area to go and see why they had missed their appointment.⁵⁷

The health visitors thus played a very important role in securing the attendance of notified TB patients and TB contacts to the TB clinic sessions because they had often become well acquainted with the TB patients' home circumstances and with their families.⁵⁸ This was especially the case prior to the discovery of anti-TB drugs, when the disease often ran a long and arduous course. This aspect of TB work was emphasised as being very rewarding by some staff members who felt that they established bonds through the regular interaction with TB patients.⁵⁹

The Care Committee's case worker also attended every TB clinic session held by the TB branch, including those sessions held away from the Chapel Street Clinic. The medical officer on duty referred those TB patients that were in need of social relief to the case worker, who worked in a separate office during the clinic sessions. The Care Committee

⁵⁵ *Ibid.*

⁵⁶ Interview with Mr M O' Leary, p.3.

⁵⁷ Interview with Mr M O' Leary, pp.3-4.

⁵⁸ Report of the MOH, Cape Town, 1938/1939, p.48.

therefore augmented the work of the TB clinics through the provision of aid to the dependants of TB patients who were considered 'constructive'⁶⁰ cases and who had accepted institutional treatment.⁶¹ The aid offered by the Care Committee included the provision of rent or part rent, special nourishment and the distribution of clothes prior to sanatorium treatment.⁶² The Care Committee also helped TB patients to find suitable accommodation, and provided accommodation at the Duinendal TB settlement where it offered occupational therapy.⁶³ Finally, it was expected that the Care Committee would keep accurate records and statistics of their work, which was an important part of the 'modern' medical approach.

Besides Batson's survey of socio-economic conditions in Cape Town, reports from the Cape Coloured Commission (1937)⁶⁴ and the Cape Flats Commission (1942)⁶⁵ revealed a stark picture of the desperate poverty and the lack of social services available for Cape Town's settled African and coloured population. These reports emphasised the connection between TB and the poor socio-economic conditions that prevailed during this period. Cape Town faced an unprecedented socio-economic and health crisis, which is evidenced in the increasing TB figures during the early 1940s. The timing of Dr Shadick Higgins' proposal for the extension of the municipal TB scheme had been fortuitous because it meant that the new Chapel Street TB Clinic and Administration

⁵⁹ Interview with Mrs R. Grant, p.12.

⁶⁰ This label was used to describe those early pulmonary TB cases who were most likely to benefit from the in-patient TB treatment regime of bed-rest and nutrition and to recover from TB successfully.

⁶¹ Report of the MOH, Cape Town, 1938/1939, p.48.

⁶² *Ibid.*

⁶³ *Ibid.* The TB Care Committee opened the Duinendal TB settlement with the aim of rehabilitating white male TB cases.

⁶⁴ Union of South Africa, Report of the Commission of Enquiry Regarding the Cape Coloured Population of the Union, UG 54-1937.

⁶⁵ Union of South Africa, Report of a Committee of Enquiry Appointed to Enquire into Conditions Existing on the Cape Flats and Similarly-Affected Areas in the Cape Division, 1942, UG 18-1943.

Centre had opened its doors to TB patients during the mid-war years. The Chapel Street TB Clinic was therefore in operation during the second wave of the TB epidemic in Cape Town, when the total death rate for all forms of TB peaked at 3.91 per 1000 people for the year ending June 1944.⁶⁶ However, the burden of this death rate still fell on Cape Town's settled "non-European" population who suffered a death rate of 6.9 per 1000 as compared with 0.73 for "Europeans" during that year.⁶⁷

As a consequence, the municipal TB branch experienced a substantial increase in both attendances and workload. The City Health Department maintained the newly established Chapel Street TB Clinic and the Church Street TB Clinic in Wynberg. Between them, these clinic centres offered six TB sessions at 2 p.m. every week.⁶⁸ Dr Hoole ran four of these sessions and part-time consultants two.⁶⁹ However, the wartime increase in incidence of TB amongst Africans and coloureds was dramatic enough to warrant the extension of TB clinic services, and TB clinic sessions were therefore started at the general clinic in Langa in December 1940 and at Windermere in July 1943.⁷⁰ The Windermere clinic held a TB session for "non-Europeans" once a week at 10 am, while at the general clinic in Langa TB sessions were held twice a month for Africans.⁷¹ By 1944 the number of these weekly sessions had increased to 7 ½ across the various clinics. As part of this TB service, the TB Officer was also available to see new cases of TB by private appointment in the mornings.⁷² By 1945, however, Dr Hoole admitted that there had been no significant improvement in the TB incidence rates and that the survival rates

⁶⁶ Report of the MOH, Cape Town, 1949/1950, p.42.

⁶⁷ *Ibid.*

⁶⁸ Report of the MOH, Cape Town, 1939/1940, p.51.

⁶⁹ *Ibid.*

⁷⁰ Report of the MOH, Cape Town, 1940-1944, p.47.

⁷¹ *Ibid.*

were also disappointing.⁷³ It was clear that the new TB branch had failed to control, or even cope with, the wartime TB epidemic through its 'direct attack' strategy. In an attempt to address this problem, Dr Hoole therefore proposed a re-orientation of the available TB services so that optimal use could be made of the restricted field-work of the TB health visitors and the limited hospital accommodation.⁷⁴

Dr Hoole's re-orientation of Cape Town's TB branch did not, however, depart from the concept of the 'direct attack'. Hoole proposed that *better use* be made of the TB clinic sessions. In this regard he suggested that the focus had to shift from reviewing 'unconstructive' or chronic domiciliary cases (who were often too ill to recover) and the examination of child contacts (who were often found to be free of TB infection) during clinic sessions.⁷⁵ The revised plan sought to discover early, unrecognised TB cases in new groups of people through the use of mass radiography, and to examine the suspect TB cases from this group during TB clinic sessions.⁷⁶ In addition, Hoole emphasised the need to admit the early 'constructive' TB cases to TB in-patient care in hospital and to cater for the sick and infectious TB patient on a domiciliary basis, through the supervision of health visitors.⁷⁷ This meant that the limited number of TB beds would not be filled by the advanced dying or chronic TB patients for extended periods of time, to the detriment of the newly discovered TB patient whose condition might deteriorate while waiting for a bed. It was in this flawed context, where expediency was necessary in the face of the rising TB incidence and an inadequate public health infrastructure, that

⁷² Report of the MOH, Cape Town, 1939/1940, p.51.

⁷³ Report of the MOH, Cape Town, 1944/1945, p.41.

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ *Ibid.* It should be noted, however, that the mass radiography machine would only arrive in Cape Town in 1948 making the aims of this planned reorganisation rather unattainable until the MRS arrived.

domiciliary care became the unplanned cornerstone of the Cape Town TB scheme before the advent of effective anti-TB drugs.

The particular route that the Cape Town TB branch took to re-orientate its resources to best cope with the limited TB hospital accommodation available was also seen in the wider picture in South Africa. In 1943, Dr G. W. Gale, an assistant Health Officer of the Department of Public Health, discussed the chronic shortage of TB beds throughout the Union of South Africa.⁷⁸ He estimated that successful TB isolation required on average one TB bed per annual TB death.⁷⁹ On this estimate, he noted, the Union had 70 percent of the beds needed for the 750 white TB deaths per annum, but, despite the addition of Mission Hospital beds and State Hospital beds, there were only 13 percent of the beds needed for 15, 000 black TB deaths per annum.⁸⁰ There was obviously a very real need for more TB accommodation for black people but this would have been financially draining for the state to cope with, let alone cash-strapped local authorities. It is therefore not surprising that Dr. Gale commented that, “fortunately domiciliary isolation can be, and sometimes is, practised very successfully”.⁸¹ This optimistic approach to the domiciliary treatment of TB reveals much about the political objectives of the South African state, where a curative solution was sought to the TB problem, but within restricted financial perimeters that did not allow for the expenditure on expensive sanatoria for blacks on the scale seen in Britain, Europe and America. The importance of fiscal and political constraints is seen in Dr Gale’s support for domiciliary TB isolation

⁷⁷ Report of the MOH, Cape Town, 1944/1945, p.41.

⁷⁸ G. W. Gale, “The Prevention of Tuberculosis in the Union, with Special Reference to Urbanised Natives”, *SAMJ* (23 October 1943), pp.321-322.

⁷⁹ *Ibid*, p.321.

⁸⁰ *Ibid*.

⁸¹ *Ibid*.

when he urged that, "Much more could be done to exploit this less costly alternative, especially among the non-Europeans".⁸²

At the same time, medical authorities cautioned that domiciliary isolation was not ideal when a TB patient's home circumstances were overcrowded or unsuitable. In this regard it should be noted that the housing situation in Cape Town had deteriorated considerably by the mid-1940s and certainly did not lend itself to the success of a TB scheme that relied on domiciliary isolation and treatment. Dr F. O. Fehrsen, the MOH for Cape Town (1944-1952) reported that the health inspectors were finding cases of overcrowding where families of five or more persons were forced to live in one small room.⁸³ He also noted that the "increase in the number of non-Europeans who [inhabited] the mountainside and the slopes of Signal Hill, and the growth in the number of unauthorised shacks on the Cape Flats and elsewhere [were] further indications of the acute housing shortage in the municipal area".⁸⁴ Wartime restrictions had led to a shortage of building materials, increased building costs and insufficient artisans, thereby retarding building in Cape Town.⁸⁵ In 1946 the post-war influx of volunteers returning from active service aggravated the housing shortage and the number of overcrowded houses increased. The influx of African work-seekers into Cape Town, coupled with increased TB incidence and mortality, caused a stir in the white press during the late 1940s, which focussed on the serious bed shortage for TB patients and emphasised that this lack of isolation led to infectious TB sufferers "*roaming the streets*".⁸⁶

⁸² *Ibid.*

⁸³ Report of the MOH, Cape Town, 1946/1947, p.2.

⁸⁴ *Ibid.*

⁸⁵ Report of the MOH, Cape Town, 1945/1946, p.3.

⁸⁶ *Cape Times*, 21 March 1947, "Five Died from TB Yesterday: alarming facts about city menace". The plight of Elsie Esau, a homeless TB-infected woman who lived on a pavement outside a student hostel near

Apart from homeless and infectious TB sufferers spreading the disease in public, contemporary press articles also emphasised the appalling home circumstances of many TB sufferers, which made the effective application of domiciliary isolation impossible. In 1947, the Cape Argus, wrote of a house in District Six:

“In two back rooms ... the scourge of Cape Town’s slums, tuberculosis, has been taking a steady toll. During the past two years in a family of husband and wife and 10 children, the husband and six children have died of tuberculosis. Two of the remaining children are now lying in one room in the last stages of the disease. There is no hospital provision for them so they must die there, after they have spread the infection through the house. In another room a girl dying of tuberculosis had two babies in bed with her. Her mother had to leave them with her while she went out to work. At night in that and the adjoining room 15 people sleep”.⁸⁷

In official reports, Dr Hoole dramatically described the distressing result of inadequate hospital accommodation for parents, where a father waiting for hospital admission had to “watch his child slowly dying of tuberculous meningitis, knowing full well that he [was] responsible for this harrowing and remorseless end”.⁸⁸

As mentioned above, Dr Hoole influenced the particular direction that the Chapel Street TB branch took with regard to the prevention and control of TB. It was during his term as TB Officer that the responsibility for TB was partly shifted from the local authority onto the individual, the public and the employer. Although he noted that many factors

District Six, caused some discussion about the lack of facilities for the large number of TB cases in the city and the threat that these people posed to public health. As much as this concern might have been about the plight of homeless TB sufferers, it also reflected white anxieties about the growth of urban black populations in areas such as District Six.

⁸⁷ Cape Argus, 1947, “The Sinister Streets of District Six”.

⁸⁸ Report of the MOH, Cape Town, 1939/1940, p.53.

contributed to the spread of TB, he emphasised that the basic cause of TB was the TB bacillus and that the individual could take an active part in TB prevention by avoiding TB and protecting themselves from the disease.⁸⁹ Hoole also placed the responsibility of being successfully treated onto the shoulders of the individual TB patient and lamented that many people were prone to “apathy, ignorance and fatalism” and failed to take either advice or treatment from the TB clinic.⁹⁰ In emphasising his point, he said that the failure of the individual was an influence as “noxious as overcrowding, malnutrition and the dearth of hospital beds”.⁹¹

Hoole blamed public apathy for the lack of finance to establish and maintain adequate TB treatment facilities. He appealed to the public to do their part in becoming “TB conscious”.⁹² In 1947, he noted that public health officials and voluntary organisations were “swamped” with the increasing numbers of TB cases and that they were doing all they could in the face of inadequate facilities for tracing TB cases and the provision of treatment.⁹³ Dr Hoole also noted that it was up to the public to insist that more money was made available for new hospitals and additional equipment.⁹⁴ Furthermore, he stated that, “the civic conscience of ratepayers alone can bring about an improvement”, adding the demand, “*build sanatoriums, not aquariums and monuments*” (my italics).⁹⁵ That same year, a TB patient undergoing TB treatment in hospital, wrote to the Cape Times that it was “a great pity that thousands of Cape Town’s potentially useful citizens [were], through the general apathy of the public, doomed to a premature grave, or, at the best, to

⁸⁹ Report of the MOH, Cape Town, 1938/1939, p.51.

⁹⁰ *Ibid.*, p.52.

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ Cape Times, 21 March 1947, “Five Died from TB Yesterday”.

⁹⁴ *Ibid.*

a life of continual ill-health.”⁹⁶ This TB patient believed that TB treatment in hospital was “an inalienable right”, noting that more in-patient accommodation should be made available and that social welfare should be improved for TB patients and their dependants.⁹⁷ The writer, who contracted TB in 1942 while in the armed forces, placed the responsibility for TB treatment on the shoulders of “Cape Town’s citizens”, noting that they should “put an end to their apathetic attitude” to TB.⁹⁸

The tension between the different strategies to control TB through either social or medical interventions is seen throughout this period. An example of Hoole’s attempt to garner public support for a medical solution to the TB epidemic is seen in 1947, when he stated that, “we want 400 more beds so that we do not have to see the futile courage and the suppressed resentment of men who are dying for lack of hospital treatment”.⁹⁹ The shortcomings of the purely medical solutions that he offered to deal with the city’s TB problem did not go without question. In reply to Dr Hoole’s public statement calling for more curative facilities, a “Citizen” wrote that, “it is not more beds in hospitals that we require but better housing conditions, which, if adopted, might and should be the means of greatly curtailing the spreading of tuberculosis”.¹⁰⁰ The writer added that, “Procrastination by our City fathers is most regrettable. Surely prevention is better than cure and generally cheaper in the long run. When are we citizens going to clean up Cape Town? Or must we wait until a plague breaks out?”.¹⁰¹ However, Hoole felt that if Cape

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

⁹⁸ *Cape Times*, 3 April 1947, “Thousands Doomed for Lack of Hospitals”.

⁹⁹ *Cape Times*, 20 August 1947, “400 Beds for TB Needed”.

¹⁰⁰ *Cape Times*, 3 September 1947, “Disease from the Slums”.

¹⁰¹ *Ibid.*

Town had the facilities and the finances to run a TB programme along international lines, there was “no doubt” that “almost immediate benefits would result”.¹⁰²

The amendment of the Public Health Act during 1946, did however, give cash-strapped local authorities some financial relief through increased refunds for their expenditure on the treatment of infectious diseases, TB and venereal diseases.¹⁰³ This meant that the Cape Town authorities could expand their curative anti-TB work. It was during this year that the TB clinic sessions were increased from a total of 7 ½ per week to 9 ½, due to two more weekly TB sessions being added to Chapel Street’s roster.¹⁰⁴ Although it became clear that black people had suffered the brunt of the wartime TB increase, the TB sessions held twice a month at Langa were closed in February 1948, showing a lack of commitment to the health needs of the African population.¹⁰⁵ Thereafter, the medical officer in charge of the Langa Hospital dealt with TB at his out-patient clinics, referring TB cases to the Chapel Street TB Clinic when necessary.¹⁰⁶ The weekly TB clinic sessions at Chapel Street, Wynberg and Windermere were all increased to a total of 13 sessions in 1949 with Chapel Street taking the lion’s share of 7 sessions, Wynberg, 4 sessions, and Windermere 2 sessions.¹⁰⁷ In addition to these daytime TB sessions, the Chapel Street TB Clinic opened from 5 to 7 p.m. for three evening TB sessions per month.¹⁰⁸

¹⁰² *Cape Times*, 9 March 1948, “Mass TB X-Rays to Start Soon”.

¹⁰³ Report of the MOH, Cape Town, 1945/1946, p.1.

¹⁰⁴ *Ibid.*, p.33.

¹⁰⁵ Report of the MOH, Cape Town, 1949/1950, p.43.

¹⁰⁶ Report of the MOH, Cape Town, 1948/1949, p.42. Report of the MOH, Cape Town, 1949/1950, p.43.

¹⁰⁷ Report of the MOH, Cape Town, 1948/1949, p.42.

¹⁰⁸ *Ibid.*

The full use made of the TB branch's expanded facilities by the public was seen in the great increase in consultations at the Wynberg TB Clinic, where TB patients had to wait for a long time before they were attended to. The TB Officer noted that this was inevitable when 80 persons attended the same afternoon session, but he also saw this phenomenon as evidence that the public had begun to recognise the value of the TB Clinic's diagnostic facilities.¹⁰⁹ The reason for this surge of attendances at the TB clinic was put down to the lack of facilities in other areas, despite the Cape Divisional Council's provision of clinics for Wynberg's neighbouring areas.¹¹⁰ By the end of the 1940s the Cape Town municipal TB branch was of the opinion that smaller local authorities which neighboured on Cape Town occasionally attempted to evade their financial obligations for TB patients from their area who spent time in Cape Town's TB institutions, especially the City Hospital and the Brooklyn Chest Hospital.¹¹¹ The question of responsibility for the payment for TB patient costs often led to disputes between local authorities and this issue became hotly disputed and loomed large during the 1950s, with the City's increased focus on migrant labourers and TB.

Reviewing the establishment of Cape Town's TB branch, it is evident that the basic strategy that Shadick Higgins outlined in his 1937 report was influenced by Philip's Edinburgh scheme. Higgins implemented a medically-orientated "direct attack" on the TB bacillus at the same time that he emphasised the importance socio-economic conditions. This period exposes the gap between the medical framework that was established to cope with the TB epidemic and the rhetoric of social reform that

¹⁰⁹ Report of the MOH, Cape Town, 1949/1950, p.43.

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.*, p.46.

accompanied it. Yet, even the medical response in terms of the direct attack was not fully achieved. Although Higgins's report envisioned a comprehensive extension of Cape Town's in-patient and TB clinic facilities, the more expensive plans for a TB hospital took longer to come to fruition than the cheaper out-patient TB clinic. During the 1940s the Chapel Street TB Clinic and Administration Centre grew in terms of the number of TB patient attendances and in the number of TB clinic sessions held at the central and subsidiary clinics. However, increasing TB clinic attendances soon outmatched the available in-patient accommodation. Making the best of a bad situation, Hoole re-organised the TB clinic services in order to cope with the increasing numbers of TB cases in the city, but continued to demand the provision of more in-patient facilities. By the end of the decade the TB branch had weathered the peak of the mid-war TB epidemic through ad hoc re-organisation but had not sufficiently controlled the growing reservoir of infectious TB cases living in the city. The importation of a new Mass Radiography machine appeared to promise a solution to the detection of these unrecognised TB cases in the city and will be discussed in the next section.

iii) New Technologies and their Effect on the Chapel Street Clinic:

“Whatever the drawbacks of mass radiography, it will provide the doctors with a partial answer to the problem of responsibility for failure to discover early cases: culpability will be shifted to the patient-that is the public- for the service will be free and open to all.”¹¹²

As described above, the Cape Town municipal TB branch saw a substantial increase in its workload during the 1940s, with increased clinic sessions and home visits undertaken by the health visitors. In 1943, the Cape Town City Health Department took the bold step of ordering a mass X-ray machine from the United States in order to expand the operations of Cape Town's TB branch. Due to wartime conditions the arrival of the machine was delayed. After yet another delay, due to the adaptation of a space allocated for the unit at the Chapel Street TB Clinic, the Mass Radiography apparatus was installed and the service opened to the public in April 1948.¹¹³ As a consequence, the City Health Department appointed Dr H. L. Ackerman as the Deputy TB Officer in 1949 in order to help Dr Hoole with the increased workload of the TB branch. In this new position, Dr Ackerman was responsible for the clinic sessions at the Wynberg TB Clinic, the Airemound Nursing Home and for the interpretation of films for the Mass Radiography Service (MRS), for which his prior experience with such a machine in Manchester had

¹¹² Cape Times, 20 August 1947, “400 Beds For TB Needed”. Dr Hoole was referring to the projected use of mass radiography in Cape Town.

¹¹³ Report of the MOH, Cape Town, 1947/1948, p.46; Cape Times, 3 June 1947, “700 more Beds for TB Sufferers”. This newspaper article noted that orders placed after the Cape Town City Council for similar equipment had been delivered to the Union Health Department and the Port Elizabeth City Council, while Cape Town continued to wait for its delivery.

qualified him well.¹¹⁴ The addition of Dr Ackerman to the Chapel Street staff allowed the TB branch's facilities to be used to optimum capacity. This section will discuss the work of the MRS and will look at how this new technology complimented and became essential to the city's "direct attack" on TB.

Two operators were employed to run the mass radiography unit, namely, Mr S. R. Hansell, who had some past experience of mass radiography in the Royal Navy, and Mr J. S. van Eeden, the organising clerk.¹¹⁵ The MRS unit differed from normal X-rays in that it had a roll of 70mm film which was smaller than the normal X-ray plate and it was able to cost-effectively take 500 exposures in a day through the medium of a rotating anode.¹¹⁶ This revolutionised the case finding efforts of the Cape Town TB branch and set the Chapel Street Clinic apart from the other TB clinics.

Dr Hoole, however, cautioned that mass radiography was not a "magic wand but a new technical provision which, with competent medical direction and trained team work" would "give many opportunities for good work in the future."¹¹⁷ If used efficiently the MRS was an invaluable case-finding mechanism. Hoole also noted that the successful use of the mass radiography unit depended on publicity, where large numbers of the public had to be persuaded of the need to voluntarily submit to TB screening.¹¹⁸ In this regard the TB branch enlisted the aid of the local press and the South African

¹¹⁴ Report of the MOH, Cape Town, 1949/1950, p.42 and p.47; Interview with Dr Ackerman, p.3. The Airemount Nursing Home was a small institution in Milner Road, Rondebosch, that offered accommodation from August 1946 for white TB patients. All the patients were examined and selected for admission by the Deputy TB Officer who also undertook to treat them.

¹¹⁵ Report of the MOH, Cape Town, 1947/1948, p.46.

¹¹⁶ Interview with Mr M O' Leary, p.10. Report of the MOH, Cape Town, 1947/1948, p.46.

¹¹⁷ *Cape Times*, 9 April 1946, "TB Challenge to Employers".

¹¹⁸ Report of the MOH, Cape Town, 1947/1948, p.46.

Broadcasting Corporation, so that they could advertise this new cost effective method of TB detection.¹¹⁹ In order to advertise the mass radiography service further, the employees of a local insurance company volunteered to take part in a propaganda film that was sponsored by the Tuberculosis Samaritan Fund.¹²⁰ It was planned to exhibit this film to social agencies, clubs, factory groups and welfare organisations.¹²¹ Yet, in the first few years the attendances at the Chapel Street MRS were smaller than the TB branch had hoped for and appeals and admonishments were made in the local press.¹²²

The mass radiography section also relied on the organising clerk to actively solicit the attendance of employees through contact with employers, welfare officers, trade unions, and industrial councils.¹²³ The appointments for larger groups were staggered into groups of about 60 to 100, in order to keep the loss of operating time and disruptions to the factory or firm to a minimum.¹²⁴ The TB branch, however, had to contend with employers' concerns that they would lose valuable working time and the fears of employees about the unfamiliar process of screening. In 1949, to allay these fears, the local press publicised the information that one batch of 100 employees who were screened at Chapel Street Clinic were back at work within an hour.¹²⁵ In preparation, the employees would queue up outside the Chapel Street mass radiography office and wait their turn to be screened. In order to put nervous employees' minds at rest, a local paper

¹¹⁹ *Ibid.*

¹²⁰ Report of the MOH, Cape Town, 1947/1948, p.46; *Cape Times*, 16 February 1949, "Unsuspected TB in City".

¹²¹ Report of the MOH, Cape Town, 1947/1948, p.46.

¹²² *Cape Times*, 24 October 1947, "Mass TB X-Rays for Workers"; *Cape Times*, 5 November 1948, "Neglect of TB Radiography". The mass radiography unit was still struggling to gain publicity in 1949, and another article appeared noting that the facilities were not being fully used by employers. (*Cape Times*, 17 May 1949 "Unconcern for TB Dangers").

¹²³ Report of the MOH, Cape Town, 1947/1948, p.47.

¹²⁴ Report of the MOH, Cape Town, 1947/1948, p.47; *Cape Times*, 17 May 1949, "Unconcern for TB Dangers".

quoted a person who had been screened as saying, "all we had to do was to strip to the waist, stand in front of the x-ray machine for half a minute, and it was all over".¹²⁶ The TB branch also offered a pre-employment screening session at 8:30 am and promoted this as a responsible action for large firms to take if they wanted to protect their workers from exposure to new, unknown infectious TB cases.¹²⁷ The benefits were also noted for the screening of persons entering pension schemes and sick benefit societies who might harbour TB, even when they appeared to be in good health.¹²⁸ The mass screening of employees, however, took on darker dimensions in the 1950's, with the use of TB screening as a measure to turn migrant labourers away from the city, a dimension that will be discussed in the following chapter.

According to Dr Ackerman, mass radiography at Chapel Street was run on the same lines as the scheme he had known in Manchester, where one operator managed the films and the other dealt with the patient cards so that they could get through the large numbers of people to screen.¹²⁹ Employees from a number of firms might be screened on a single roll of film. Once a roll of film was completed, the TB Officer would inspect each X-ray plate on the roll and would call out that person's number to the clerk who would record the doctor's diagnosis.¹³⁰ If a possible case of TB was found by the mass radiography service, a card was sent to recall the person for a second check-up at the TB Clinic where, if found to be tuberculous, he/she would then be instructed on how to prevent spreading the disease. The value of the mass radiography unit lay in its ability to discover the

¹²⁵ *Cape Times*, 17 May 1949, "Unconcern for TB Dangers".

¹²⁶ *Ibid.*

¹²⁷ Report of the MOH, Cape Town, 1947/1948, p.47.

¹²⁸ *Ibid.*

¹²⁹ Interview with Dr Ackerman, p.7.

¹³⁰ Interview with Mr M. O' Leary, p.10.

unknown or unsuspected TB case in the early stages of the disease, when symptoms had not manifested themselves yet. This was seen as the most beneficial aspect of the mass radiography service, but its success was dependent on an overall infrastructure that included TB sanatoria and hospitals where these early cases could be isolated and treated. With the serious shortage of TB accommodation in Cape Town, this ideal scheme was not possible. The TB branch had to be satisfied with the knowledge that the TB patient would at least be aware of his or her condition and could therefore take precautions not to spread the disease any further while staying at home.¹³¹

With regard to the direction taken by medical authorities to deal with TB during this period, Packard notes that it is not surprising that the underlying causes of poverty and ill-health were not addressed directly by those who recognized them.¹³² He notes that the state alone could provide the resources necessary to combat the underlying economic and political causes of TB.¹³³ The National Party victory in 1948 coincided with the era of the discovery of the first effective anti-TB drugs, streptomycin in 1944 and para-aminosalicylic acid (PAS) in 1946. This meant that the Nationalist government could take the concept of a direct medical attack on TB to a new level, with the provision of a curative solution to the TB epidemic that conveniently dovetailed with their policy of separate development and the migrant labour system. Thus, environmental reform and calls for a stable African workforce could be set aside through the provision of purely medical solutions. The next chapter will look at how the Cape Town TB branch continued to operate in relation to the new political dispensation. As shown above, the inequitable

¹³¹ Report of the MOH, Cape Town, 1947/1948, p.46.

¹³² R. M. Packard, White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa. (Pietermaritzburg, 1989), p.247.

¹³³ *Ibid.*

socio-economic circumstances between blacks and whites during this period played an important role in entrenching and perpetuating the particular TB profile of the city, where TB exacted its greatest toll amongst African and coloured communities. The basis of a curatively focussed TB scheme had, however, been established with the Chapel Street TB Clinic in the 1940s, and it was this scheme that would be expanded in the apartheid years.

The Chapel Street TB Clinic and Administration Centre certainly established itself as a central “hub” from which Cape Town’s municipal TB scheme could be run during the 1940’s. The Chapel Street Clinic experienced a period of consolidation during this pre-antibiotic era and the groundwork was laid for the introduction of new technological aids for diagnosis such as mass radiography and for the advent of effective TB drugs. British TB schemes clearly exerted a strong influence on the Cape Town TB scheme, although there are sufficient references to the United States’ TB campaign to reveal that Britain was not the sole influence. The serious shortage of TB accommodation for TB sufferers undermined the efforts of the municipal TB branch to deal with the TB problem according to the best contemporary TB scheme, in the form of the Edinburgh Plan. This led to a necessary expediency of choices made by the municipal TB branch that prefigured the problems that would occur again in the 1950’s and beyond, when financial constraints and priorities seriously undermined any effort to control TB.

Chapter Three

The Chapel Street TB Clinic and its Subsidiary TB Clinics:

The Double Edged Sword of the Streptomycin Era, c1950-1964

“...the TB rates in the non-Europeans, who constitute four-fifths of our population, are many times as great as in the European; this country is faced with a tuberculosis problem enormously greater in proportion to its resources than any other country of the Western world”¹

By the 1950s South African medical authorities were well aware that TB was a public health problem that overwhelmingly affected blacks. For example, in Cape Town, the TB death rate for whites in 1950 was estimated at 0.53 per 1000 people, in contrast to 4.19 for blacks.² The discovery of new TB drugs such as streptomycin (1944), para-amino salicylic acid (PAS) (1946), and isoniazid (INH) (1952), appeared to offer a compelling short-term and financially expedient medical solution that did not require far-reaching and expensive socio-economic reforms. Moreover, the new TB drugs did not require a major redirection of the current TB scheme and could be readily adopted into the TB clinic system. Although the introduction of antibiotics fitted neatly into the Cape Town TB branch's "direct attack" scheme, the new drugs led to a drastic change in TB treatment and brought about a fresh set of problems. The streptomycin era held a number of paradoxes. Firstly, the new drugs were a double-edged sword in that they appeared to offer a solution to the TB problem but also led to the creation of new drug

¹ Editorial, "Tuberculosis and Chemotherapy", SAMJ (30 May 1953), p.466.

resistant strains of TB. Although antibiotics could be used to treat TB in a “direct attack”, their efficacy was ultimately undermined by the poor socio-economic conditions of many TB sufferers. This was especially the case for Cape Town’s settled black population, seen in a long history of structural poverty and deprivation. Lastly, the policy of repatriating sick African workers from Cape Town to ‘homeland’ areas, particularly the Transkei, became far more common from the 1950s onwards. Randall Packard identifies the mass removal of Africans from urban and rural areas to the newly created ‘homelands’ as the “great disappearing act” of TB, which removed many TB cases from the official South African statistical register and beyond the purview of white society.³

i) The Chapel Street TB Clinic and Administration Centre:

Increased Clinic Attendances in the Apartheid era

This section will focus on the chief factors that shaped the policy of the Cape Town TB branch with respect to the new TB drugs. The concept of the direct attack on TB, that was prominent in the 1940s still held sway, and the TB drugs enabled the expansion of this approach. Thus TB antibiotics did not lead to a clean break from established bureaucratic TB schemes, rather they allowed for the established scheme to be adapted and taken into a new phase of management. However, there were a number of paradoxes in this new phase of TB management that undermined the TB clinic’s work.

² Report of the MOH, Cape Town, 1949/1950, p.42.

³ R. M. Packard, White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa (Pietermaritzburg, 1990), pp.292-298.

This section will discuss how TB sufferers were encouraged to attend the municipal TB clinics, although the TB clinics were unable to cope and struggled to deal with the increased attendances. The paradox encountered here was that, although TB antibiotics offered an opportunity to sideline socio-economic reforms, their efficacy was undermined by the poverty of TB sufferers. Disability grants awarded to TB patients were sufficient only to keep a TB sufferer alive, but were not enough for TB patients to make a complete recovery. These factors undermined the Cape Town TB branch's attempt to control TB through the Chapel Street TB Clinic and its subsidiary clinics during the 1950s. Moreover, it is suggested that the Cape Town municipality's failure to prevent and successfully treat TB during this period provide the basis for the serious TB problem that the city experiences today.

In 1950 Cape Town's TB Officer, Dr Hoole, gave a fairly optimistic report of the work undertaken by the Chapel Street TB Administration Centre and its subsidiary TB clinics. According to Hoole, more people were being examined at the clinics (largely due to the work of the MRS), more cases were found in a curable stage, aid to dependents had improved and co-operation from general practitioners, patients and employers was more general.⁴ Hoole believed that the increased demand for the TB clinics' diagnostic facilities was "welcome evidence of the public recognition of their value".⁵ To be successful, he believed, the TB branch had to encourage a high level of voluntary attendance so that it could continue to discover new cases of TB. In this regard, the Chapel Street TB Clinic did, in fact, experience an annual growth in attendance figures

⁴ Report of the MOH, Cape Town, 1950/1951, p.41.

from when it first opened.⁶ However, it is clear that the staff found it increasingly difficult to cope with the large numbers of people attending the TB clinics. In his annual report Hoole also complained that the progressive annual increase in patient attendances put a strain on the unexpanding medical staff. He noted that two doctors attended to 160 or more persons during a single session and he believed that the work of the doctors was “lamentably remote from clinical medicine” and that it carried with it “the dangers of haste and fatigue”.⁷

According to the Cape Times, in June 1953 the total attendances at the Chapel Street TB Clinic numbered as many as 3000 a month, of whom at least 1000 were estimated to be newcomers “anxious” to be examined for the first time.⁸ However, Hoole was quick to declare that this was not due to an “alarming” increase in the incidence of TB in Cape Town.⁹ Instead, he attributed the acceleration in voluntary attendance at the TB clinics to the new anti-TB drugs, stating that the word had spread about the efficacy of streptomycin and the other new drugs when patients accepted prompt treatment.¹⁰ However, this increase could also be linked to the increased active case-finding once the MRS was established, where the highest percentage of new cases was found between 1948 and 1953. Certainly, it appeared that black TB cases had greater confidence in submitting themselves to treatment once it became known that they might receive TB drugs while waiting for hospitalisation, instead of the cod liver oil that had been given

⁵ Report of the MOH, Cape Town, 1949/1950, p.43.

⁶ See: Appendix, figures 12 and 13, showing the annual attendance figures from 1937-1964.

⁷ Annual Report of the MOH, Cape Town, 1952, p44.

⁸ Cape Times, 18 June 1953, “TB Treatment at Home Planned”.

⁹ *Ibid.*

¹⁰ *Ibid.*

before.¹¹ In response to this overwhelming workload at the TB clinics, Hoole told the Cape Times that, "We were never busier but we are not grumbling".¹² Nevertheless, his thinly disguised petition to his superiors for more staff in the annual official reports was essential if the clinics were to cope with the results of encouraging greater awareness, acceptance and new attendances through the medium of the press.

However, this apparent success in the growth of TB clinic attendance was self-limiting. The following year the annual growth in the total number of new attendances ceased to increase for the first time since the Chapel Street TB Clinic had opened.¹³ Yet again Hoole chose to interpret this positively. He believed that the clinic services had reached a saturation point because a very large proportion of the people for whom the clinic services had been intended had by then attended one of the municipal TB clinics.¹⁴ Although Hoole's explanation may have been partly correct, this was an uncritical perspective of the work of the TB clinics. It was more likely that the TB clinic sessions had reached a saturation point in terms of their capacity and that TB clinic overcrowding had set a limit on the number of people who could be examined. By 1957 the TB clinics were struggling to cope with the large volume of attendances, despite the appointment of a third TB Officer in October 1954 to help Dr Hoole and his deputy, Dr Ackerman.¹⁵ Apart from restricting the actual number of people that could be examined in each clinic

¹¹ The Medical superintendent at the Nessie Knight Hospital also noted the increased acceptance of TB hospital treatment among Africans as a result of the use of TB drugs in the rural Transkei. R. L. Paterson, "Domiciliary Treatment of Pulmonary Tuberculosis", SAMJ (27 March 1954), p.279; J. P. De Villiers, "The Tuberculosis Problem in South Africa in the Light of Recent Advances", SAMJ (14 December 1957), p.1277.

¹² Cape Times, 18 June 1953, "TB Treatment at Home Planned".

¹³ Report of the MOH, Cape Town, 1953/1954, p.46.

¹⁴ *Ibid.*

session, by Hoole's own admission, the overcrowding at the TB clinic sessions "set limits to the patience and goodwill of the public".¹⁶ He believed that a wait of two to three hours at the TB clinic sessions would deter the seemingly fit, however co-operative they might have felt initially.¹⁷

Moreover, the physical expansion of the clinic service was necessary if the TB branch wished to avoid the loss of new TB investigations and the ability to treat as many early TB cases as possible. The growth of the city and the expansion of the locations on the outskirts of Cape Town resulted in many TB patients living in areas further away from the central Chapel Street TB Clinic. The TB branch attempted to follow this movement and to situate clinics closer to the areas where they were most needed.¹⁸ The appointment of the new TB Officer at the TB branch allowed for the opening of a much-needed clinic at Athlone in December 1954, where housing schemes had recently been established.¹⁹ This led to a small reduction in the attendances from Athlone residents at the central Chapel Street TB Clinic.²⁰ In June 1957 the Langa hospital re-established TB clinic sessions, which was undoubtedly in response to the growing influx of migrant labourers and a factor in the increased TB notifications from this area.²¹ Following this, the TB

¹⁵ Report of the MOH, Cape Town, 1954/1955, p.45.

¹⁶ Report of the MOH, Cape Town, 1957, p.46.

¹⁷ *Ibid*, p.42.

¹⁸ Hoole's intention to establish TB clinics closer to the poverty-stricken areas where they were most needed is seen in his comment that, "there is no doubt that propinquity secures patronage, and further clinic buildings well sited in neglected and remote areas will produce better results." Report of the MOH, Cape Town, 1957, p.46.

¹⁹ See: Appendix, Figure 2. For the municipal areas.

²⁰ Report of the MOH, Cape Town, 1954/1955, p.45.

²¹ Report of the MOH, Cape Town, 1958, p.48.

clinic in Nyanga West was established in April 1959 in order to service that new settlement area.²²

By 1960 the TB branch had expanded to include a total of six TB clinics where TB cases could be diagnosed and treated viz. the main Chapel Street TB Clinic and administration centre, Wynberg, Athlone, Windermere, Langa and Nyanga West. X-ray facilities were available at four of these clinics in order to provide an immediate diagnosis for those attending for the first time.²³ The total number of TB clinic sessions held by the TB branch increased from thirteen sessions per week in 1950 to a total of 25 sessions by 1960, with three extra evening sessions per month at the central TB clinic in Chapel Street. The TB branch continued to run these evening TB sessions at 7.30 p.m. throughout the decade.²⁴ Hoole believed that these sessions were popular and rewarding.²⁵ However, these were the only evening clinic sessions in the Peninsula and this service was not expanded to the other TB clinics.

Yet, the expansion in the TB branch's service did not automatically translate into an effective campaign to manage TB. Although the TB branch was clearly attempting to make its service accessible to the people who needed it most, the frequency of clinic sessions and the site of TB clinics were not the only factors affecting the success of the TB programme. The economic issue of financial aid to TB patients also affected the work and possibly the attendance rates of the TB branch. Despite Hoole's claim in 1950

²² Report of the MOH, Cape Town, 1959, p.45.

²³ Report of the MOH, Cape Town, 1959, p.51.

²⁴ *Ibid.*

that the provision of financial aid for TB patients' dependents had improved, the bureaucratic obstacles involved in obtaining financial aid remained a problem. In order for TB patients to receive any money from the state's unemployment fund, they were required by the Department of Labour to present a monthly medical certificate.²⁶ This created a burden for the medical officers at the TB branch who claimed that the system contributed to the overcrowding at TB sessions where their work was held up by the completion of multiple forms. Hoole complained that pulmonary TB patients were incapacitated for a minimum of six months and that a single certificate should suffice for this period.²⁷

From the patient's perspective, the diagnosis of TB in a breadwinner could be a devastating economic blow to an entire family's survival, which was exacerbated by the political climate during the apartheid era. As mentioned in the previous chapter, the TB Care Committee assisted TB patients at the TB clinic sessions with the provision of food, blankets, clothing and the payment of rent. However, it should be noted that this form of social assistance was not always available in the areas outside of central Cape Town.²⁸ The Care Committee caseworker based at Chapel Street also gave advice to TB patients about the benefits that they might be eligible for. The Care Committee claimed that the caseworker explored every other avenue of assistance for which a patient might be eligible before they assisted new TB cases financially.²⁹ The other avenues of

²⁵ Report of the MOH, Cape Town, 1960, p.52.

²⁶ Report of the MOH, Cape Town, 1957, p.42.

²⁷ *Ibid.*

²⁸ Cape Times, 11 June 1951, "Servants Apply for TB Test".

²⁹ Care Committee, Cape Town, Report for the year ended 31 December 1950, p.4.

financial assistance might include payments from compulsory or voluntary sick benefit schemes, government disability grants and grants under the Children's Act and from the Board of Aid.³⁰ The Care Committee also attempted to help TB patients with regard to the actual claiming of these grants. For instance, it approached the Minister of Health, Dr A. J. Stals, in 1950 to investigate the delay in the payment of government disability grants to TB patients.³¹

Yet, although public health officials and medical authorities dealing with the management of TB might have admitted to the importance of nutrition, the state allowance remained meagre and simply kept TB cases and their dependants alive at a subsistence level.³² These subsistence grants did not allow for recipients to build up their strength sufficiently to make a full recovery. Indeed, it would not be misleading to suggest that the grants were intended to keep alive those TB cases receiving TB drug treatment so that the expensive drugs were not wasted.³³ Thus, food aid was primarily given as a supplementary grant in order to keep the TB drug scheme afloat and not as a real contribution to improving the pervasive conditions of poverty.

By 1954 the Care Committee was noting that it invariably found that the small disability grants from the government had to be supplemented for patients to maintain a minimum standard of living due to the high cost of living.³⁴ Indeed, in that year the Committee

³⁰ *Ibid.*

³¹ Care Committee, Cape Town, Report for the year ended 31 December 1950, p.6.

³² 3/CT; 95-96; 471; Letter from the MOH to the Regional Director (9 December 1963). Grants in aid were only intended as a "supplement" for TB patients.

³³ Report of the MOH, Cape Town, 1953/1954, p.48.

³⁴ Care Committee, Cape Town, Report for the year ended 31 December 1954, p.5.

needed to supplement its usual income from the Community Chest in order to deal with rising costs and “unprecedented distress” amongst TB patients’ families.³⁵ Thus, even if TB patients were eligible for a government disability grant, the amount was insufficient and always dependent on race. For example, the disability grant for African TB cases was far from satisfactory: with a maximum amount of £9 per year, it fell short of the amount required to purchase a loaf of bread per day.³⁶ By 1957, the Care Committee was lamenting that the government disability grant of £10-10-0 per month for whites, £4-2-6 for coloureds and £3-15-0 for Africans every second month was simply not sufficient “to keep a home together”.³⁷ This did not change and by 1960 the grants of aid were still insufficient to cover the needs of TB patients and their dependants.³⁸

Yet, in 1961 the secretary of the Cape Peninsula TB Council, Mrs. N. Cuff, reported optimistically that:

“At one time many people, particularly the breadwinners of families, dreaded going to clinics if they contracted TB, partly because they feared they might be put off work and their families would suffer.

Now that they know that they can get assistance they go more readily. This is a great help in the drive against TB, as the earlier a case is treated, the better the chance of recovery”.³⁹

However, despite the efforts of voluntary organisations, this assistance did not reach all TB patients. It was here that the state clearly side-stepped its responsibility for the health

³⁵ *Ibid.*

³⁶ *Cape Times*, 11 June 1951, “Servants Apply for TB Test”.

³⁷ Care Committee, Cape Town, Report for the year ended 31 December 1957, p.8.

³⁸ Report of the MOH, Cape Town, 1960, p.47.

and welfare needs of black workers and their families. Moreover, the state's policy of apartheid directly impacted on the lives of African TB sufferers. This is evidenced in a letter written by an African TB patient, Mr J. Seape, undergoing treatment in the Brooklyn Chest Hospital in 1964:

"...I am now almost 15 years in Cape Town, working and married here, with five children all up-country by my parents. To-day I am lying in hospital for the last six months suffering from T.B. I have gave (sic) up my room and sent all my belongings to my parents because I can't afford to pay rent as I am getting no allowance anywhere. Now the worse of them all, the Langa registration office order (sic) my wife to go out of the urban area before the end of this month, because she was late to change her pass in time. Now I am prepared to go to Native Affairs for advice or to Black Sash, but we must go out after every six weeks; now I don't know what to do..."⁴⁰

Mr Seape, who had been resident in Cape Town for longer than six months might have been eligible for TB treatment in Brooklyn Hospital at the expense of the City Council, but this made him and his family more vulnerable to the effects of apartheid once he became ill. The out-patient treatment of TB patients at TB clinics also became more difficult due to apartheid removals affecting patients' ⁴¹access to clinics and the health visitors case-holding.

Moreover, the manner in which social aid was granted revealed that TB treatment remained within the context of controlling TB cases. On the one hand, domiciliary TB

³⁹ *The Argus*, 4 May 1961, "How TB Struck a Family Down".

⁴⁰ *Cape Times*, 20 March 1964, "My wife has to go..."

⁴¹ 3/CT; 95-96; 471; Letter from Dr Hoole to the MOH (18 January 1963). Dr Hoole noted that the Housing Section and Registration officer was "co-operative" in supplying the clinic staff with TB patients new addresses if they had been moved by official agencies.

treatment gave TB cases greater personal freedom as compared to in-patient treatment where they were subjected to a strict hospital regime. On the other hand, however, domiciliary TB treatment was more invasive and brought the TB branch's staff into the TB patient's own home on a regular basis. The TB branch was also known to use the TB grants as a means of coercing or encouraging TB patients to accept treatment and to withhold grants if they did not comply with the TB Clinic's treatment scheme.⁴² Yet, unlike Seattle's Firland Sanatorium, where coercion included the forcible detention of recalcitrant TB patients in locked wards from the late 1940s, to protect the public health,⁴³ this was not the case in Cape Town where there had been no jail sentences or cases of enforced detention by the close of the 1950s.⁴⁴ Dr D. P. Marais was in favour of "making an example" of "absconding" or 'non-compliant' TB patients on the grounds that "half treatment was more dangerous than no treatment at all".⁴⁵ Yet, the Union government, like Britain, did not believe that compulsory detention was the correct approach to the problem and preferred to rely on the persuasion of TB patients.⁴⁶ This was partly due to the belief that compulsion was "bad public health practice" and that it would scare people away from TB treatment centres, and also due to the lack of accommodation to enforce treatment in this manner on a large scale.⁴⁷ Thus, the new drugs demanded a stable population who were required to commit to a full course of

⁴² Cape Times, 22 July 1949, "Long Waiting Lists at TB Clinic".

⁴³ B. H. Lerner, Contagion and Confinement. Controlling Tuberculosis along the Skid Road (Baltimore, 1998), pp132-133.

⁴⁴ The Argus, 27 February 1959, "TB Man's Sentence for Defaulting".

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*; L. Bryder, Below the Magic Mountain, p.133; R. Coker, "Civil Liberties and Public Good: Detention of Tuberculous Patients and the Public Health Act 1984", Medical History, vol. 45, no. 3 (2001), p.348.

⁴⁷ *Ibid.*

treatment under medical supervision, which will be discussed in the context of the city's domiciliary drug treatment scheme in the next section.

During the 1950s, the Cape Town TB branch had been forced to expand its TB clinic scheme in order to cope with the City's growing TB problem. The inadequate subsistence grants that were provided for TB patients and their dependants so that the TB drugs would not be wasted reveals the government, and Cape Town municipality's, reluctance to address the serious root causes of black ill health during this period. In line with the government's favoured focus on a short-term curative scheme, the City Health Department chose to expand its TB clinic scheme from the Chapel Street TB Clinic. Municipal TB clinics were established in the new housing areas and this would eventually, in the next decade, remove the focus from the central Chapel Street TB Clinic to its satellite clinics. The reluctance of the government and industry to provide for the needs of the City's black work force meant that the TB problem increased during the 1950s. The lack of resources available to deal with the problem made the adoption of a short-term curative solution to cope with the growing TB epidemic a compelling option for Cape Town's medical authorities. The next section will discuss the impact of the streptomycin era on the work of the Chapel Street TB Clinic and Administration Centre in greater detail.

ii) The Cape Town City Council's Efforts to Control TB in the Streptomycin

Era: Drugs, Domiciliary Care and Declining TB Death Rates

*"But what is the good of new treatment if, as fast as sufferers are patched up, others go down with the same disease because their living conditions make them easy targets for infection?"*⁴⁸

The general response of the South African medical authorities to the new drugs was one of cautious optimism at the beginning of the 1950s.⁴⁹ The municipal Health Department continued to manage TB through the modern direct attack that focussed on the TB bacillus in the light of the new medical knowledge of the bacteriological age and the germ theory. During the pre-antibiotic era, Cape Town had built up a TB infrastructure that was geared towards diagnosing and preventing TB through medical methods while sidelining broad environmental reforms. The development of new drug-based methods of TB prevention and treatment did not change the basic focus of this "direct attack" on TB, though the means of attack was very different. Thus the Cape Town municipal Health Department could implement a TB prevention and drug treatment programme from the late 1940s, with very few adjustments to the existing TB management infrastructure. However, by the mid-1950s it had become clear that the initial high aims, however cautious, that accompanied the advent of TB drugs would not be achieved. The

⁴⁸ *Cape Times*, 6 September 1956, "TB Unbeaten".

⁴⁹ *Cape Times*, 4 June 1952, "Minister on TB"; "Drug Resistance of Tubercle Bacilli Following Antibiotic Treatment", *SAMJ* (19 July 1952), p.585; "Tuberculosis and Chemotherapy", *SAMJ* (30 May 1953), pp.465-466.

continued disparity between the service available to whites and blacks, the poverty of black TB patients and the system of migrant labour ultimately undermined the TB branch's attempts to control the TB epidemic through the system of domiciliary drug treatment.

The first part of this section will look at the prevention methods, such as pasteurisation, BCG vaccination and mass radiography, that were incorporated in the city's anti-TB scheme during the 1950s. These methods became an integral part of the TB branch's medical 'direct attack' on TB. The second part of this section will discuss how the fear of TB-infected migrant labourers entering the city superseded the threat posed by the existing reservoir of TB within Cape Town's settled populations. Lastly, the TB branch's efforts to institute a domiciliary TB drug treatment scheme will be discussed in order to reveal how the City Council's Health Department approached TB from a medical perspective despite the rhetoric of social reform.

As mentioned above, this decade witnessed a number of new developments in the field of TB prevention. The first of these was the pasteurisation of milk. Active attempts by the Cape Town municipality to eradicate a threat posed by infected milk supplies to the public health date back to the 1940s.⁵⁰ As a result of a severe outbreak of enteric fever during 1943, Cape Town's MOH, Dr Shadick Higgins, submitted a report calling for the

⁵⁰ Discussions about the possibility of bovine TB infecting milk and meat supplies date back to 1899. See: D. C. Campbell Watt, "Prevention of Phthisis", *SAMJ*, vol. 6, no. 2 (March 1899), pp.237-240; By an Expert, "Our Milk Supply in Relation to Tuberculosis", *SAMJ*, vol. 6, no. 2 (March 1899), p.240.

overcrowding, and hard physical effort with fatigue.⁵⁶ In Cape Town, the MOH, Dr F. O. Fehrsen, claimed that internationally BCG vaccine was accepted as the most “hopeful” measure in the field of TB prevention,⁵⁷ and Dr Hoole declared that TB was so bad in Cape Town that the TB branch could not afford to miss any measure that might be beneficial.⁵⁸ Yet, although responses to BCG vaccination appeared to be fairly positive, the SAMJ cautioned that enthusiasm might well have outrun discretion and common sense.⁵⁹ As a result, the South African medical authorities were generally inclined to follow the example of Great Britain and the United States of America in cautiously accepting BCG.⁶⁰ The debates about the merits of BCG vaccination reveal a similar tension between purely medical interventions and the role of social reforms, that occurred in Britain and America.⁶¹ This tension is seen in South Africa in a report that the danger of BCG vaccination lay in the “misplaced enthusiasm” of “needle-happy inoculators”.⁶² The article cautioned that this enthusiasm for BCG “could lead to the belief that tuberculosis could be prevented simply by the prick of a needle”, which would divert the focus of the anti-TB drive away from its central problems which were environmental factors such as poor housing, overcrowding and malnutrition.⁶³ The same

⁵⁶ B. A. Dormer, “Control of Tuberculosis”, SAMJ (18 June 1949), p.489.

⁵⁷ Cape Times, 7 August 1950, “City Use of New TB Vaccine”.

⁵⁸ *Ibid.*

⁵⁹ Editorial, “BCG Vaccination against Tuberculosis”, SAMJ (28 February 1953), p.172.

⁶⁰ B. A. Dormer “Procedures in the Control of Tuberculosis”, SAMJ (2 February 1952), p.96; Cape Times, 3 March 1952, “Warning on State TB Campaign”.

⁶¹ Although Georgina Feldberg claims that the response of North American physicians was distinctive because they “did not rush to embrace the quick technological fix”, the South African medical profession issued the same consistent reminders about the social, political and economic aspects of the disease. G. D. Feldberg, Disease and Class. Tuberculosis and the Shaping of Modern North American Society (New Brunswick, 1995), p.6. In Britain, Linda Bryder shows that it was only after the Second World War that BCG was seriously considered for the first time. L. Bryder, Below the Magic Mountain. A Social History of Tuberculosis in Twentieth Century Britain (Oxford, 1988), p.227.

⁶² Cape Times, 3 March 1952, “Warning on State TB Campaign”.

⁶³ *Ibid.*

reasons for caution are given in American responses to BCG vaccination, and Feldberg shows that some physicians feared that the vaccine would deflect attention away from the social roots of the disease.⁶⁴ It should be noted that these were not the only concerns about BCG vaccination and that there were also medical debates about the efficacy of the vaccine and its interference with an accurate tuberculin test reading.⁶⁵

Although tentative pilot studies took place during this period, it was only in the 1960s that the use of BCG vaccinations became part of a major national preventative campaign, and 1973 before the vaccination of newborn babies in South Africa finally became compulsory.⁶⁶ Thus the use of BCG vaccination could not have appreciably improved the Cape Town TB branch's TB prevention campaign during this period. What is significant, however, is the obvious tension between the rhetoric of social reform, which acknowledged the social and biological dimensions of the TB problem, and the ascendancy of the rational or direct medical attack on the disease, which was influenced by germ theory. Unfortunately, the intersection of these medical developments and knowledge about the disease with the political economy in South Africa meant that the government failed to materially support the rhetoric of social reforms in its TB scheme and that medical intervention continued on a separate path.⁶⁷

⁶⁴ G. Feldberg, *Disease and Class* (1995), p.150.

⁶⁵ *Cape Times*, 2 March 1953, "Vaccine in Fight Against TB".

⁶⁶ In an attempt to confer some immunity for the first black nurse aids recruited to work at the Dr A. J. Stals Memorial Sanatorium in 1949, the Cape Town City Council undertook tuberculin tests and gave the non-reactors BCG vaccine. However, this was not done on a large scale and supplies of BCG remained difficult to get hold of up until the late 1950s. J. P. De Villiers "The Tuberculosis Problem in South Africa in the Light of Recent Advances", *SAMJ* (14 December 1957), p.1276.

⁶⁷ State plans to institute a wide-scale government campaign to immunise Africans continued as a separate medical intervention despite the debates in medical journals and the press. *Cape Times*, 16 January 1952, "Mass Vaccinations Against TB".

In addition to the new methods of TB prevention, the TB branch continued with its aim of finding the early infectious TB case through the use of mass X-ray technology, which was viewed as the most valuable case-finding asset. In the first two years of its operation (1948-1950), the MRS at Chapel Street Clinic saw a 73% increase in miniature film examinations taken.⁶⁸ By 1950 the accommodation for this service was inadequate to cope with the large increase in attendances.⁶⁹ Within the next few years, despite the constant requests of the TB branch, the MRS service remained in the same cramped quarters at Chapel Street.⁷⁰

The success of the MRS in discovering the early, unrecognised case of TB was measured according to how many cases of TB were discovered. Hoole observed that, if screening was to be regarded as a practical and economic service, it should provide 25% of new TB cases when it was intensively applied.⁷¹ It was found that the MRS unit at the Chapel Street Clinic provided 19.6% of the new cases of pulmonary TB discovered in 1955. In the next year this figure was given at 15.3% and in 1957 as 17%. Yet, although these figures were below the estimate given, Hoole defended the MRS by noting that all the cases were found among the seemingly fit who were in the early stages of TB and were capable of recovering without expensive hospital treatment.⁷² However, the TB branch was not finding all TB cases at an early enough stage. The

⁶⁸ Report of the MOH, Cape Town, 1949/1950, p.49.

⁶⁹ *Ibid.*

⁷⁰ See: Appendix, Figure 15, showing the total films taken at the Chapel Street MRS from 1948-1964.

⁷¹ Report of the MOH, Cape Town, 1954/1955, p.48.

⁷² Report of the MOH, Cape Town, 1957, p.48.

notifications of TB patients who were either very sick or dead on notification reveal the number of TB cases that the TB branch did not pick up.⁷³ These figures declined towards the end of the decade, possibly revealing a real increase in the TB branch's success in finding TB cases at an earlier stage.⁷⁴ However, paradoxically, this success placed an added strain on the TB beds available.

The pressure for a more optimal use of the MRS as a cost-effective case-finding mechanism saw the more selective use of the MRS, primarily for groups with a known high incidence rate.⁷⁵ This meant that the regular X-ray screening that had been offered to the white employees of oil companies, the civil service and the police force was no longer encouraged.⁷⁶ Conversely, this decade saw a number of articles in the local press stressing the importance of screening African migrant labourers, factory employees and domestic workers. By the end of the decade, Hoole believed that TB was disappearing in those factories that made regular use of the MRS as a pre-employment device and as a means of checking permanent staff.⁷⁷ However, the Chapel Street MRS was not as successful in its attempts to get black domestic workers X-rayed and the press was used to encourage white employers to get their domestics to make use of the service.⁷⁸ Hoole

⁷³ See: Appendix, Figure 11, showing the decline of late TB notifications.

⁷⁴ It should be noted, however, that the increasing number of African migrant labourers who left Cape Town, of their own accord or through repatriation once they became ill, would have created a pool of infectious TB cases who never came to the notice of the TB branch at Chapel Street.

⁷⁵ The government withdrew financial support for Cape Town's free MRS service, stating that industry should pay for the service. The Cape Town City Council chose to continue to offer the service free of charge because it was felt that the demand for payment would jeopardise the work of the MRS. (Argus, 1 August 1959, "City to Bear Cost of X-Rays for Tuberculosis").

⁷⁶ Report of the MOH, Cape Town, 1961, p.55.

⁷⁷ Report of the MOH, Cape Town, 1959, p.52.

⁷⁸ Cape Times, 12 April 1950, "Few Turned Up for Free TB X-Ray". In 1954, housewives were singled out to be at fault for not making full use of the Chapel Street TB screening service. Cape Times, 6 October 1954, "City Waiters Sent for TB Screening".

was not above the use of scare tactics. In 1950 he told the Cape Times that every year between 200 and 300 domestic servants were discovered to suffer from infectious TB,⁷⁹ adding that each year white children died of tubercular meningitis that was contracted from undetected cases of infectious TB in domestic staff.⁸⁰

Race and class also shaped Hoole's perceptions of African migrant labourers: to him they were less vulnerable workers entering Cape Town than a threat posed to the city. The Cape Town TB branch's approach to TB prevention thus contained a racist paradox, where prevention translated into the control of African migrant labour more than it did the actual prevention of TB among Africans themselves. This was seen in 1957, when Dr Hoole noted that the increase in TB cases from outside the city was due to the influx of Africans, many of whom, he believed, travelled to Cape Town in search of diagnosis and cure.⁸¹ If these 'outsiders' were not located within a period of six months, he noted, they became the responsibility of the Cape Town municipality. Accordingly, Hoole urged that "it behoves an alert civic authority to provide adequate measures for the early discovery of these cases in order to prevent spread and also avoid permanent financial responsibility."⁸² His attitude towards migrant labourers was therefore one that did not question the political perspective which viewed Africans as 'outsiders'. Indeed, he suggested a method of controlling Africans entering Cape Town through the use of mass X-ray screening at the point of entry into the city, such as the railway station at Langa, or for these workseekers to be diverted through the MRS at the

⁷⁹ Cape Times, 12 April 1950, "Few Turned Up for Free TB X-Ray".

⁸⁰ *Ibid.*

⁸¹ Report of the MOH, Cape Town, 1957, p.42.

Chapel Street TB Clinic.⁸³ He justified this approach by stating that the control of migratory cases was essential because, even if they secured work while ill and infectious, their condition deteriorated and they inevitably became destitute and would deprive local cases of hospital accommodation.⁸⁴

If the TB branch was displeased with the number of TB cases entering Cape Town from outside the city limits, it was also well aware of Cape Town's role in exporting TB from the city to the rural areas. Dr Hoole admitted in 1957 that, "each annual report points out that the tuberculosis mortality in Natives is unknown, as they are returning home in even greater numbers and to such a degree that tuberculosis must be listed as one of the important exports of Cape Town."⁸⁵ By the end of the 1950s black TB death rates in Cape Town were far from accurate because the Native Affairs Department's policy of repatriation created unnaturally low TB mortality statistics. As a result of this policy, TB-infected workers returned to rural areas that were economically depressed and on the whole lacking in an infrastructure to provide even the most rudimentary forms of TB treatment. Although the Cape Town municipality did not overtly condone this policy, it did not question the use of repatriation as a means to evade the financial responsibility of treating the large numbers of migrant labourers who were entering the city. Hoole acknowledged the danger of this situation, stating that "what we gain by this swing in Cape Town is lost in the rondavels of the Transkei."⁸⁶ The short-term financial

⁸² *Ibid.*

⁸³ *Ibid.*

⁸⁴ Report of the MOH, Cape Town, 1958, p.48.

⁸⁵ Report of the MOH, Cape Town, 1957, p.45.

⁸⁶ Report of the MOH, Cape Town, 1959, p.48.

expediency favoured by the Cape Town TB branch led to a reservoir of ill-health and TB accumulating in rural areas such as the Transkei, that undermined the gains made by Cape Town's anti-TB measures in the city. This would eventually bedevil the city's attempts to curb the disease.

A similar epidemiology is seen in William Johnston's history of TB in Japan, where rapid urbanisation and industrialisation intersected to weaken and expose impoverished rural workers to the TB bacillus through exploitative work in factories and life in overcrowded urban barracks.⁸⁷ As in South Africa, workers were sent home as soon as they became too ill with TB to remain efficient and this exchange rapidly spread the disease throughout the rural areas.⁸⁸ Unlike South Africa, however, Japan's TB epidemic receded by the mid-1950s through a combination of improved living and working standards and concerted state-controlled medical interventions, using BCG inoculations and TB drugs.⁸⁹ The critical difference here was that black Capetonians did not benefit from a similar rise in standards of living. Yet, the city's TB branch redoubled its efforts to deal with TB from a medical perspective.

As discussed in the previous chapter, the sheer volume of TB patients in Cape Town waiting for hospital beds forced the TB branch to accept and make the best of a system of domiciliary TB isolation in the pre-antibiotic era. The long waiting period for TB beds had to be acknowledged as a problem that undermined all other curative efforts at

⁸⁷ W. J. Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan* (Cambridge, 1995), pp.73-74 and pp.93-94.

⁸⁸ *Ibid*, p.85.

TB management because infectious TB patients were not adequately isolated. In this context the domiciliary isolation scheme was far from ideal because TB patients could seldom follow the preventative measures designed to stop the spread of their disease to their families and to the public due to their poor home circumstances. This break in Cape Town's TB service was often blamed for the continued spread of the disease. It also undermined TB treatment in hospital because early cases of TB would deteriorate while waiting for hospital accommodation, becoming more infectious and less amenable to the current treatment of adequate nutrition and bed rest.

By the 1950s, this position was growing more serious, and it was estimated that 902 TB sufferers were waiting for hospital beds in May 1953;⁹⁰ nine months later this figure had increased to 1214.⁹¹ With this pressure on the city's in-patient TB facilities, many TB sufferers would have to wait at least a year before a bed in a TB institution would become available.⁹² Thus, the Cape Town TB branch found itself in a double bind, because, even if it could cope with the increased caseload at its out-patient TB clinics, it could not provide hospital accommodation for those who were in urgent need of it.⁹³ Hoole explained that this was why the Cape Town Health Department was considering the treatment of "suitable cases" at home with the new TB drugs.⁹⁴ He believed that

⁸⁹ *Ibid.*, p.24 and pp.98-99.

⁹⁰ *Cape Times*, 18 June 1953, "TB Treatment at Home Planned".

⁹¹ *Cape Times*, 17 February 1954, "TB Treatment at Home: MOH's plan for those awaiting hospital".

⁹² *Cape Times*, 18 June 1953, "TB Treatment at Home Planned".

⁹³ *Ibid.*

⁹⁴ *Ibid.* The East London municipal health department was forced to take similar measures in the face of limited financial resources, inadequate TB accommodation, poverty stricken residents and high TB rates. The Deputy MOH reported that his department resorted to the out-patient treatment of TB cases but that this was made difficult by the patient's home circumstances. J. S. Lewis, "Tuberculosis in East London", *SAMJ* (31 October 1953), p.981.

preliminary treatment at home during the long wait for admission to hospital would be extremely valuable in halting the advance of the disease.⁹⁵ Moreover, he believed that many “non-European” homes possessed every factor necessary for the successful treatment of tuberculosis, except the ability to pay for the costly new drugs and the medical service to administer them.⁹⁶ This was an over-optimistic view considering the failure of the TB branch’s attempts at domiciliary isolation in the past, but it was born out of a desperate need to find a workable solution to the lack of hospital accommodation. More telling, perhaps, was that quite apart from meeting the needs of TB patients waiting for treatment in TB hospitals, both Hoole and his MOH, Dr E. D. Cooper, emphasised that domiciliary treatment would be much cheaper than the cost of hospitalisation.⁹⁷ This contrasts the response of American physicians, who, prior to the 1960s, advised against the use of TB drugs outside of a specialised hospital environment, with one physician noting that the money saved was a “false economy” because TB patients might remain infectious if not adequately supervised.⁹⁸

Nevertheless, Cooper submitted an official report to the Secretary for Health, proposing that the TB branch administer domiciliary TB drug treatment to TB patients waiting for hospital accommodation. He considered it a “hardship” to deprive TB patients of the new

⁹⁵ Report of the MOH, Cape Town, 1953, p.40. In addressing the shortage of hospital accommodation Dr E. D. Cooper also noted that the patient’s stay in hospital would in many cases be reduced, admission to hospital would be accelerated and the waiting list for TB treatment in hospital would be reduced. “The Domiciliary Treatment of Pulmonary Tuberculosis as a Public Service”, *SAMJ* (6 March 1954), p.197.

⁹⁶ *Cape Times*, 18 June 1953, “TB Treatment at Home Planned”.

⁹⁷ *Cape Times*, 18 June 1953, “TB Treatment at Home Planned”; “The Domiciliary Treatment of Pulmonary Tuberculosis as a Public Service”, *SAMJ* (6 March 1954), p.197. The vast difference in costs is evidenced in 1956, when the *Cape Times* reported that the Cape Town City Council had spent £44, 000 on the TB clinic scheme and well over £300, 000 on TB hospitalisation during the previous year. (*Cape Times*, 5 September 1956, “TB Cases in the Peninsula in the Past Six Years”).

treatment because he believed that the new drugs offered TB patients the “hope of recovery or improvement in their condition”.⁹⁹ Although it promised to revolutionise the treatment of TB in Cape Town, his proposal remained well within the existing medical framework and he noted that qualified nursing sisters under the supervision of a medical officer would administer TB treatment.¹⁰⁰ This would account for Cooper’s support of domiciliary TB drug treatment as the best option *in suitable cases* while there was no room in hospital (my emphasis).¹⁰¹

Furthermore, Cooper pointed out that domiciliary drug treatment could also render *some* patients non-infectious, thereby limiting the spread of the disease (my emphasis).¹⁰² He was aware that this treatment scheme would not be applicable to all TB patients, but he focussed on the need to provide some sort of intermediate plan in the face of Cape Town’s TB crisis. In this regard, the SAMJ also noted fleetingly that the scheme might not be effective for those who were living under slum conditions, but it went on to state that it would nevertheless be a useful addition to the municipal anti-TB scheme.¹⁰³ This perspective explains why medical authorities were prepared to gloss over the negative aspects of TB drug treatment in view of the ‘greater good’, and this intermediate plan came to replace the provision of TB beds as a short-term means to manage TB. Yet, the medical authorities were not being realistic about the home circumstances of many

⁹⁸ G. Feldberg, Disease and Class, p.205.

⁹⁹ “The Domiciliary Treatment of Pulmonary Tuberculosis as a Public Service”, SAMJ (6 March 1954), p.197; Cape Times, 17 February 1954, “TB Treatment at Home”.

¹⁰⁰ “The Domiciliary Treatment of Pulmonary Tuberculosis as a Public Service”, SAMJ (6 March 1954), p.197.

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*

¹⁰³ Editorial, “The Decline of Tuberculosis”, SAMJ (6 March 1954), p.188.

poverty-stricken TB patients. Their conscious sidelining of environmental factors thus undermined the new scheme.

There thus existed a paradox between the rhetoric of the need to consider environmental factors and the actual medical TB programmes that were established. This is seen in the insightful perspectives of the TB specialist and chief of the anti-TB section of the National Health Department, Dr B. A. Dormer. Dormer's less than full belief in a narrow medical approach to TB control is evident in a paper that he presented at the Second National Conference on TB in 1951. He noted that:

"Even if we treat cases to cure and return them to a community where stresses are unchanged, they will always break down again- a fact which has been a bitter pill for the clinician to swallow. There is a modern tendency to control tuberculosis by applying a simple series of procedures, such as mass radiography of the total population- the removal of persons suffering from tuberculosis- curing them, rehabilitating them and returning them to ordinary life. This system of control will not be effective because it ignores the stresses which produce the susceptibles- a case pronounced clear to-day as a result of mass X-ray can be dead of tuberculosis in three months if the environmental stress is sufficiently great."¹⁰⁴

Yet, despite his published views about the importance of environmental factors in the control of TB, Dormer was supportive of the drive to provide domiciliary TB drug treatment. Dormer believed that it was essential for the state to find alternative methods to deal with the TB problem, preferably by methods that did not disrupt and break up the patient's family life.¹⁰⁵ This was a solution born of necessity on a national level. The

¹⁰⁴ B. A. Dormer, "Procedures in the Control of Tuberculosis", SAMI (2 February 1952), p.95.

¹⁰⁵ Cape Times, 26 January 1954, "Brilliant Plan to Control TB".

state could simply not afford to supply the estimated 11 000 beds that were required for the Union in 1954.¹⁰⁶ Domiciliary TB drug therapy allowed many TB patients to continue working in order to support their families. It also revolutionised ideas about TB treatment because TB patients were no longer required to endure prolonged periods of complete physical rest in hospital. Moreover, it was estimated that the cost to the local authority and the state for each TB patient treated in this manner would be reduced from £450 per year to £8 for outside or domiciliary treatment.¹⁰⁷ At worst, infectious TB patients could be put into hospital for a few months until they turned sputum negative (non-infectious) before they were returned home as soon as possible to continue working.¹⁰⁸

At the same time that the new antibiotics appeared to offer a solution for Cape Town's TB programme, they brought about a fresh set of problems in the control of TB. Right from the start, reports that the administration of particular drugs, such as streptomycin, on their own could lead to drug resistant strains of TB bacilli revealed a local awareness of international debates about the pitfalls of the new anti-TB drugs. The cautious approach of some medical professionals was reflected in the SAMJ which stated that clearly the last word on TB drug schedules had not yet been said.¹⁰⁹ In fact a number of articles appeared in the SAMJ about the optimal methods of TB treatment through a combination of drugs in order to avoid drug resistance developing.¹¹⁰ The danger of

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.*

¹⁰⁹ Editorial, "Drug Resistance of Tubercle Bacilli following Antibiotic Treatment", SAMJ (19 July 1952), p.585.

¹¹⁰ *Ibid.*; Editorial, "Tuberculosis and Chemotherapy", SAMJ (30 May 1953).

half-cured TB patients passing on drug resistant strains to other people was therefore an important consideration from the very beginning of TB drug treatment and makes the TB branch culpable for their part in the particular manner in which TB drugs were administered to people whose poverty made them vulnerable (for example: physically, through malnutrition, alcoholism, and other stress factors, socially, through lack of money for transport costs to get to clinics, and politically, through fear of repatriation or the loss of work) to incomplete treatment courses and treatment interruption.

As mentioned above, Cooper was clearly aware of the possibility that TB patients could remain infectious despite the administration of the new TB drugs. Dr Hoole, also realised the danger inherent in the new scheme. He declared that:

“It is logical that if current treatment prolongs the lives of infectious cases, the chances of infection of others are increased especially if a greater number are to be treated at home. In this way the number of chronic and partially disabled persons has increased and the carrier population has probably increased. If this trend continues, more and more persons will be infected by tuberculosis and pass through a shorter or longer period spreading the disease, unless it is diagnosed early and isolation and prompt and full treatment initiated.”¹¹¹

Yet, despite this knowledge, he directed the TB branch to follow through with plans of domiciliary TB drug treatment to patients whose poverty would seriously undermine their ability to complete the required minimum of a six-month course of treatment.

¹¹¹ Report of the MOH, Cape Town, 1952/1953, p.40.

Other medical practitioners were aware of the dangers inherent in the new antibiotic treatment for TB. Three years later another medical practitioner, Dr S. B. Sachs, observed in an article in the SAMJ that, before the introduction of TB drugs, infectious TB cases would have rapidly become bedridden, thus limiting the spread of the disease to the immediate household.¹¹² He suggested that the high TB death rate in the pre-antibiotic era also set a time limit on the spread of the disease. With the new treatment methods TB cases lived longer and there was no guarantee that the patient was sputum negative (not infectious) while he or she was ambulant.¹¹³ Thus, if drug resistant strains developed, they would be spread over a wider area for a longer period of time.

However, it should be noted that Cooper did not unequivocally support the provision of anti-TB drugs as the ultimate solution to Cape Town's TB problem. There was a gap between his rhetoric of social reform and his curative approach to Cape Town's TB problem. He still viewed the provision of adequate housing and nutrition as a priority in the treatment of TB and did not believe that the new drugs would be effective without these important conditions being met. For instance, at the annual meeting of the Cape Province TB Council in 1954, he stated that "the problem of Tuberculosis will never be eradicated till overcrowding and the shocking housing position are correctly tackled".¹¹⁴ Yet, Cooper did not view this aspect of TB prevention as the responsibility of his department. Rather, he saw it as something that fell under the authority of the state and industry. This is seen in his appeal to industry to play its part in improving the feeding of

¹¹² S. B. Sachs, "The Domiciliary Treatment of Pulmonary Tuberculosis", SAMJ (4 August 1956), p.738.

¹¹³ *Ibid.*

¹¹⁴ Cape Times, 17 July 1954, "More houses called for to fight TB: MOH urges meals at work".

all employees, and to the provincial authorities to increase school-feeding schemes.¹¹⁵

The fragmentation of these responsibilities was a major flaw in any TB campaign because the rhetoric of the medical officers did not lead to any appreciable improvement in broad environmental factors, such as adequate housing and nutrition.

Nowhere was the disparity between the provision of TB services for white and black TB patients more clearly highlighted than once TB drugs became available and the TB death rates consequently declined. While the annual decline in white pulmonary TB mortality rates accelerated, the drop in the mortality rates for blacks slowed down from 1949.¹¹⁶ However, this was due not only to the disparity in living conditions between these groups but also to the inequitable distribution of public health facilities. Hoole admitted that this difference was due to the contrasting facilities available for the two groups, noting that facilities for blacks had to be increased.¹¹⁷ However, overall, the TB death rate for all races in Cape Town dropped steadily from 1948, which might have seemed encouraging, but Dr Hoole cautioned that TB prevention was still lagging “hopelessly” behind treatment and that, under the present methods, more people were contracting TB than dying from it.¹¹⁸

It was clear that the TB branch was falling short of its goal to prevent TB through the discovery of the early infectious TB case. As mentioned above, this had always been

¹¹⁵ *Ibid.*

¹¹⁶ Report of the MOH, Cape Town, 1951/1952, p.42.

¹¹⁷ *Ibid.*

¹¹⁸ *Ibid.* This is seen in the decreasing TB mortality rates compared to the increasing TB incidence (see: Appendix: Figures 9 and 10).

one of the primary aims of the TB branch. The TB Officer noted the failure of the clinics to discover new cases of TB, but, as seen in the 1940s, he blamed this failure on the TB patients themselves. An example of this is seen in Hoole's observation that the delay in TB cases reaching the notice of the TB clinic was mainly due "to the poverty and impercipient or obtuseness of the patient" and, he added, to the failure of doctors to send notifications in to the department.¹¹⁹ In 1955, Hoole noted that the TB branch was failing to isolate the infectious TB case and he claimed that this deficiency applied particularly to African men who were more often infectious when they were first discovered. Furthermore, he claimed that African men showed a "determined reluctance" to be admitted to the limited accommodation available in hospital.¹²⁰ The following year, he claimed that "it is astonishing that so many persons with advanced disease, particularly men, can remain unknown at least to official agencies by avoiding the case-catching net- however wide the mesh- until abject illness or some catastrophe brings them to the notice of the clinics."¹²¹ This could have been due to a number of reasons, such as the fear of a loss of work, repatriation, and destitution of the TB sufferer's family.

By the mid-1950s, despite the optimistic belief that TB could be cured with the new anti-TB drugs, the poverty of black TB sufferers made this impossible. The disclosure that nearly 20 000 people had contracted TB in the Cape Peninsula between 1950 and

¹¹⁹ Report of the MOH, Cape Town, 1951/1952, p.46.

¹²⁰ Report of the MOH, Cape Town, 1954/1955, p.41.

¹²¹ Report of the MOH, Cape Town, 1956, p.41.

1956 revealed that the disease was far from being controlled.¹²² In response to these figures, Dr Cooper acknowledged that the high TB rates were a “sad reflection” on Cape Town and that they were due to poor housing and malnutrition among blacks.¹²³ Cooper narrowed his focus even further and specifically mentioned the high TB incidence among African migrant labourers.¹²⁴ He believed that this was due to their lack of prior exposure to TB and the “overcrowded and slumlike dwellings” that they inhabited in the city.¹²⁵ This reasoning, which stemmed from the “virgin population” theories of the late nineteenth and early twentieth century, placed the responsibility for TB on the shoulders of African migratory workers and deflected the focus from the failure of the municipality to adequately provide for this section of the population.

In his official report for 1956, Dr Hoole also commented on the “disappointing” results of the TB branch’s work in view of their expenditure and effort.¹²⁶ Although he noted that there had been a universal fall in TB mortality rates to a greater extent than ever before in Cape Town, he also focussed on the plight of African TB cases and warned that the displaced mortality statistics for Africans falsified the final picture.¹²⁷ The removal of more African TB cases either voluntarily, or as Hoole euphemistically put it, “under official encouragement” from Cape Town to rural areas, meant that their deaths

¹²² *Cape Times*, 5 September 1956, “TB Cases in the Peninsula in the Past Six Years”.

¹²³ *Ibid.*

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

¹²⁶ Report of the MOH, Cape Town, 1956, p.41.

¹²⁷ *Ibid.*, p.43.

were not recorded for Cape Town.¹²⁸ The following year, he noted that the “disturbing conclusion” had to be drawn that, despite the newer therapies and the greater expenditure of money and effort, Cape Town had failed to reduce the number of new TB victims among its settled population.¹²⁹ He observed that this confirmed the view that the tasks of prevention continued to be handicapped by the late discovery of infectious cases, the inadequate treatment and isolation of current cases, as well as the poor nutritional and housing standards under which these groups were forced to live.¹³⁰

Thus, despite the work of the MRS, the new drugs and considerable effort and expenditure, the TB branch faced a large reservoir of infectious TB cases by the close of the decade. This is seen in Dr Hoole’s admission in 1960 that “under the present circumstances the tuberculosis population is annually swelled by those we fail to cure; half-treatment results in half-cure and the calamitous accumulation of infectious “chronics” designated by the phrase ‘*Survival without Recovery*’”.¹³¹ This ‘survival without recovery’ was in great measure due to the implementation of the new TB drug therapy and the subsequent fall in the death rate. This established a foundation of infectious TB cases who spread the disease over a wider space and for a longer amount of time. Furthermore, for a number of reasons, not all TB cases managed to successfully complete their treatment course and this left the TB branch with a pool of half-treated and infectious TB cases, some of whom could harbour multi-drug resistant (MDR)

¹²⁸ The Native Affairs Department was repatriating more sick and destitute Africans and this had the effect of reducing the actual TB statistics for Cape Town. Report of the MOH, Cape Town, 1953/1954, p.44. Report of the MOH, Cape Town, 1956, p.43.

¹²⁹ Report of the MOH, Cape Town, 1956, p.42.

¹³⁰ Report of the MOH, Cape Town, 1957, p.42.

¹³¹ Report of the MOH, Cape Town, 1960, p.47.

strains of the disease. Thus, in retrospect, although the TB branch attempted to make the best of a bad situation, their domiciliary drug treatment scheme failed to control the TB epidemic. In addition, this failure might well have added an extra burden to the city's TB epidemic, with the survival of infectious MDR TB cases.

By the close of the decade the Chapel Street TB Clinic and its subsidiary clinics had made a concerted effort to manage the TB epidemic through a curative TB drug treatment scheme. The concept of a direct attack on the TB bacillus held sway, and became more compelling with the advent of TB drugs. For the first time domiciliary TB treatment became a real possibility and the idea of controlling the epidemic through isolation gave way to a promise of eradicating the disease completely. The treatment regime for TB changed from enforced isolation, bed rest and nutritious food in a TB hospital to one that included domiciliary TB drug treatment and the ability for some TB patients to continue working. Yet, although it seemed that the pressing need for TB accommodation had been dealt with successfully through the provision of domiciliary TB treatment by the end of the decade, this did not change the underlying roots of the TB epidemic. Medical authorities might have continued to mention the importance of the role of environmental factors, such as overcrowding and poor housing and poor nutrition, but the TB drugs offered too tempting a short-term curative solution to the problem. Moreover, the TB branch incorporated the new scientific developments into their TB management scheme without drastically changing the existing TB infrastructure. Thus, the TB epidemic was never actually controlled through the work of

the Chapel Street TB Clinic and administration centre because this scheme could only ever address part and not the whole of the TB problem.

University of Cape Town

Conclusion

A Clinic Without A Community

As discussed in Chapter One, medical authorities raised considerable concerns about the prevalence of TB in South Africa at the turn of the century. Cape Town was no exception, and, as the oldest port city, had a wide distribution of TB mortality. This had not changed in the 1960s, despite the concerted efforts of the Cape Town TB branch to control pulmonary TB. The fact remained that TB was found wherever it was looked for, especially amongst black Capetonians, and in 1961 it still posed one of the most important public health challenges in the city.¹ This conclusion will firstly discuss Cape Town's status as a TB hot-spot and will look at the role that the Chapel Street TB Clinic played in this context. The second part of this section will discuss the Chapel Street TB Clinic's contribution to TB management in the city. Lastly, the significance of the Chapel Street TB Clinic will be discussed, and will be placed in the context of the second epidemic wave that hit the city from the 1960s onwards.

Cape Town has been a TB 'hot-spot' since the turn of the twentieth century. This is seen in the high TB mortality rates that first came to light with the compulsory recording of births and deaths in the city in 1895. In looking at how Cape Town remained a TB hot-spot through the twentieth century the actions of the City Council come under the spotlight. A unifying theme of this thesis has been the gap between the rhetoric of social reform and the implementation of a more narrowly focussed medical response by public health officials to the epidemic. Cape Town's medical authorities continued to emphasise

the importance of socio-economic conditions although they promoted medical solutions.

The Chapel Street TB Clinic provides an important lens through which to view this response because its history also provides some insight into why Cape Town has remained a TB hot-spot.

In the 23 years covered by this study, the Chapel Street TB Clinic and Administration Centre grew into a well-known central hub for municipal anti-TB work in Cape Town. Under Dr Hoole's direction (1938-1964), the city's TB branch witnessed a period of rapid change, from the small Newmarket Street TB Clinic to the creation of the Chapel Street TB Clinic complex. The TB branch incorporated the new methods of diagnosis and TB treatment wherever possible. This is seen in the diagnosis of TB being speeded up with the purchase of the mass radiography machine in 1948 and the expansion of the TB branch's case-finding abilities with mass X-ray drives. In terms of TB treatment, the work of the Chapel Street TB Clinic and Administration Centre was revolutionised with the ability to offer effective TB drug treatment on an out-patient basis from the early 1950s. Yet, despite the City Council's expenditure, and the considerable commitment and conviction of the Chapel Street staff, the TB branch did not solve Cape Town's TB problem, an outcome that is highlighted by Cape Town's current status as a TB hot-spot.

In discussing the history of the Chapel Street TB Clinic and Administration Centre it is evident that, while the Clinic scheme provided a much needed service to the tuberculous poor, it fell short of its own goals. This failure was due to a number of reasons. Firstly, from the very beginning, the gap between the rhetoric of social reform and the narrow

¹ Report of the MOH, 1961, p.47.

medical focus of the TB scheme undermined the work of the Chapel Street TB Clinic and Administration. Successive MOH's and Dr Hoole noted the close connection between TB and poverty, but their actions on this basis were curtailed. Most importantly, the government was both unable and unwilling to foot the bill for the necessary social reforms. Another factor, much lamented by some medical officers, was that industry did not take responsibility for its workers in terms of adequate wages, meals at work and housing. Furthermore, the social revolution required to improve living standards for all Capetonians was not a palatable option for those citizens who benefited from the existing social structure, which was stratified by race, gender and class.

Shadick Higgins's conviction that TB could not be controlled by medical means alone is seen in his encouragement of the voluntary TB Care Committee, in line with the Edinburgh scheme. As discussed in the previous chapters, the TB Care Committee closely followed the recommendations of the TB Officer and attempted to provide a social service for TB patients that complemented the curative work of the TB clinics. The Care Committee's focus changed over time, from the provision of support for TB patients returning from in-patient treatment at the Nelspoort Sanatorium, to the welfare support of TB patients who received out-patient care. The Committee continued to emphasise the importance of helping TB cases to recover from the disease and to regain their financial independence. Yet the Committee's efforts proved to be too small in the face of Capetonians increasing poverty. The Committee, more often than not, found itself providing desperately needed welfare assistance for TB cases and their families to subsist on, without being able to change the family's unfavourable home conditions. However,

despite these difficulties, it should be noted that the Committee case worker, like the TB health visitors, did play an important role in establishing a supportive relationship with TB patients and their families, possibly offering much-needed emotional, if not sufficient financial, assistance.

Yet, even though Shadick Higgins's projected TB scheme for Cape Town included the rhetoric of social reform and the aid of the TB Care Committee, anti-TB efforts remained well within a medical, curative context. Shadick Higgins's TB report for Cape Town in 1938 reveals that he envisioned a 'comprehensive' anti-TB scheme run on international lines, but the social welfare aspects of this plan never challenged the political status quo. He set the goal of controlling TB through a system that used the TB clinic as the central point of TB diagnosis and as a "Clearing house" from where TB cases were referred to TB hospitals and sanatoria for suitable in-patient treatment. Yet, this is where his medically orientated scheme failed.

The Cape Town City Council was not able to cope with the expenditure that the building and maintenance of TB hospitals required. Consequently, although some provision was made for TB in-patient treatment, the city suffered from a serious shortage of beds throughout the period under review. Even if the value of TB in-patient treatment prior to the discovery of effective TB drugs is debated, the shortage of hospital beds does represent a failure according to the plan that Higgins envisioned. Moreover, the lack of TB accommodation meant that the TB clinic system carried a greater burden in out-patient TB treatment and care. This led to the TB clinic resorting to a system of

domiciliary TB treatment prior to the discovery of effective TB drugs. Therefore, a history of the TB branch reveals that, although a comprehensive anti-TB scheme was envisioned, it was only partly achieved.

The shift from the ideal of in-patient TB treatment to the treatment of TB cases on an out-patient basis brought with it a number of problems. As mentioned in Chapter Three, the home circumstances of TB patients came under the spotlight and the role played by poor social conditions in the persistence of TB amongst Capetonians was more clearly realised. The provision of social welfare could not remedy the underlying causes of this poverty, which were based in the political and economic realities of Cape Town society. This led to a Catch-22 situation, where the Care Committee and City Council attempted to provide some assistance for the tuberculous needy without ever materially altering the conditions that made them vulnerable to TB in the first place.

The new TB drugs also brought with them complex problems of drug resistance and an even greater need for patient compliance than ever before. This added a new burden of responsibility on the system of domiciliary visiting by TB nurses and the clinic's system of TB case-holding. Moreover, if TB patients did not complete their course of therapy, they posed a double danger, in that they were not only infectious but could also pass on drug resistant TB. In addition, the TB drugs helped to keep infectious TB cases alive without the guarantee that they were not infectious. Certainly this accelerated the decline in the city's TB mortality rate for all races from the 1960s onwards, giving the illusion that TB was under control.

However, by the mid-1950s the TB Officer admitted that the TB mortality rate could no longer be used as an accurate yardstick with which to judge the city's anti-TB scheme. The declining TB mortality rates did not translate to a decrease in TB incidence rates. As mentioned in the previous chapter, it created a reservoir of TB chronics who survived without recovering and who served as foci of the disease. Thus, the TB bacillus was more prevalent in communities least able to withstand persistent exposure to TB. Labouring under conditions of poverty, with poor housing, overcrowding, inadequate food and periods of unemployment, black Capetonians proved more susceptible to TB infection or re-infection. The double bind was that although Capetonians were no longer dying from TB, they were still spreading the disease.

The Chapel Street TB Clinic's role in controlling the TB epidemic in Cape Town can be more accurately measured in terms of its goal of finding TB cases in the early stages of the disease in order to curb its spread. In this respect the Chapel Street TB Clinic and Administration did achieve some measure of success. This is seen in a reduction of the numbers of TB cases who were either very ill and 'bedfast' or dead on notification to the TB branch. These figures dropped steadily from 1945-46.² In that year, 7.7% of all notified TB cases were very ill and 'bedfast' when they came to official attention, and 13.6% of all notified cases were only notified as tuberculous after death,³ as compared to

² See: Figure 10.

³ Report of the MOH, Cape Town, 1945/1946, p.35.

0.2% and 1.3% in 1964.⁴ However, these figures do not reveal the numbers of Africans who were repatriated or left for rural areas of their own accord once they became ill.

In conclusion, the City Council had to make the best of available resources and redirect the TB scheme in order to accommodate the large number of poor TB patients in the city. If it was paradoxical that the city's efforts to control TB were actually limited to medical solutions while underlying social conditions were acknowledged, it was even more so that they were not even able to fully implement the medically focussed scheme that had been envisioned. The Cape Town City Council's efforts to control TB through the Chapel Street TB Clinic and Administration Centre were ultimately undermined on a number of levels. The gap between the rhetoric of social reform and the application of medical solutions to the TB problem remained a weakness throughout the period from 1941 to 1964. This led to the medical treatment of TB patients being hampered by their socio-economic conditions, as discussed in Chapter Three. Furthermore, the Chapel Street TB Clinic's work was hampered by the central government's actions. With insufficient funding, the TB Clinic system was heavily relied on to cope with a TB epidemic on medical lines but without a fully-fledged medically-orientated infrastructure, seen in the constant lack of hospital beds for TB patients. Moreover, the central government's political policies of forced removals and migrant labour exacerbated the conditions that made black people vulnerable to TB. Thus, even if the Chapel Street TB Clinic and Administration Centre had been able to deal with the TB cases that passed through the doors of its clinics by purely medical means, the medically focussed TB clinic scheme

⁴ Report of the MOH, Cape Town, 1964, p.58.

would never have been able to effect the basic socio-economic changes that were actually necessary to control and eventually eradicate the city's TB epidemic.

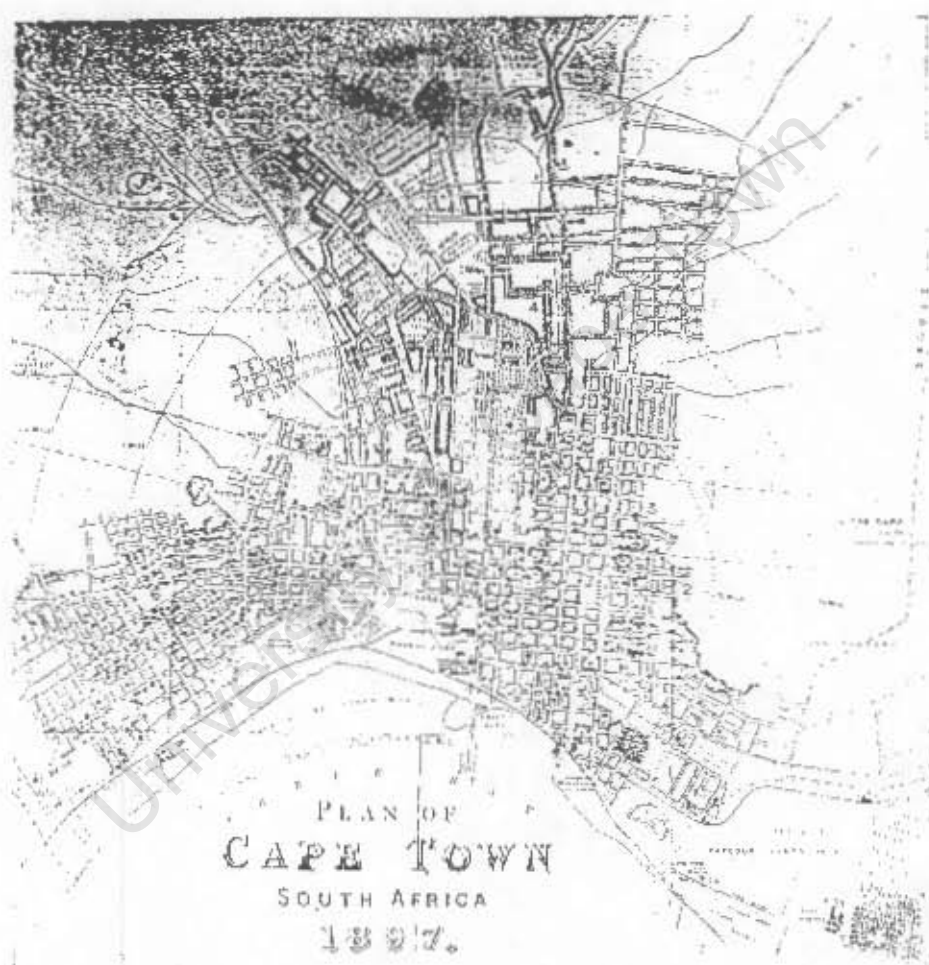
University of Cape Town

Appendix

Figure 1.

Map Showing the Distribution of TB Mortality in Cape Town
from July 1895 to June 1898

The Corporation of the City of Capetown.



Shewing distribution of Deaths from Tuberculosis in Capetown during three
years (July 1st, 1895, to June 30th, 1898)

(Source: Report of the MOH, Cape Town, 1899.)

Figure 2.

Map Showing the Suburbs of Greater Cape Town, 1981



(Source: Report of the MOH, Cape Town, 1981, p.12.)

Figure 3.

Entrance to an Unidentified TB Clinic

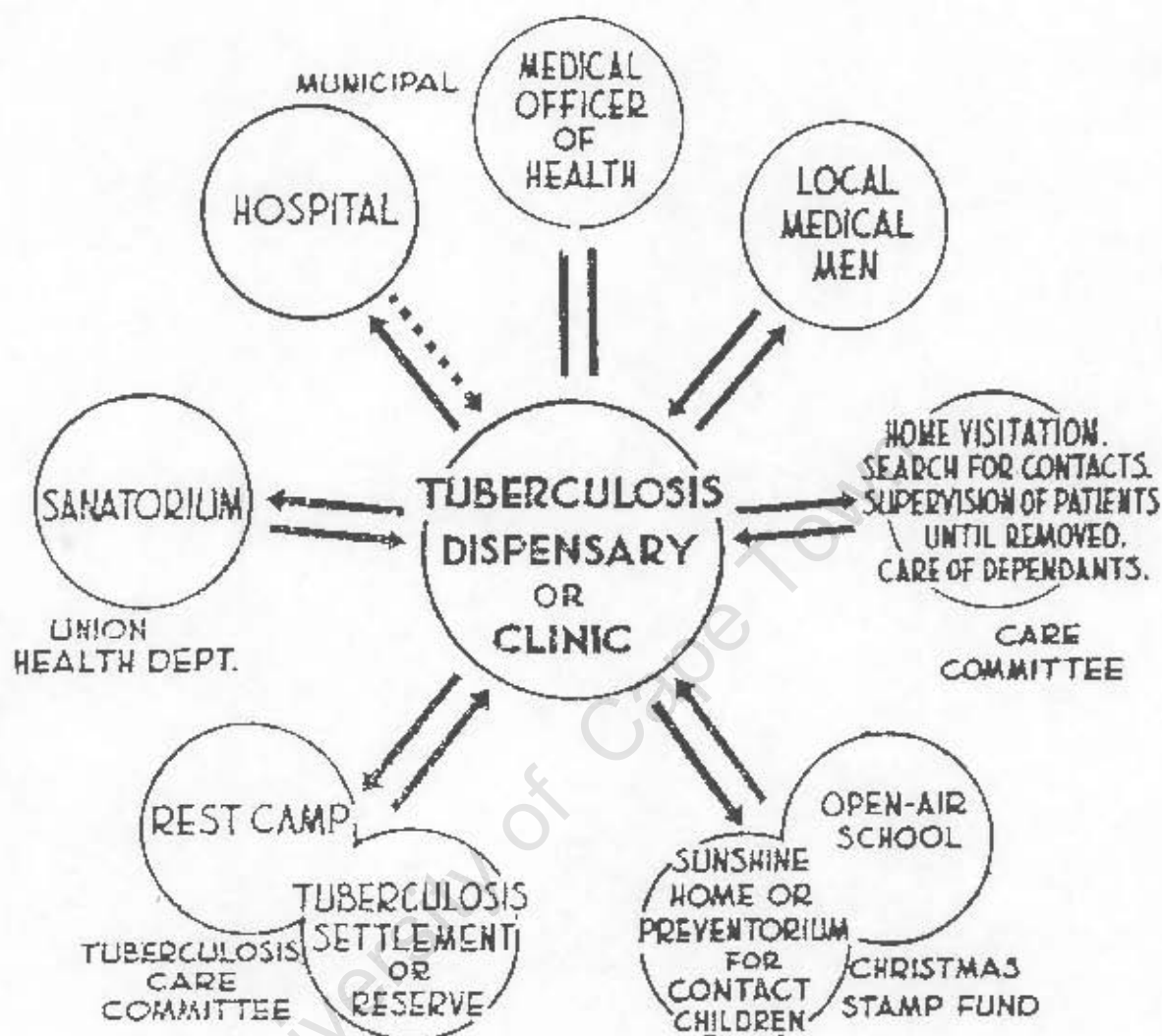


Taking the clinic times and the street number above the door into account, it is highly likely that this is a photograph of the TB Clinic at 50 Newmarket Street, c1929-1941.

(Source: National Library, Cape Town, ref: PHA "Cape Town, Social Conditions, 1939".)

Figure 4.

The Edinburgh Plan



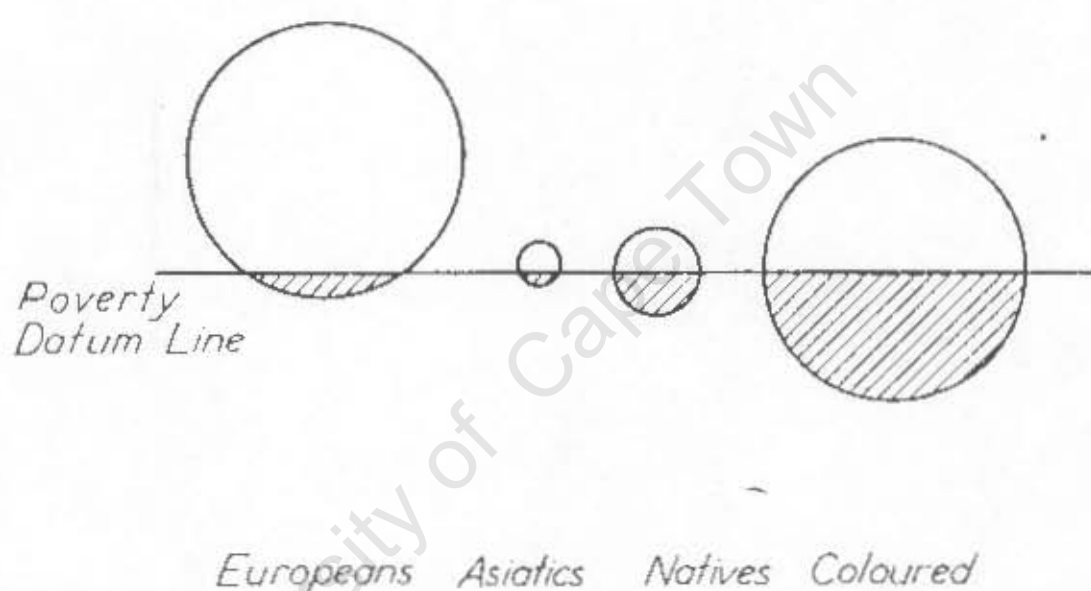
**A CO-ORDINATED SCHEME FOR
TUBERCULOSIS CONTROL.**
"The Edinburgh Plan"

Fig. 1.

(Source: D. P. Marais, "The Co-ordination of Effort in Tuberculosis Control in South Africa". SAMJ (14 November 1936). p.738.)

Figure 5.

Depiction of Poverty in Cape Town According to Race, c1938/39

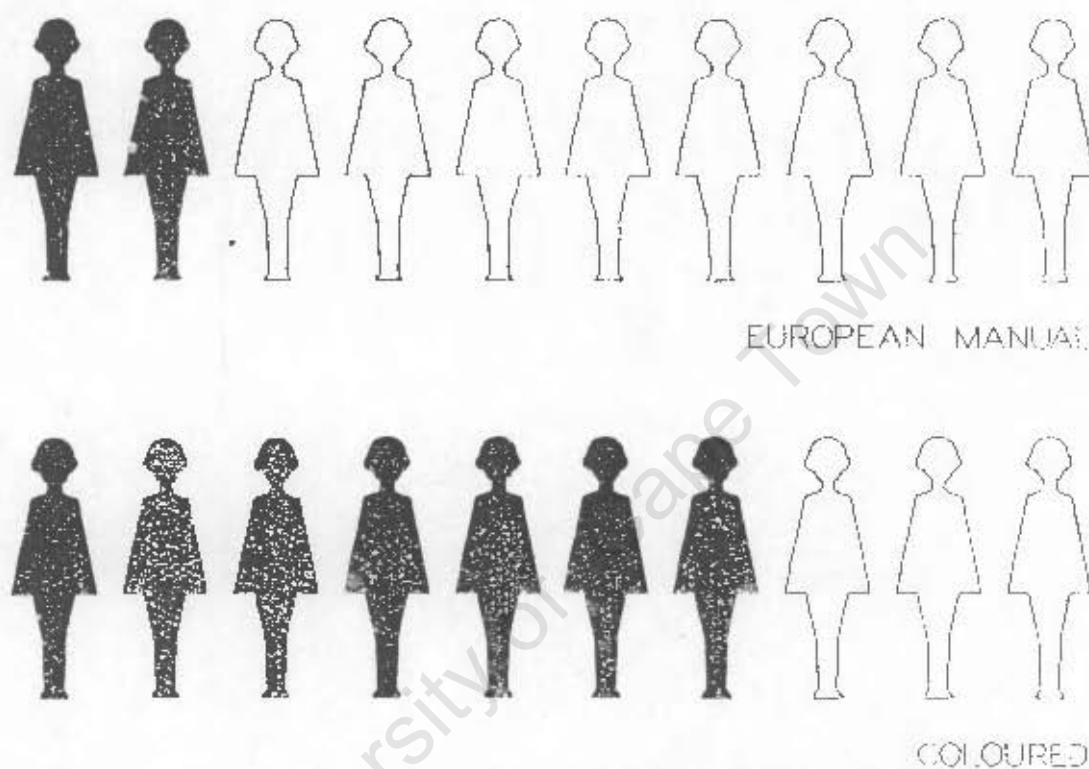


The figure shows the socio-economically submerged proportions of the several ethnic groups.

(Source: E. Batson, Official Report of the Social Survey Conference (Cape Town, 1942), p.34.)

Figure 6.

Child Poverty in Cape Town, 1938/39



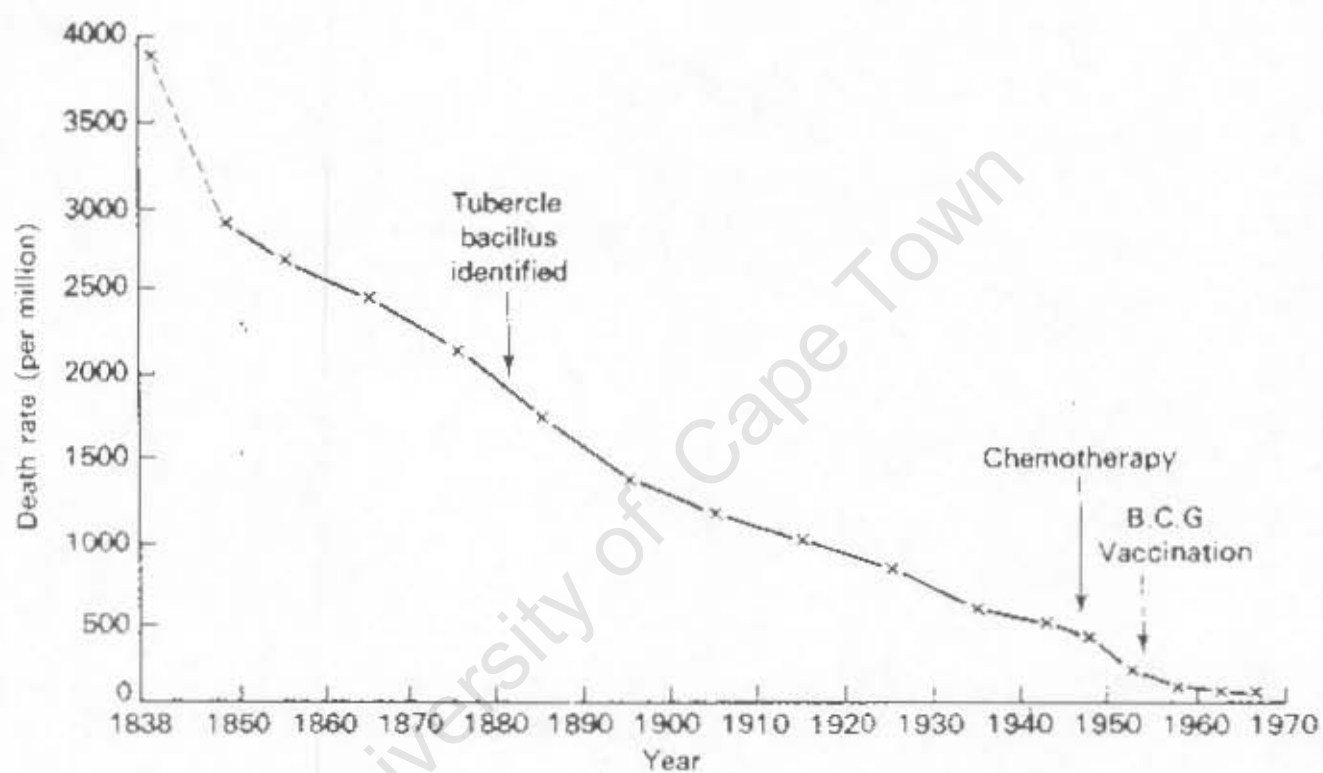
CHILD POVERTY IN CAPE TOWN.

According to figures compiled by Miss E. Parlo from Social Survey data, two in every ten children of European manual workers are below the Poverty Datum Line, seven of every ten Coloured children.

(Source: E. Batson, Official Report of the Social Survey Conference (Cape Town, 1942), p.35.)

Figure 7.

McKeown's Graph Showing Respiratory TB Mortality in England and Wales:
1838-1970

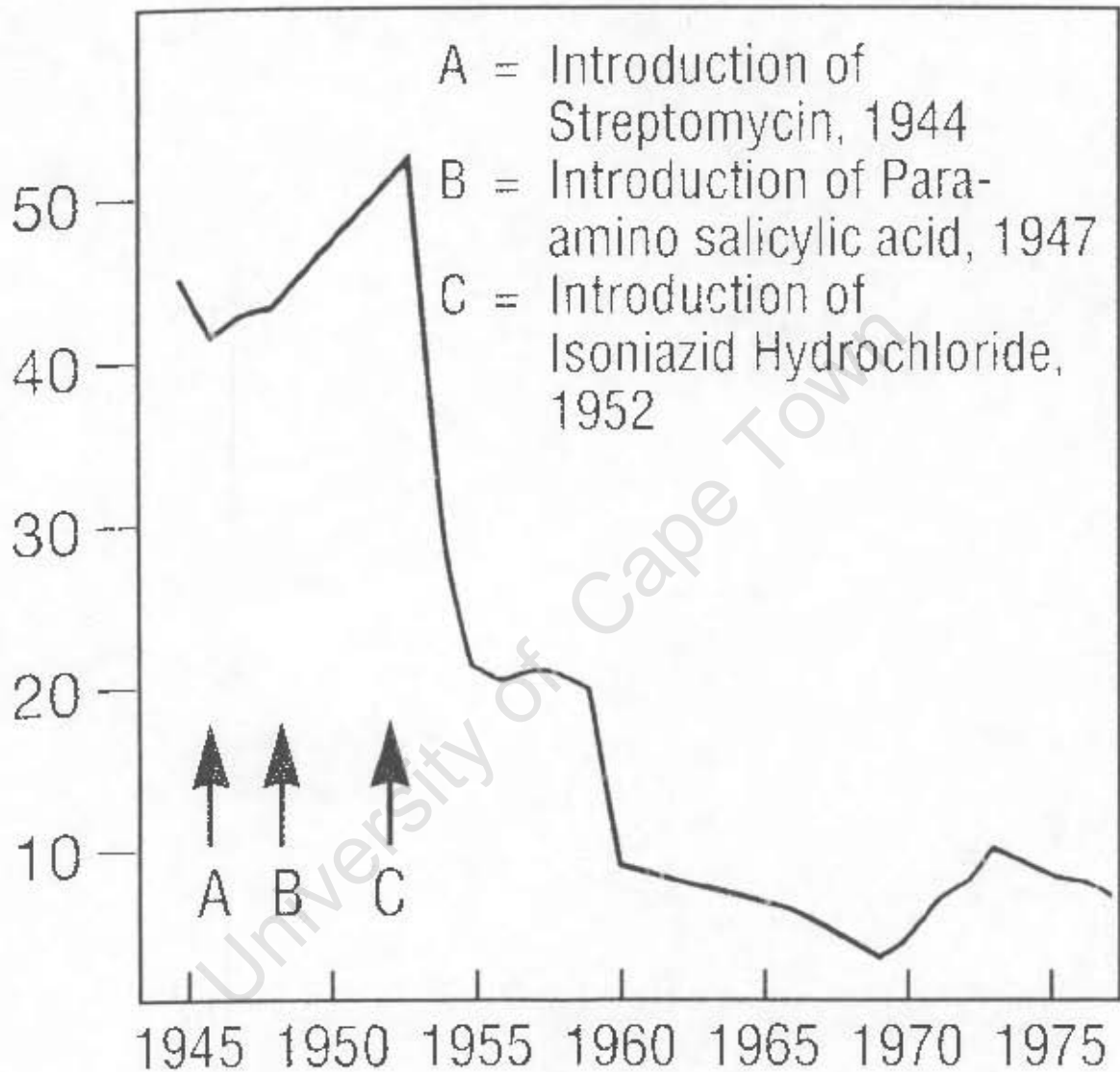


Respiratory tuberculosis: death rates, England and Wales.

(Source: T. McKeown, *The Modern Rise of Population*, (London 1977), p.93.)

Figure 8.

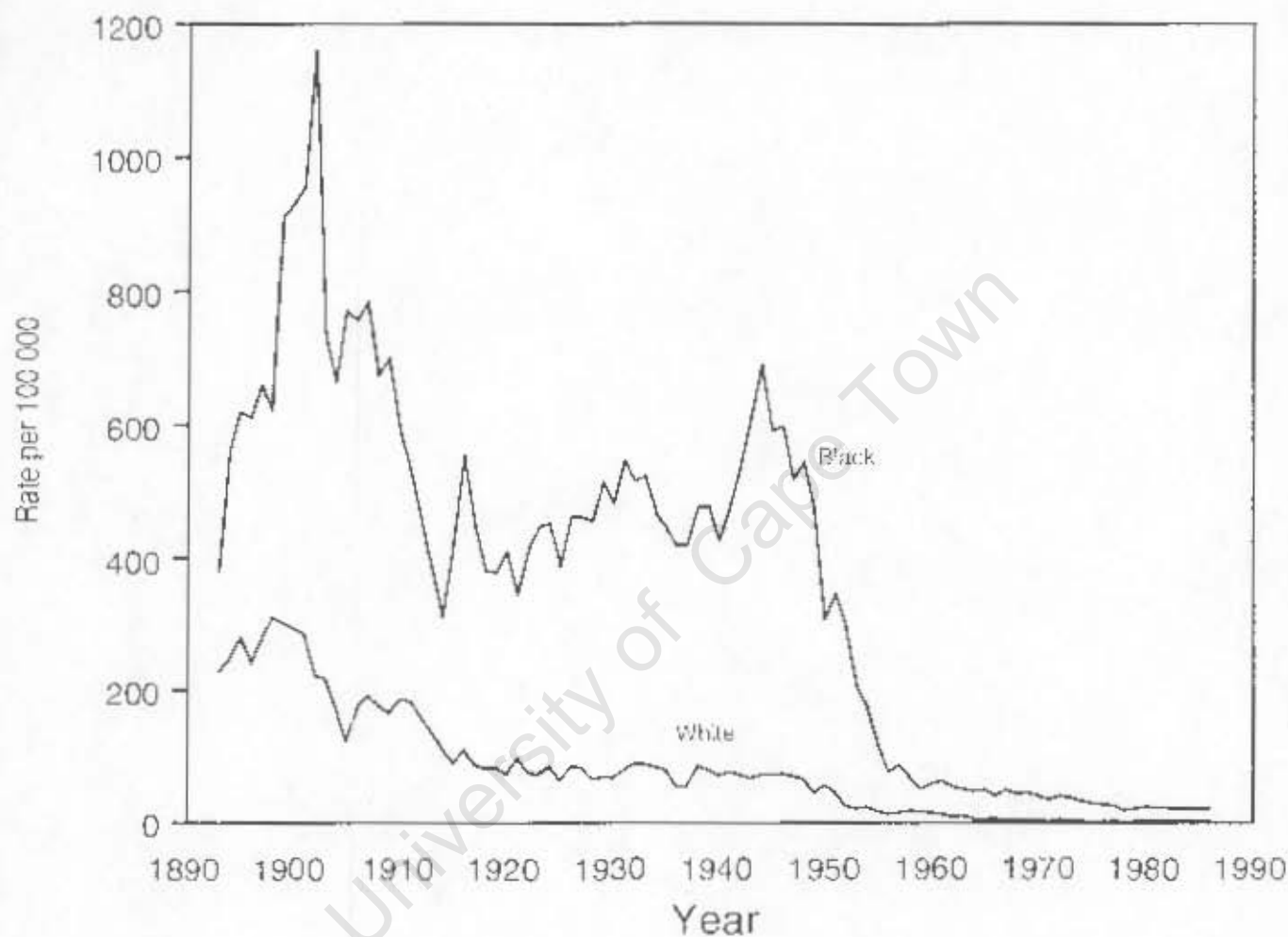
TB Mortality Rates in South Africa, 1945-1977



(Source: H. Kustner, "Trends in Four Major Communicable Diseases". *SAMJ*, vol. 55 (1977), quoted in C. Metcalf, "A History of Tuberculosis", in H. M. Coovadia and S. R. Benatar, *A Century of Tuberculosis: South African Perspectives* (Cape Town, 1991), p. 27.)

Figure 9.

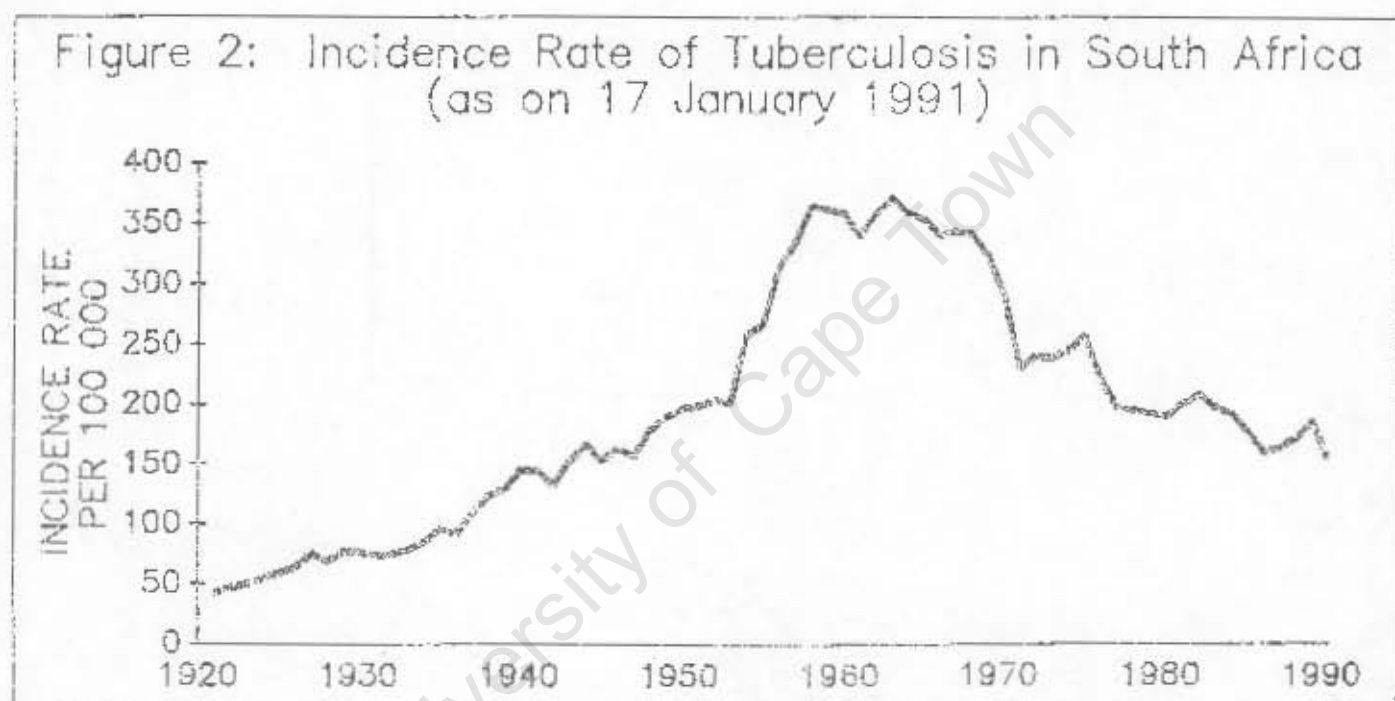
TB Mortality Rate in Cape Town, 1893-1986



(Source: K. Styblo, "Surveillance of Tuberculosis", *International Journal of Epidemiology*, vol. 5 (1976) (sic), pp.63-68, quoted in P. M. Strebel and J. R. Seager, "Epidemiology of Tuberculosis in South Africa" in H. M. Coovadia and S. R. Benatar (eds.), *A Century of Tuberculosis: South African Perspectives* (Cape Town, 1991), p66.)

Figure 10.

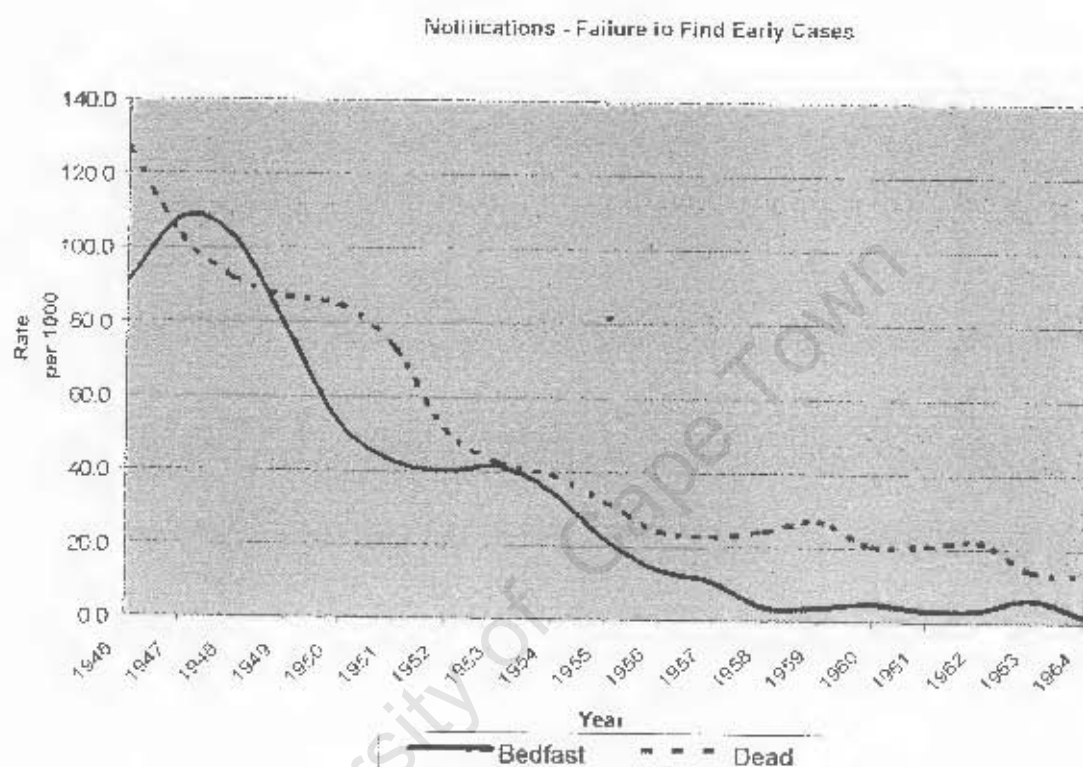
TB Incidence Rate in South Africa, 1920-1990



(Source: H. Kustner, "Tuberculosis in the Cape Province", *Epidemiological Comments*, vol. 18, no. 1 (January 1991), p.4)

Figure 11.

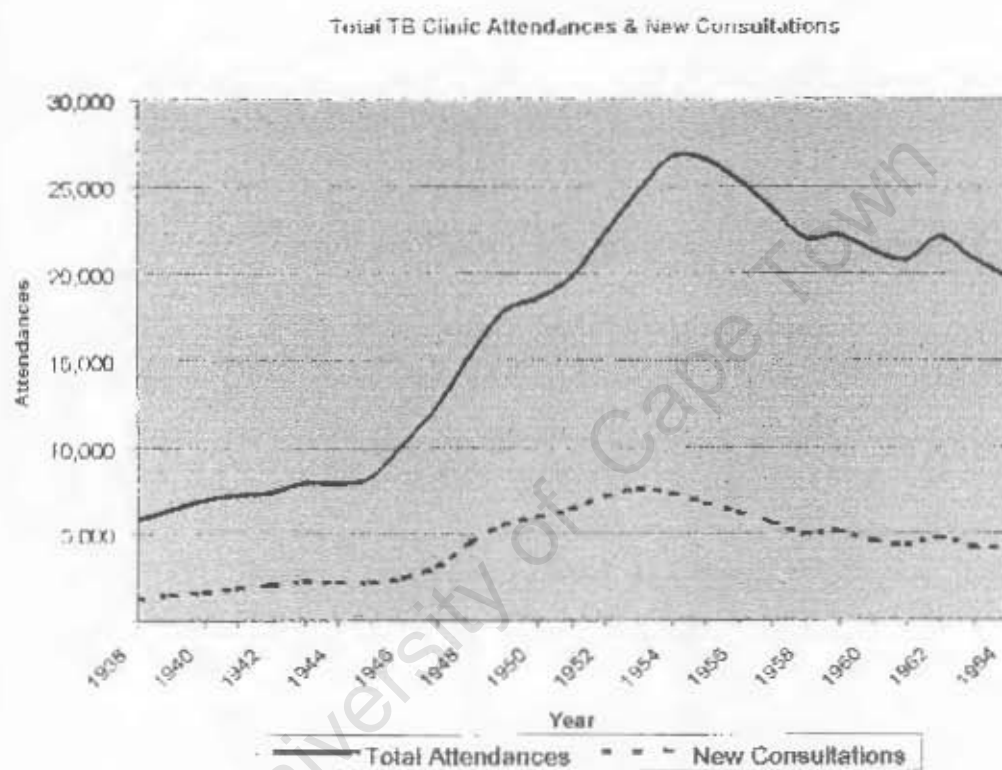
TB Notifications in the Cape Town Municipal Area: Failure to Find the Early and Infectious TB Case, 1945-1964



(Source: Reports of the MOH, Cape Town, 1945-1964.)

Figure 12.

Chapel Street TB Clinic: Attendances and New Consultations, 1937-1964



(Source: Reports of the MOH, Cape Town, 1937-1964.)

Figure 13.

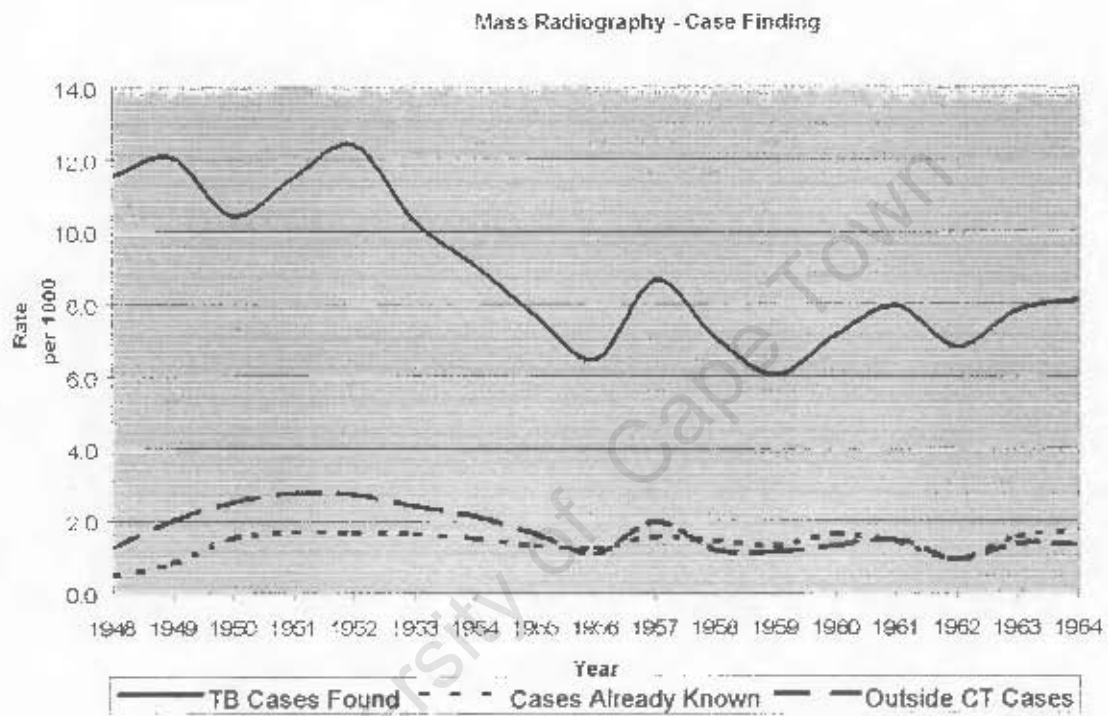
**Chapel Street TB Clinic:
New Consultations as a Proportion of Total Attendances, 1937-1964**



(Source: Reports of the MOH, Cape Town, 1937-1964.)

Figure 14.

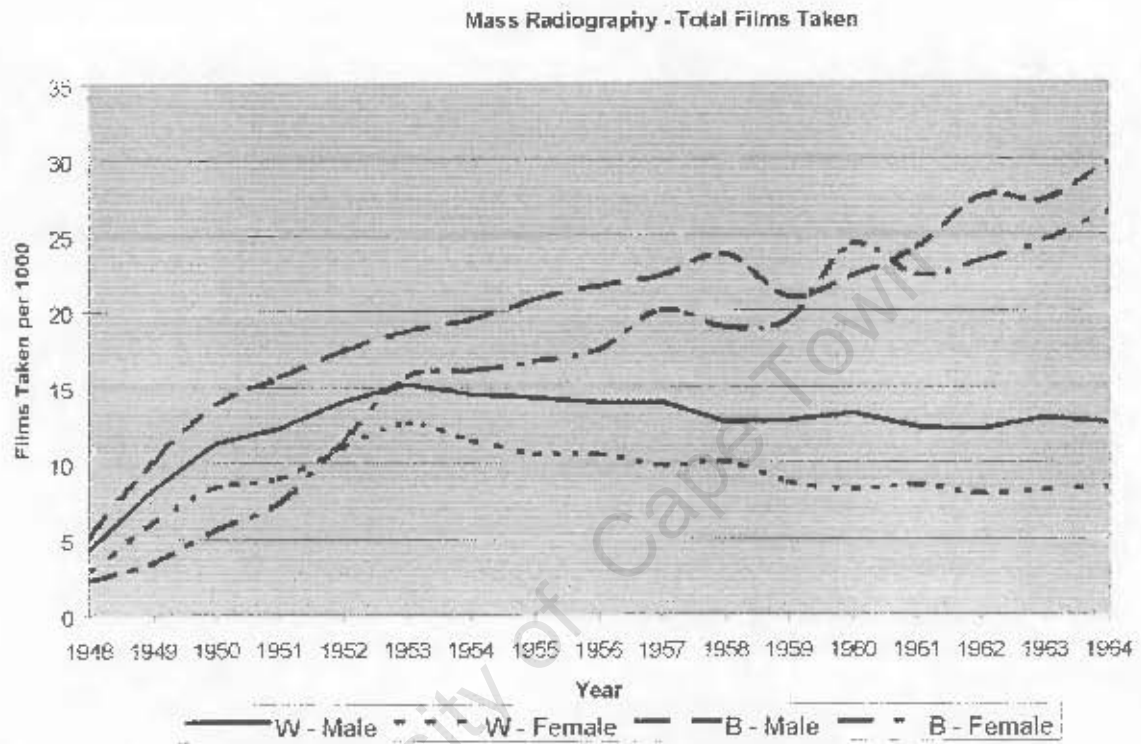
Chapel Street Mass Radiography: Case Finding, 1948-1964



(Source: Reports of the MOH, Cape Town, 1948-1964.)

Figure 15.

Chapel Street Mass Radiography: Total Films Taken, 1948-1964



(Source: Reports of the MOH, Cape Town, 1948-1964.)

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Dr H. R. Ackermann
 Dr I. Combrink
 Dr Durcan
 Mrs. L. Fortune
 Mrs R. Grant
 Mr. M. O' Leary

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Dr H. R. Ackermann, 4 August 2000

Re: his recollections of Cape Town's TB epidemic, surgical TB treatment through APT, the advent of Streptomycin and other TB drugs, and the Chapel Street TB Clinic while he was employed as a TB Officer.

Dr I. Combrink, 12 December 2000, District Six Museum, Cape Town

Re: his recollections of District Six, TB and the Chapel Street TB Clinic.

Dr Durcan, 18 July 2000, Chapel Street Clinic

Re: informal discussion about her recollections of the Chapel Street TB Clinic, and observation of her work with TB patients at the Chapel Street Clinic.

Mrs L. Fortune, 29 November 2000, District Six Museum, Cape Town

Re: her recollections of District Six, TB and the Chapel Street TB Clinic.

Mrs R. Grant, 12 October 2000, TB Care Offices

Re: her recollections of Chapel Street TB Clinic while she was a TB nurse working at Chapel Street TB Clinic and about her subsequent work as a case worker for the TB Care Committee.

Mr M. O' Leary, 25 January 2001

Re: his recollections about the Chapel Street TB Clinic and about his employment as an administrative clerk, and his move from Chapel Street Clinic due to promotions within the Cape Town City Health Department.

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