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Tuberculosis and Migrant Labour in the High Commission Territories: Bechuanaland: 1885–1998

Britain acquired the High Commission Territories (HCTs or protectorates) of Bechuanaland (Botswana), Basutoland (Lesotho) and Swaziland (eSwatini) largely as a result of conflict with the Boer Republics around the turn of the twentieth century. The Territories were poor, had dispersed rural populations and few natural resources. Britain was determined to keep the costs of its empire to a minimum. It administered the HCTs on the principle that expenditure should not exceed the revenue obtained through taxation and made little investment in basic services and infrastructure. Generating sufficient revenue was a constant problem. In 1929, for example, administrative costs absorbed 79 per cent of Bechuanaland's total government expenditure.[1] The South Africa Act of 1909 provided for the eventual transfer of all three territories to South Africa so long as *native interests* were protected, and successive South African governments made every effort to promote that transfer. Constitutional advances were slow after the Second World War, and the

[1] J.E. Spence. 'British Policy Towards the High Commission Territories'. *The Journal of Modern African Studies,* Vol. 2, No. 2, 1964, p. 230.

J. McCulloch, P. Miller, *Mining Gold and Manufacturing Ignorance*,
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perceived legitimacy of South Africa's repeated claims that the HCTs were part of the Union diminished with the advent of apartheid.[2]

There was little coordination between the Territories, which were run as separate administrative units. The High Commissioner resident in South Africa had final responsibility for the HCTs. Resident Commissioners controlled the day-to-day administration in each Territory. As heads of government, the governors of the HCTs could initiate policies, share in their implementation and preside over the executive council. In practice those powers were circumscribed by the Colonial Secretary who had to approve the colonies' annual budgets and could veto legislation. In addition, not least because of the need for British policy to conform to ILO conventions, most labour policy was decided in London. Despite those constraints, the slowness of communications and lack of central capacity meant that most governors had a good deal of independence. As late as 1914 the Colonial Office had a staff of less than 140, and of necessity British colonial policy favoured decentralisation.[3]

The High Commissioner's role was politically sensitive as he had to oppose Pretoria's discriminatory policies, resist its demands for the incorporation of the HCTs into the South African Union and maintain smooth relations between Britain and South Africa. Reconciling those interests was made more difficult by the Territories' dependence on selling labour to the mines. In addition to the income from capitation fees paid by the WNLA and the NRC and the repatriation of wages, migrant labour simplified tax collection. Some men paid their tax out of the advance they received in signing on; the arrears of others were collected on pay days by HCT representatives in Johannesburg.[4] The permanent suspension of recruiting would have created serious political and economic problems for the High Commissioner's office. The negative impact of the mines on public health was referred to regularly by medical

[2] See David E. Torrance. 'Britain, South Africa and the High Commission Territories: An Old Controversy Revisited'. *The Historical Journal*, Vol. 41, No. 3, 1998, pp. 751–772.

[3] On the day-to-day workings of the empire see L.H. Gann and Peter Duignan. *The Rulers of British Africa 1870–1914*. London: Croom Helm, 1978.

[4] Spence, 'British Policy Towards the High Commission Territories', p. 229.

officers and district commissioners, but after the ban on Tropical recruiting was lifted in 1938, such references all but disappeared from the Resident Commissioners' correspondence.

To a large extent, the interests of the Resident Commissioners and the Chamber coincided. The HCTs were starved of funds for essential services, and they soon became dependent upon the revenue from contracting labour to the gold mines. Selling migrant labour, however, came at a cost. From as early as 1912, the annual medical reports from the three Territories suggested that the mines were spreading tuberculosis into vulnerable populations. The correspondence from the Departments of Health, Native Commissioners and the Resident Commissioners' Offices reveals that the WNLA and the NRC were doing so without making any effort to reduce the impact of this entrenched practice. In fact, the Chamber's secrecy regarding repatriations was characteristic of recruiting throughout the colonial period. Medical repatriations were one of the obvious costs of a system in which a physical elite travelled south and, having served their contracts, returned home seriously ill. Another point of dispute, discussed in the next chapter, was the WNLA's refusal to pay pensions in place of lump sums to that small number of men compensated for occupational disease.

Taxation and Mining

Bechuanaland (now Botswana), a large territory with low rainfall and much desert, was proclaimed a British Protectorate in 1885, as part of an effort to prevent Boer settlers establishing Afrikaner states in Tswana territory.[5] The Protectorate covered a vast land mass with a rudimentary road and rail system. On European maps, it is divided in half by Latitude 22° South. To help defray the costs of colonial administration, in 1899 a Hut Tax ranging from 5s to 10s per annum was imposed on all adult males, with substantial penalties for non-payment. Chiefs were made tax collectors and received a 10 per cent commission. Since there were few alternative sources of cash, they encouraged men to go to the mines. In

[5] Torrance, 'Britain, South Africa and the High Commission Territories', p. 753.

1904, the Protectorate's major revenue streams consisted of an Imperial Grant in Aid of £15,000 and a Hut Tax of £11,500. Over the years, the Hut Tax was raised. From 1919, Hut and other Native Taxes became the largest components of recurrent revenue.[6] As locals tried to cram more people into each hut to minimise their tax liability, overcrowding intensified the risk of TB infection.[7]

In 1899, in order to counter abuses of labour, the Bechuanaland administration issued a Proclamation to regulate recruiting. That was followed in 1907 by a law requiring the attestation of all labour contracts for working *outside* the territory before a government officer. That legislation, which was more progressive than the labour laws operating *within* the Protectorate, gave men a further incentive to go to the mines. In Bechuanaland itself, a version of the draconian Masters and Servants Act of the Cape of Good Hope (No. 15 of 1856) was still in force in 1949. Under that Act all (non-white) employees were required to give notice before leaving an employer, and the abandonment or desertion of employment without notice was an offence punishable by fine or imprisonment.[8] Whatever the legal framework, there were few opportunities in Bechuanaland for wage labour, which in any case offered far lower pay than the Johannesburg gold mines. In 1913, when the Union government imposed a ban on the recruitment of Tropical labour, recruiting to the gold mines was focused on the southern part of the Protectorate. For the following 24 years, Bechuanaland lay at the centre of the Chamber's efforts to have the ban lifted.

The end of the First World War saw an increase in the number of men leaving Bechuanaland in search of work. At the beginning of 1924, the mines extended their normal period of contract from six to nine months. Four years later, the Assisted Voluntary Scheme (AVS) was introduced. Recruits were given an advance to meet their rail fare and on arrival in Johannesburg were free to select an employer. The AVS also enabled men

[6] Dile Delarey Kote, Recruitment of Mine Labour in Botswana 1899–1945, B.A. (History) thesis, University of Botswana, Lesotho and Swaziland, 1976, pp. 20–22.

[7] Packard, R.M. *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa.* Berkeley: University of California Press, 1989, p. 102.

[8] See Letter from G. Nettleton, Government Secretary, Mafeking, to the High Commissioner, Cape Town, 15th March 1949. BNA S117/1/3. Labour Native, 1949–53.

to work for a shorter period than the normal nine months' contract. Under the bonus system, men who returned to the mines within four months were taken on again at the same rate of pay as when they left, instead of starting again at the minimum.[9]

The 1921 Bechuanaland census showed a population of 150,185 blacks and 1743 whites. Population density was very low. The low rainfall meant that only one-tenth of the land was suitable for cultivation. Villages congregated where there was water, but it was difficult to cultivate vegetable or fruit gardens. Meat, which at one time was easily obtained by hunting, had become a luxury.[10] The cattle posts and farmlands where milk and fresh fruit were available were so far from the villages that most of the population was malnourished. By 1930, migrants' wages were the most important source of family incomes, and it could be catastrophic for a man to fail the entry medical.[11] In 1938 in the Kweneng District, where several decades later Steen and his colleagues conducted their path-breaking study of occupational lung disease, more than £20,000 in remittances flowed from the gold mines, and nearly half of that sum went to pay the Native Tax.[12] Such heavy reliance on oscillating migration—and the necessity to pay taxes to the colonial administration—transformed the whole country from a self-supporting agricultural economy into a labour reserve.

When, in September 1938, the British Secretary of State asked Colonial governments to consider setting up machinery for regulating and monitoring labour conditions, the Bechuanaland Resident Commissioner declined. Secretary of State MacDonald pointed out that the far-reaching economic and social changes sweeping the empire were bringing

[9] I. Schapera. 'Migrant Labour and Tribal Life: A Study of Conditions in the Bechuanaland Protectorate'. Report Presented to the B.P. Administration, Public Records Office, DO 119 1268 Schapera, 1944, pp. 71–72.

[10] *Annual Medical & Sanitary Report, 1930*. Bechuanaland Protectorate, p. 18. BNA S88/9 Annual Medical Report, 1930.

[11] See Julie Livingston. 'Physical Fitness and Economic Opportunity in the Bechuanaland Protectorate in the 1930s and 1940s'. *Journal of Southern African Studies,* Vol. 27, No. 4, 2001, pp. 793–811.

[12] M. Leepile. 'The Impact of Migrant Labour on the Economy of Kweneng 1940–1980', *Botswana Notes and Records,* Vol. 13, 1981, p. 34.

potential conflict between employers and workers.[13] Those changes made labour departments an important sector of government. In reply, the Resident Commissioner Forsyth Thompson noted that the amount of labour employed *within* Bechuanaland was too small to warrant a special labour department. Besides, the High Commission Territories were unique among the Colonial Dependencies in that practically all their wage labour was employed *outside* their borders in South Africa. Consequently, the general supervision of employment and worker welfare was in the hands of the Union Government rather than the Protectorate.[14]

The impact of increasing labour migration on food production and people's health soon became obvious. In his review of health services in the Protectorate in the mid-1930s, Sir Walter Johnson found the physique of the Bechuana poor compared with that of South Africans. The principal cause was malnutrition. The normal diet was inadequate: 'Besides the lack of protein of good biological value the native of Bechuanaland is living on the verge of vitamin deficiency which shows itself from time to time in outbreaks of scurvy'.[15] From the time a child was weaned, its diet during most of the year consisted almost entirely of mealie meal and millet porridge.[16] With the exception of chiefs and a few headmen, it was difficult or impossible for the bulk of the population to obtain milk.

Initially, transport costs were recovered from the miners, but from 1934 the ILO insisted that travelling expenses be paid by the recruiter or employer. In 1939 the WNLA and NRC agreed to bear the cost of rail fares *to* the mines. However, repatriation costs continued to be paid by the miners. Men from the north were also charged 30s for trousers, a vest and blankets, which were deemed necessary for Tropical recruits.[17] The

[13] Circular signed Malcolm MacDonald, The Dispatch, Downing Street, London, 5th September 1938. BNA, S116/3 Labour Supervision.

[14] Letter from A. Forsyth Thompson, Resident Commissioner, Mafeking, to The High Commissioner. Pretoria, 8th November 1938. BNA, S116/3 Labour Supervision.

[15] *Commission of Enquiry into Medical Matters, 1937*, p. 46. BNA S392/7/1.

[16] See *Annual Medical & Sanitary Report, 1930 Bechuanaland Protectorate*, p. 1. BNA S88/9 Annual Medical Report, 1930.

[17] Pauline Cuzon. The History of TEBA in Botswana. unpublished manuscript, July 1985, p. 72.

Native Labour Proclamation of 1941 No. 56 made written contracts and a medical certificate compulsory.[18] In the period from 1938 to 1942, doctors from the Scottish Livingstone Hospital examined 6829 mine recruits at Molepolole and Thamaga. Of that number, 793 were rejected with chest conditions.[19] From February 1949, all medical examinations of men recruited by the NRC were conducted at Mafeking by the Bechuanaland Government Medical Officer. The first 500 examinations in any year were paid for at the rate of 2s 6d per head, and examinations in excess of 500 at 1s.[20] In Bechuanaland deferred pay was voluntary, but the vast majority of men chose to accept it. In 1937, the proportion of men accepting deferred pay was 89 per cent; in 1943, when the average for the Union and High Commission Territories was just under a half, it reached 95 per cent.[21]

In 1937, the Union Government formally removed the prohibition on recruiting from North of latitude 22^0 South. The WNLA was confident that the 'Tropical Areas' would become its main source of additional labour. Northern Bechuanaland was to supply at least 2600 men per annum who, on their return home, would draw a total of £25,000 in deferred pay. The WNLA anticipated that around 10 per cent of men offering for employment would be rejected.[22] Soon after the ban was lifted, C.N.A. Clarke, who had replaced Charles Rey as the Bechuanaland Resident Commissioner, began receiving complaints from Chiefs that too many men were leaving the Reserves. Like his predecessors, Clarke was aware that his administration relied on revenue from migrant labour, but he was also concerned about the social costs of mining employment.

[18] Proclamation No. 56 of 1941, Bechuanaland Protectorate, pp. 14–15, 20. BNA S114-7-2 Labour, Native Recruitment, Bechuanaland, 1937–44. The Proclamation was based on the ILO's Recruiting of Indigenous Workers Convention, 1936 (No. 50) and the Contracts of Employment (Indigenous Workers) Convention, 1939 (No. 64). See also I. Schapera, 'Migrant Labour and Tribal Life, p. 137.

[19] Letter from Dr P.M. Shepherd, Superintending Missionary, Scottish Livingstone Hospital, Molepolole, to the Principal Medical Officer, Bechuanaland Protectorate, Mafeking, 8th March 1943. BNA S438-2-2 Tuberculosis in B.P. 1940–1953.

[20] Letter from District Superintendent, NRC Ltd, to the Director of Medical Services, Bechuanaland Government, Mafeking, 8th February 1949. BNA Med 15/8. Recruits for Mines, Farms, 1947.

[21] Schapera, 'Migrant Labour and Tribal Life', pp. 140–42.

[22] Notes from the WNLA on Tropical Areas Administration, 21st July 1945, W. Jones, District Manager, Francistown, Northern Bechuanaland. BNA S344/10/1, Recruiting north of Parallel 22.

A large proportion of teenage males were at the cattle posts during their school-going years. As soon as they left the posts, many went to work in the mines. As a result, the schools were filled with girls, and a large proportion of young men were illiterate. Clarke wanted a compulsory system of deferred pay to ensure men returned home at the end of their contracts. He also wanted educational facilities for workers at their place of employment and a formal agreement on the repatriation of medical rejects. He hoped to persuade the NRC and WNLA to concentrate on certain specified areas and thus make it easier to monitor the social impact of recruiting.[23]

Tuberculosis was the other subject which was often discussed by the Bechuanaland Native Advisory Council. At a meeting in March 1939, for example, Chief Bathoen (Bangwaketse) noted that many young men were repatriated from the mines with the disease. He pointed out that the number of recorded cases only referred to hospital patients rather than to all of those who were infected. People were suffering, but patients who could not be looked after at home were being rejected at the hospitals.[24] There was a marked increase in admissions during 1939, with Mission Hospitals bearing much of the burden. However, in the absence of isolation wards, tuberculosis cases were advised to live on the lands and not in the villages.[25] Bathoen asked if the government could provide special care at Lobatse and Serowe. S.J. Molema (Barolong) agreed that the tuberculosis figures were alarming. Like Chief Bathoen, he wanted isolation wards where cases could be treated. Lot Moswele (Batlokwa) commented that 'in our childhood days no such disease was known amongst us'. The Principal Medical Officer agreed that the official figures for tuberculosis did not give an accurate picture, as many patients were not reporting to local Medical Officers. While on the mines, migrant workers were fed well, but when they returned home there was the problem of malnutrition. He explained that the government wanted to conduct a

[23] Letter from C.N.A. Clarke, Resident Commissioner, Mafeking, to the High Commissioner, Cape Town, 8th December 1937, pp. 2; 5–6. BNA S114/7/1 Labour Recruitment, Bechuanaland.

[24] Extract from Minutes, 20th Session Native Advisory Council Held 6th to 10th March 1939, pp. 76–77. BNA S438/2/1 Tuberculosis in the B.P., 1938–39.

[25] *Annual Medical and Sanitary Report 1939*, Bechuanaland Protectorate, p. 4. BNA, S397/1/1 Annual Medical Reports 1939–1945.

survey before it invested in prevention and care. He promised to get more information from the WNLA on those repatriated with tuberculosis, so they could be traced.[26]

With the outbreak of the Second World War the competition for labour intensified. The WNLA was pressing for a higher quota, while the Resident Commissioner was anxious to preserve local food production. In order to restrict the flow of men to the mines, Clarke initiated Proclamation No. 56 of 1941, which placed a number of conditions on cash advances, the recruitment of agricultural workers and repatriations.[27] Before the Proclamation came into effect, Mr Gordon Turner of the NRC and Bechuanaland Resident and Assistant Resident Commissioners had met in Mafeking to discuss its likely impact. Clarke acknowledged that the Territory relied on revenue from miners and that it was vital that such revenue continue. The NRC was paying the government a capitation fee of 24s per head, and any curtailment of recruiting after the war would have to be gradual because of the impact on the Territory's economy.[28] Following a heated discussion, Clarke made a number of concessions. He was prepared to grant exemption from the requirement that recruits should not stay away from home for more than 18 months. In contradiction of ILO conventions, Clarke also agreed that the NRC and the WNLA would be exempt from paying the recruits' travel costs. By December 1942, it was estimated that 15,000 men were working on the Rand and probably another 20,000 on South African farms and in other South African industries. That represented well over a half of the Protectorate's 60,000 (male) taxpayers, and according to the Government Secretary, the labour exodus was disrupting family life.[29]

The one area in which the Bechuanaland administration refused to cooperate with the WNLA and the NRC was over their demands to

[26] Extract from Minutes, 20th Session Native Advisory Council, pp. 75–78.

[27] Proclamation No. 56 of 1941, Bechuanaland Protectorate, pp. 14–15, 20. BNA S114-7-2 Labour, Native Recruitment, Bechuanaland, 1937–44.

[28] Notes of Discussion at Mafeking on 10 October 1941, between the Resident Commissioner, the Assistant Resident Commissioner and Mr Gordon Turner of NRC to consider aspects of Proclamation No. 56 of 1941. BNA. S114-7-2, 1937–44, Labour, Native Recruitment, Bechuanaland.

[29] Memo from the Government Secretary to A.D. Forsyth Thompson, Resident Commissioner, Mafeking, 5th December 1942. BNA S387/5 Recruitment of Labour, 1942.

siphon off mine rejects to white farms in Southern Rhodesia. In April 1941, William Gemmill wrote to the Resident Commissioner requesting the WNLA be allowed to recruit mine rejects for Southern Rhodesian tobacco farms. In return, the WNLA would establish a system of deferred pay and compulsory repatriation.[30] The Bechuanaland government rejected Gemmill's request on the grounds that the Protectorate's manpower was already insufficient for local food production.[31] Soon after the war, the WNLA again requested permission to forward reject labour to Southern Rhodesia.[32] The WNLA pointed out that the local population was facing a famine and men either remained at home, aggravating the situation, or wandered in search of work. The WNLA's Francistown office had seen unprecedented numbers seeking recruitment, and there was the usual high proportion of rejects. The District Commissioner at Francistown supported the WNLA request, citing the drought and the prospect of crop and stock losses.[33] The Government Secretary was unsympathetic. Although there was a crisis, the wages offered in Southern Rhodesia were too low to support a family.[34] The Resident Commissioner agreed.[35] In a subsequent review, the Government Secretary wrote: 'In plain fact it is that we do not want to encourage the recruitment of labour

[30] Letter from William Gemmill, Witwatersrand Native Labour Association Ltd., Salisbury, to Lt.-Col. C.N.A. Clarke, Resident Commissioner, Mafeking, 15th April 1941. BNA S344-11. Recruiting of Natives, Suggested Scheme for Rejects, 1941–44. For a discussion of the complex political background see Alan Jeeves. 'Migrant Labour and South African Expansion, 1920–1950'. *South African Historical Journal*, No. 18, 1986, pp. 73–92.

[31] Letter from Government Secretary, B.P. Government, to W. Gemmill, General Manager, Witwatersrand Native Labour Association Ltd., Salisbury, 17th June 1942. BNA S344-11 Recruiting of Natives, Suggested Scheme for Rejects, 1941–44.

[32] Letter from District Manager, Witwatersrand Native Labour Association Ltd., Francistown, to The Government Secretary, B.P. Government, Mafeking, 8th April 1947. BNA S344-11. Recruiting of Natives, Suggested Scheme for Rejects, 1941–44.

[33] Letter from Acting District Commissioner, Francistown, to The Government Secretary, Mafeking, 7th May 1947. Subject: Recruiting of Agricultural Labour for Southern Rhodesia. Recruiting of Natives, BNA S344-11 Suggested Scheme for Rejects, 1941–44.

[34] Letter from District Commissioner to The Government Secretary, Mafeking, 30th May 1947. Subject: Recruiting of Agricultural Labour for Southern Rhodesia. BNA S344-11, Recruiting of Natives, Suggested Scheme for Rejects, 1941–44.

[35] Letter from G.E. Nettelton, Government Secretary, Resident Commissioner's Office, Mafeking, to The District Manager, Witwatersrand Native Labour Association Ltd, Francistown, 4th July 1947. BNA S344-11, Recruiting of Natives, Suggested Scheme for Rejects, 1941–44.

in the Bechuanaland Protectorate for Southern Rhodesia in any way'.[36] The government used the same reasoning to reject subsequent requests from the WNLA.[37] Clarke's resistance is easily explained. Employment on white-owned farms in Southern Rhodesia was the last resort for migrant workers whose health was in decline after extended periods underground. The pay was at best less than a third of that on the gold mines, and white farmers had a well-deserved reputation for violence and the non-payment of wages.[38]

High-Level Negotiations About Mine Labour After the Second World War

After the Second World War, the demand for mine labour increased again, fuelled in part by the opening of the new Free State Mines in South Africa. Low mine wages tied men and their families to a perpetual cycle of migrancy. For the administration, repatriated wages under the deferred pay scheme enabled gold miners to pay their tax and to meet their family obligations. In that sense at least, the interests of the administration and the mines coincided. From the perspective of local communities, the situation looked worse. In January 1947 Bathoen II, Paramount Chief of Bangwaketse, wrote to the Resident Commissioner about migrant labour. Bathoen pointed out that migration gave the mines access to a large pool of skilled men and made families dependent on their income. The system of voluntary deferred pay was supposed to induce men to return home, but the mines also encouraged miners to

[36] Letter from G.E. Nettelton, Government Secretary, Resident Commissioner's Office, Mafeking, to Mr Bent, District Commissioner, 20th December 1947. BNA S344-11, Recruiting of Natives, Suggested Scheme for Rejects, 1941–44.

[37] Letter from Acting District Manager, WNLA Ltd., Francistown, to the Government Secretary, B.P. Government, Mafeking, 1st July 1952. Subject: A.N.I. Engagements. BNA S344-11, Recruiting of Natives, Suggested Scheme for Rejects, 1941–44.

[38] See Jock McCulloch. *Black Peril, White Virtue: Sexual Crime in Southern Rhodesia, 1902 to 1935*. Bloomington: Indiana University Press, 2000, pp. 36–56.

return to Johannesburg within six months by offering the same rate of pay they received when they had left.[39]

Six months later the High Commissioner, Sir Evelyn Baring, met with Mr W. Lawrence, General Manager of the NRC and Mr G. Lovett, the Chamber's legal advisor, to discuss deferred pay. Men were tending to go to work in the Union at an earlier age, stay away longer and return home later. Baring wanted an arrangement whereby HCT men would not be permitted to work continuously.[40] While Lovett and Lawrence were sympathetic, they offered no solution. The issue of deferred pay was just as intractable. Baring pointed out that the main purpose of deferred pay was to encourage men to return home, thereby ensuring they spent their earnings in the Territories. While he appreciated that a compulsory deferred pay system was out of question, he wanted a limit placed on the withdrawal from deferred pay accounts while men were in the Union. Mr Lovett explained that neither the NRC nor the WNLA had the right to withhold wages.

Baring briefed London on the meeting later the same month. From previous negotiations with the Chamber, he was fully aware of his weak bargaining position. If he quarrelled with the mines' representatives, they could draw as much voluntary labour from the Territories as they wanted, and he would gain no concessions. As a result, his administration's fragile control over the workforce would diminish even further.[41] Baring believed he had only one card to play. The mining industry knew that Africans resident with their families in towns hardly ever worked on the mines. The industry was beginning to realise that, if nothing was done, tribal and family life in the HCTs and the Scheduled Areas of the Union would break down, with large numbers of men moving to the towns with their

[39] Letter from Bathoen II, Paramount Chief of Bangwaketse, Kanye, Bechuanaland Protectorate to 'My Friend', 6th January 1947. Subject: Migratory Labour. BNA S387/7/1. Recruitment of Native Labour in B.P. General, 1941–48.

[40] Notes of Meeting between the High Commissioner and Representatives of the Chamber of Mines on 8th August 1947, Regarding Certain Native Recruiting Matters, p. 4. BNA S387/7/1. Recruitment of Native Labour in B.P. General, 1941–48.

[41] Letter from Sir Evelyn Baring, High Commissioner, Pretoria, to A. Sillery, London, 23rd August 1947. BNA S387/7/1. Recruitment of Native Labour in B.P. General, 1941–48.

families.[42] Those men would then be lost to the mines.[43] The attraction of the towns was very great, and Baring shared the Chamber's desire to slow that process down.

In mid-1946, Baring held discussions with the NRC about recruiting in Bechuanaland. He wanted a maximum service period of 18 months, at the end of which miners would be repatriated and remain at home for at least six months. The NRC agreed in principle but insisted on the exclusion from such an agreement of highly skilled men such as drillers and shaft sinkers.[44] The District Commissioners were asked for their views on the proposed changes. Mr W.F. Mackenzie at Serowe felt that there was little the administration could do. The limit of 18 months could not be forced on the NRC as a very large number of men re-engaged, many within a week. In addition, the mines were 'likely to make use of any available loophole' to get the labour they wanted. He was sure the only effective means of securing the return of miners was compulsory deferred pay. Mackenzie was also sure that the NRC would oppose any such measure as it would probably divert labour from the mines.[45] As usual, the outcome favoured the mines. In theory re-engagements were allowed so long as the total period of continuous service did not exceed 18 months. The Resident Commissioner could, however, waive that clause following a request from the NRC or the WNLA.[46]

In July 1948, the Bechuanaland High Commissioner gave up. At a conference of Resident Commissioners he convened in Johannesburg, he explained that if they made deferred pay a condition of contract, it would

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[42] Scheduled Areas were introduced in South Africa under the Native Land Act of 1913. The Act in effect enshrined racial segregation into law, reserving about 7 per cent of land for the country's 67 percent of black inhabitants, and making it illegal for them to purchase land elsewhere in the country.

[43] Letter from Sir Evelyn Baring, High Commissioner, Pretoria, to A. Sillery, London, 23rd August 1947. BNA S387/7/1. Recruitment of Native Labour in B.P. General, 1941–48.

[44] Circular Memorandum from V.P. Kilenberger, Acting Government Secretary, Mafeking, to All District Commissioners, 4th November 1946. Subject: Migratory Labour. BNA. DCS 30/6. Native Labour Recruiting, 1941–47.

[45] Letter from W.F. Mackenzie, District Commissioner, District Commissioner's Office, Serowe, 15th November 1946, to The Government Secretary, Mafeking, Subject: Migratory Labour. BNA, DCS 30/6. Native Labour Recruiting, 1941–47.

[46] Letter from W. Gemmill, General Manager (Tropical Areas), WNLA Ltd., at Johannesburg, to the Government Secretary, Mafeking, Bechuanaland Protectorate, 9th September 1944. BNA S387/7/1 Recruitment of Native Labour in B.P. General, 1941–48.

serve no useful purpose as the contract was between the labourer and the NRC and could be varied by mutual consent. In an admission that he was powerless, he suggested the Resident Commissioners should individually try their hand negotiating the issue directly with the Chamber.[47] Writing in the same year, a critic of the WNLA questioned its impact on Bechuanaland and its government. 'A single powerful trade or interest is generally an unhealthy, if not a sinister, thing, especially in a country which is naturally poor'. 'The South African gold-mining industry', he concluded, 'is permanently dependent upon being subsidised by a semi-bankrupt African peasant pastoral economy in the distant reserves beyond its own national borders'.[48]

By 1960, the critical chorus abated. In that year, the Resident Commissioner in Mafeking, R.H.M. Thompson, gave the migrant labour system his full support. Each year around 20,000 Bechuana went to the South African mines on nine-month contracts. According to Thompson, the recruiting system and the treatment of workers were excellent. The mine compounds, although modest, were clean, the medical care was meticulous and the men were well fed. To monitor their welfare, the mines were visited by officers of the High Commission Territories Agency. Neither District Officers nor Chiefs forced young men to go to the mines. Thompson did admit, however, that when an able-bodied man appeared before a Court charged with the non-payment of taxes, he would frequently agree to go to the mines to pay his arrears.[49]

Tuberculosis and the Medical System

During the nineteenth century, visiting physicians commented on the absence of tuberculosis in Bechuanaland, a fact they attributed in part to the region's dry climate. This view was endorsed by Dr Neil Macvicar in

[47] Summary of Minutes of Resident Commissioners' Conference, 19th–21st July 1948. BNA S387/7/1 Recruitment of Native Labour in B.P. General, 1941–48.

[48] A. Sandiland, review of I. Schapera, *Migrant Labour and Tribal Life*. In *Africa. Journal of the International African Institute,* Vol. 18, No. 2, 1948, p. 145.

[49] Letter from R.H.M. Thompson, Resident Commissioner, Mafeking, to the Rt Hon A. Creech Jones, MP, 5th October 1960. BNA S387/7/4 Recruitment of Labour 1960.

his pioneering medical history from 1908.[50] Subsequent surveys, including the South African Institute for Medical Research (SAIMR) 1932 study of tuberculosis and mine labour, reached the same conclusion.[51] Prior to 1920 tuberculosis remained uncommon, and it appears transmission only began in earnest with increasing migration of gold miners to South Africa. Whatever the case, there was a much higher incidence of TB in the southern half of the Protectorate, where mine recruitment was more common, and most of those diagnosed with TB were returning miners. The relationship between mine work and tuberculosis was widely recognised among the Tswana and the term 'maintisl' or 'minetisis' associated the disease with mine work.[52]

Bechuanaland's tiny Medical Department served a vulnerable and dispersed population prone to malnutrition. The dominant themes in the Annual Reports for the period 1915–1930 refer to the lack of staff; the threat posed by infectious diseases, especially malaria, smallpox and syphilis; and the widespread problem of a diet deficient in vitamins and protein. The Reports also acknowledge the lack of reliable data.[53] At the beginning of that period, tuberculosis was seldom mentioned and always in connection with men returning from the gold mines.[54] As late as 1926, the Annual Report notes that tuberculosis was 'not a disease of the Bechuanas or their country'. The returns for the following year show that most of the 142 tuberculosis cases were former miners.[55] Active

[50] See Neil Macvicar. 'Tuberculosis among the South African Natives'. *South African Medical Record,* Vol. VI, No. 11, 10th June 1908, pp. 161–176.

[51] See *Tuberculosis in South African Natives with Special Reference to the Disease Amongst the Mine Labourers on the Witwatersrand*. South African Institute for Medical Research, Johannesburg, March 1932, pp. 31–45.

[52] Andrew S.C. Mushingeh. A History of Disease and Medicine in Botswana, 1820–1945. PhD Dissertation in History, St John's College, University of Cambridge, August 1984, pp. 189–190. See also Wazha G. Morapedi. 'Migrant Labour and the Peasantry in the Bechuanaland Protectorate, 1930–1965'. *Journal of Southern African Studies,* Vol. 25, No. 2, 1999, pp. 211–21; 189.

[53] Registers of births and deaths were only introduced from 1941. See I. Schapera. 'Migrant Labour and Tribal Life: A Study of Conditions in the Bechuanaland Protectorate'. Report Presented to the B.P. Administration, Public Records Office, DO 119 1268 Schapera, 1944, p. 28.

[54] The Annual Report for 1915, for example, makes no reference to tuberculosis. See *Annual Medical Report for 1915–16 Bechuanaland Protectorate*, p. 1. BNA S189/9 Health Section, League of Nations 1935–45.

[55] *Annual Medical & Sanitary Report 1927–29, Bechuanaland Protectorate*, p. 5. BNA S417 1927–29. Annual Medical & Sanitary Reports.

tuberculosis was noticed in several cases as a sequel to bronchial pneumonia in men who, some years earlier, had worked on the mines.[56]

There was a sustained expansion of medical services in the years after the First World War. Funding increased tenfold from £2260 in 1919 to £21,509 in 1936, with most of the money going to government hospitals in the population centres of Lobatse, Serowe and Francistown. In addition, grants from the Colonial Development Fund provided two travelling dispensaries and support for the building of mission hospitals at Maun and Sofala. In 1936, the Protectorate's European staff consisted of a Principal Medical Officer, eight Medical Officers, three matrons and six nurses. There were 164 hospital beds for 260,000 Africans, or one per 1585 persons.[57] There were, in addition, six medical missionaries whose salaries were subsidised by the government. While that extra funding was welcome, the Resident Commissioner, C.F. Rey, acknowledged that there was still an urgent need for additional staff. During 1933 the expenditure on Medical Services represented just 8 per cent of the Protectorate's total budget, well below the average of 10 per cent of revenue spent in territories under the Colonial Office.[58]

In 1934, about 389 cases of tuberculosis were reported throughout the territory. This was a dramatic increase on the 36 cases just seven years earlier. From that point, there was a steady rise in the numbers. As the NRC and the WNLA intensified their recruiting, several Medical Officers complained that the economic benefits of oscillating migration were outweighed by the spread of disease. There were no specialist beds, pathology testing was outsourced to the SAIMR in Johannesburg and the first X-ray plant in the territory was only installed at Lobatse in 1933. The official policy was to advise chiefs and headmen to send those with active TB to the cattle posts where they would die in relative isolation.[59]

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[56] *Annual Medical & Sanitary Report 1930, Bechuanaland Protectorate*, p. 13. BNA S88/9 Annual Medical Report, 1930.

[57] *Commission of Enquiry into Medical Matters 1937*, pp. 8; 16. BNA S392/7/1.

[58] Memorandum on Bechuanaland Protectorate Health Proposals from Colonial Office, London, signed A.J.R. O'Brien and A.T. Stanton, 19th November 1934. BNA, Health Deputation MPS 1934 S392/5.

[59] Mushingeh, A History of Disease, pp. 190; 192–3.

There was little improvement over the next decade. In 1943, the Principal Medical Officer identified a number of flaws in the health service. There was a lack of medical facilities and personnel, the indigenous population was reluctant to accept new medical doctrines and the distances separating the centres of settlement presented a severe handicap.[60] According to the 1940 census, there was one hospital bed for each 1067 members of the population and just one X-ray plant for the whole population, but no specialist radiographer. Twelve years later the European staff had increased by just three. Low salaries and strenuous work conditions made it difficult to attract Medical Officers and European Sisters.[61]

In June 1933 Dr P.M. Shepherd, a mission medical officer at Molepolole, reported on the large numbers of men being rejected for mine work. Dr Shepherd noted that the NRC had good reason for instructing medical officers to examine 'with special care' the lungs of those who reported a previous mining experience. Out of a group of 500 men Shepherd reviewed between January and May 1933, only half were passed fit. Of the 207 men rejected outright, 125 had already been to the mines. Of that group, most had served five or more contracts and were no longer capable of underground work. Shepherd acknowledged that persistent droughts and malnutrition were a factor in the men's poor physiques. 'It raises the question as to how far the Bechuana generally at present are suited for mining'.[62] Shepherd, who was writing six months before the ban on Tropical recruitment was lifted, had in effect identified a cycle in which drought and malnutrition drove men into migrant work. After serving a number of contracts their health began to fail, and they were rejected at the next entry medical.

Even as the negative impact of mining on public health became more visible, observers noted that it was difficult to estimate its extent. In 1935 the Principal Medical Officer, Dr H.W. Dyke, noted that while there had been a threefold increase in tuberculosis in just eight years, at best

[60] Memorandum prepared by Principal Medical Officer on Health Services of the Bechuanaland Protectorate, 15th January 1943, p. 1. BNA S393/1/1 Health & Medical, 1942–50, S393/1/1.

[61] *Annual Medical & Sanitary Report, 1948. Bechuanaland Protectorate*. BNA S397/1/3, 1948 & 1949, Annual Medical, p. 1.

[62] Mine Recruits: Report of Dr P.M. Shepherd re poor physique of and main causes of rejection, Molepolole, B.P., June 1933, p. 3. Mine Recruits, 1934, S398/6 Botswana National Archive.

hospital admissions represented only a fraction of the actual cases.[63] Owing to a lack of accommodation, those admitted were kept for only a week and then returned to their villages, where Dyke believed they became 'reservoirs of infection'. He recommended segregation on the lines used with lepers. In the 1940 annual review, when a total of 289 new tuberculosis cases were reported, the Principal Medical Officer wrote: 'Facilities for the exact diagnosis of dormant disease and of disease resulting from work on the mines in the Union of South Africa do not exist in the Territory. I am therefore very doubtful about the value of the present figures on the incidence of the disease'.[64] In theory, the Chamber of Mines provided District Commissioners with a weekly list of men repatriated with tuberculosis so that treatment could be continued by local medical officers. In practice that did not happen. Dr J.W. Sterling lamented that there were no facilities for the diagnosis of dormant disease, nor for the treatment for returning miners.[65] Like the other HCTs, Bechuanaland had no specialist facilities.[66]

Two Health Studies into Mines and Disease in Bechuanaland

In response to persistent reports that miners were spreading disease, in 1937 the British Secretary of State appointed a Commission headed by Sir Walter Johnson, former Director of Medical and Sanitary Services in Nigeria. Johnson was asked to evaluate the threat posed by venereal disease and tuberculosis in the Bechuanaland Protectorate and to identify how best to monitor men invalided from the mines.[67] The date is

[63] Extract, *Annual Medical and Sanitary Report, 1934*. H.W. Dyke, Principal Medical Officer, 30th April 1935 p. 1. BNA S 438/2/1. Tuberculosis in the B.P. 1938–39.

[64] *Annual Medical and Sanitary Report 1940. Bechuanaland Protectorate*, p. 2. BNA, S397/1/1. Annual Medical Reports 1939–1945.

[65] Minute from Dr J.W. Stirling, Principal Medical Officer, Mafeking, to the Government Secretary, 15th November 1940. BNA S438-2-2 Tuberculosis in B.P. 1940–1953.

[66] Notes on Tuberculosis in the High Commission Territories, June 1940, p. 6. BNA S438-2-2 Tuberculosis in B.P. 1940–1953.

[67] *Commission of Enquiry into Medical Matters*, 1937, p. 1. BNA S392/7/1.

significant: in 1937 the South African government permanently lifted the ban on Tropical recruiting.

Johnson dismissed the official data on tuberculosis as unreliable, concluding that so little was known about the disease it was difficult for him to make recommendations. He was certain, however, that men repatriated with phthisis were a threat to public health. According to staff at the Free Church of Scotland Mission hospital in Molepolole, although tuberculosis accounted for only 2 per cent of out-patients, among those men examined at entry medicals for the NRC, roughly 10 per cent were tubercular. Johnson noted that the rise in the tuberculosis rate from 216 cases in 1934 to 332 in 1936 corresponded to the renewal of the WNLA's recruitment in the North. There was an obvious hazard from the mines, and Johnson recommended that repatriated cases be carefully monitored. He also found that the large numbers of men being rejected at entry medicals suggested that mine work was taking a heavy toll. In 1936, there were 9205 men recruited for the mines and 493 rejected. Of those 318 were experienced miners with defective lungs, and a further 68 had hearing loss acquired on the mines. Johnson pointed out that NRC and the WNLA had the capacity to establish a referral system, and he recommended that as a matter of urgency isolation wards be built at Lobatse. He also recommended that a survey be set up, using a travelling dispensary fitted with an X-ray plant, to establish the extent of the problem. He hoped the Chamber may help with funding it.[68]

In early December 1939, the Bechuanaland European Advisory Council complained that cattle production had fallen because of the absence of so many men on the mines.[69] The Resident Commissioner agreed, and commissioned Professor Schapera, a South African social anthropologist known for his work on the Tswana, to report on the causes, extent and impact of labour movements.[70] Of necessity, Schapera relied heavily on data and other assistance from the WNLA and the NRC. In a 300-page study, he devoted only 3 pages to the spread of

[68] *Commission of Enquiry into Medical Matters*, 1937, pp. 37–38; 57; 61–61; 40. BNA S392/7/1.

[69] Minutes of 27th Session of European Advisory Council, 27th November to 6th December 1939, pp. 60–61. BNA S387/5 Recruitment of Labour, 1942.

[70] The report was eventually published as I. Schapera. *Migrant Labour and Tribal Life*. London: Oxford University Press, 1947.

infectious disease from the mines and made no reference to tuberculosis. Schapera did, however, comment at length on the controversial topic of the conduct of mine medicals.

In his report, Schapera estimated that during the period 1928–1943, almost 13 per cent of men applying for the mines were rejected because of 'chest troubles and poor physique'. Those figures were all the more disturbing given that labour agents made a preliminary selection and unfit men were unlikely to offer themselves to the NRC. The high rejection rates were accompanied by longer periods of service of those passed fit. From 1930, the average length of time spent at home by migrant labourers fell, and the intervals between visits home became longer. Men went to the mines to support their families, but after serving three or four contracts they were no longer able to perform such work. Schapera estimated that nearly two-thirds had a career lasting less than five years.[71] His report, like the 1937 report by Sir Walter Johnson, offered a warning about the hazards of mining for men drawn from such a vulnerable population.

Prior to the introduction of chemotherapy in the early 1950s, patients with tuberculosis were encouraged to leave their villages and live at the cattle posts to lessen the spread of infection. For the small number admitted to hospital, the recommended treatment consisted of rest for several months with a diet rich in protein, with patients expected to drink at least two pints of milk a day.[72] In practice such diets were never provided. Chemotherapy dramatically changed the potential outcomes for patients. However, the new medicine brought its own problems. A large part of the health budget was spent on tuberculosis, but there was a lack of uniform treatment schedules. In theory, once chemotherapy came on stream, those in home care were to be brought to a hospital by ambulance and have a chest X-ray every six weeks.[73] None of that happened. There were

[71] Schapera, 'Migrant Labour and Tribal Life: A Study of Conditions in the Bechuanaland Protectorate', Report, pp. 22–23; 69; 74.

[72] See Diet for African Tubercular Patients, Athlone Hospital, Lobatsi. Undated (1944). BNA Med 7/1 TB General, 1944.

[73] Circular No. 13/55, 'Tuberculosis', from M.L. Freedman, Director of Medical Services, Medical Department, Mafeking, to all Government Medical Officers and Medical Missionaries, 3rd March 1955, p. 1. BNA S438/2/3. Tuberculosis in the Bechuanaland Protectorate, 1960–1963.

just 44 dedicated tuberculosis beds in the territory, there were no BCG or other vaccination programmes, no facilities for thoracic surgery, and no special clinics or dispensaries to treat or monitor out-patients.[74]

According to WNLA data, between 1953 and 1954 silicosis alone and silicosis with tuberculosis was diagnosed in a total of 269 cases, at a rate of 3.28 per 1000.[75] In theory, the NRC was to notify the Bechuanaland administration of all recruits repatriated on medical grounds, and to forward a report to the Medical Officer or Medical Missionary in the recruit's home district. This never apparently happened. The official correspondence shows that in 1957, the HCTs' office in Johannesburg believed that the WNLA kept tubercular miners in hospital until the disease was arrested or the patient had become non-infective.[76] That was not the case in the 1950s, and it was still not the case at majority rule in 1994. As the Oosthuizen report put it in 1954, 'Sick natives are all repatriated through the WNLA hospital and it appears that the criterion for deciding whether they are fit for repatriation is fitness to travel, the measurement of which is the ability to stand'.[77]

In 1957 Dr T.H. Davey, a Bechuanaland government medical officer, wrote a brief but highly critical review of tuberculosis management. The service was understaffed, and medical officers spent much of their time on outside commitments, such as conducting medicals for the WNLA to generate income. As a result, they had heavy workloads, but much of

[74] Memorandum, 'Particulars for Bechuanaland Protectorate', from Dr M. L. Freedman, Director of Medical Services, Mafeking, to The Secretary-General, The National Association for the Prevention of Tuberculosis, London, 2nd August 1956. BNA Med 7/5 1955. Medical Tuberculosis. BCG, or Bacillus Calmette-Guerin, was a vaccine to prevent tuberculosis. It was first administered to humans in 1921.

[75] Extract from *Bechuanaland Protectorate News-Letter* No. 24, January 1956, 'Recruiting', Dated 7th January 1956. BNA Med 15/8. Recruits for Mines, Farms, 1947.

[76] Memo from Agent for the High Commission Territories, Johannesburg, to Deputy High Commissioner for Basutoland, the Bechuanaland Protectorate and Swaziland, Cape Town, 10th July 1958. Subject: Treatment in South Africa of African Workers from other Territories. BNA, S387/7/3. Recruitment of Labour, Native in BP, 1957.

[77] See Report of the Departmental Committee of Enquiry into the Relationship Between Silicosis and Pulmonary Disability and the Relationship Between Pneumoconiosis and Tuberculosis. Part 2 The Relationship Between Pneumoconiosis and Tuberculosis, 1954. SANA, F33/671 Treasury, p. 133.

their effort was not devoted to government business.[78] Davey also noted that the lack of a laboratory service made the management of infectious disease all the more difficult. Treatment was often not completed, and this led to a high rate of drug resistance. At a Medical Officers' Conference at Gaborone in August 1966, one senior officer, Dr Thomas, spoke of the threat posed to school children by teachers with drug-resistant strains. Second-line drugs were expensive, and neither government nor mission hospitals could afford to treat the patients who needed them. More than 2000 teachers were employed in state and mission schools, and Thomas suggested that they should be X-rayed on appointment and periodically thereafter.[79]

The National Tuberculosis Programme (NTP) was launched in 1975, but many of problems that had plagued the service since the 1920s persisted. The lack of capacity meant that less than 30 per cent of tuberculosis patients completed treatment.[80] That was in part due to the high turnover of medical staff, as well as the failure of some doctors to follow the NTP's prescribed regimes. At the inception of the Programme, the reported incidence of tuberculosis was between 200 and 500 cases per 100,000 and the rate of drug resistance around 30 per cent. A generation later, with the arrival of HIV/Aids, the lack of biomedical capacity would prove equally devastating.

Two Unsuccessful Compensation Cases

The British High Commissioners' Office was aware that it was very difficult for men from the HCTs to apply for compensation once they had left employment. Most miners were not aware of their rights; once their disease developed, many were too ill to travel to Johannesburg for

[78] Dr T.H. Davey, 'Comments on Government Medical Activities and Projects in Bechuanaland, 1957. Prophylactic Campaigns Now in Being', to The Government Secretary, Mafeking, 18th June 1957, p. 10. BNA S393/1/3. Health & Medical Position in B.P. Health Services up to 1963.

[79] Minutes of the Medical Officers' Conference Held at Gaborone on the 6th and 7th of August 1966. BNA MED 12/16 Medical Officers' Conference, 1966.

[80] E.T. Maganu, *Botswana National Tuberculosis Programme: Tuberculosis in Botswana Results of an Epidemiological Survey 1981*, p. 4. Ministry of Health, Gaborone, Government Printer.

examination. Some of the obstacles to compensation were due to circumstances such as distance and the lack of medical capacity in the HCTs. Others seem to have been systematically created by employers. Two cases illustrate the difficulties faced by black miners and their surviving relatives in receiving compensation, the employers' efforts to shift costs from the mines onto the Bechuanaland medical service and the Chamber's determination to control health data. Chomati Letsepe was living at Mochudi when he was recruited by the Main Reef at Rustenburg in 1936. He worked at the mine for the next 21 months. Letsepe fell ill and was sent to hospital. He then asked to be allowed to return home. The mine doctors agreed to his request but did not tell him what their diagnosis was. Letsepe did not receive compensation and paid for his journey home himself. He was then examined by Dr Burger, the Medical Officer at Mochudi, who diagnosed tuberculosis.[81] The case eventually reached the Department of Native Affairs in Johannesburg, which sought to lodge a claim for compensation on Letsepe's behalf. As was required under the relevant regulations, the Department asked that a specimen of the patient's sputum and a chest X-ray be sent to the Miners' Phthisis Medical Bureau in Johannesburg.[82] Chomati Letsepe died at Mochudi in July before he could be examined. No claim was lodged by his surviving relatives, who were opposed to a post-mortem.[83]

The case of Seatuma Gopolang, a fellow miner from Mochudi who also contracted lung disease, provides another typical example of company practices. Gopolang had worked underground at Robinson Deep mine for only five months in 1937 when he became ill and was admitted to the mine hospital. From there he was sent to the WNLA Compound and four days later repatriated without compensation. Gopolang was ill

[81] Memo from Acting District Commissioner, District Commissioner's Office, Mochudi, to The Government Secretary, Mafeking, 14th March 1939. Subject: Phthisis Compensation Chomati Letsepe. BNA S332/5/1. Phthisis: Miners' Compensation for B.P. Native Mine Workers.

[82] Letter from Director of Native Labour, Department of Native Affairs, Johannesburg, to The Government Secretary, Resident Commissioner's Office, Mafeking, 7th June 1939. Subject: Claim for Compensation Native Chomati Letsepe. BNA, S332/5/1. Phthisis: Miners' Compensation for B.P. Native Mine Workers.

[83] Memo from Assistant District Commissioner, District Commissioner's Office, Mochudi, to The Government Secretary, Mafeking, 26th July 1939. Subject: Chomati Letsepe. BNA S332/5/1 Phthisis: Miners' Compensation for B.P. Native Mine Workers.

but had been given no diagnosis, so he went to the local doctor at Mochudi. The doctor concluded that Gopolang had tuberculosis. The District Commissioner wrote in protest to Government Secretary: 'The fact that he was discharged before the completion of his contract leads one to think that the mine authorities were aware of his condition'.[84] The Government Secretary wrote to the Robinson Deep asking that compensation be paid.[85] According to the mine's management, Gopolang was repatriated because he was 'mentally deficient'. The mine medical officer claimed there was nothing wrong with his health and that he could not have contracted phthisis in the short period he was employed.[86] That was the end of the matter.

The obstacles faced by men like Chomati Letsepe and Seatuma Gopolang were raised by the Agent for the HCTs, Mr A.G.T. Chaplin, at the Stratford Commission in March 1942. Chaplin pointed out that the applications for compensation had to be submitted to the Director of Native Labour in Johannesburg and include a record of the applicant's work history supported by a medical report, a sputum specimen and an X-ray. Based on those materials, the Medical Bureau would then decide on whether compensation was warranted. The problem of distance, as well as the lack of X-ray facilities in the Territories, made it impossible for miners to comply.[87] Chaplin also made a written submission in which he argued that the improvements in detection and monitoring used to exclude sick men from employment meant that tuberculosis must have been contracted on the mines. He wanted the Chamber to keep comprehensive work and medical records, and to use X-rays at entry and exit medicals. Chaplin suggested that on arrival in Johannesburg, recruits be

[84] Letter from Acting District Commissioner, District Commissioner's Office, Mochudi, to the Government Secretary, Mafeking, 13th June 1938. Subject: Phthisis Compensation—Seatuma Gopolang. BNA S332/5/1 Phthisis: Miners' Compensation for B.P. Native Mine Workers.

[85] Letter from G.H. Nettleton, for Government Secretary, to the Manager, Robinson Deep Limited, Johannesburg, 11th July 1938. BNA S332/5/1 Phthisis: Miners' Compensation for B.P. Native Mine Workers.

[86] Letter from Manager, Robinson Deep Limited, Johannesburg, to The Government Secretary, Mafeking, 17th August 1938. Subject: Native Seatuma Gopolang. BNA, Phthisis: Miners' Compensation for B.P. Native Mine Workers, S332/5/1.

[87] A.G.T. Chaplin, Draft Memorandum to be submitted by the Agent for the High Commission Territories in Johannesburg to the Miners' Phthisis Commission. Undated, circa March 1942, p. 2. BNA S332/5/1 Phthisis: Miners' Compensation for B.P. Native Mine Workers, S332/5/1.

issued with a card recording their medical and mining history, and that a full report of all miners suffering from miners' phthisis or tuberculosis be submitted to the Commissioner of his home district.[88]

Tuberculosis Surveys After the Second World War

The two major barriers to controlling the spread of tuberculosis were the lack of medical capacity and the lack of data. The first was due to imperial policy and the state of the economy and lay beyond the reach of the local administration. There was little industry in Bechuanaland, and it was not until the eve of independence that the first occupational health legislation was enacted.[89] The Moshaneng Asbestos Mine, with just 350 workers, was the largest employer, followed by the abattoir at Lobatse, which employed 300 men. The work conditions at Moshaneng were appalling, but there was no resident doctor, and the mine produced no health data.[90] The second barrier to controlling the spread of tuberculosis could have been easily resolved by the Chamber: the WNLA and the NCR had the expertise and capacity to collect whatever data they wished.

In 1937, the Commission headed by Sir Walter Johnson recommended that a survey be held to identify the extent of occupational lung disease.[91] The Principal Medical Officer, Dr D. Drew, suggested the administration approach the Chamber for assistance. The Chamber, he noted, had an interest in the control of tuberculosis in a Territory which supplied a great deal of the mine labour.[92] The Resident Commissioner also sought

[88] Memorandum of Further Evidence Submitted by the Agent for The High Commission Territories in Johannesburg to the Miners' Phthisis Commission, 5th August 1942, p. 1. BNA S332/5/1 Phthisis: Miners' Compensation for B.P. Native Mine Workers.

[89] Bechuanaland Protectorate: Answers to 'Policy Questionnaire' for 5th Inter-African Labour Conference, May 1957. BNA S504/1. CCTA Research in Africa South of the Sahara, 1957.

[90] See, for example, Memo from Acting Government Secretary, Mafeking, to the High Commissioner, Mafeking. 6th June 1950. BNA, Asbestos Deposits Moshaneng Mine, 1950. S62/3/3.

[91] *Commission of Enquiry into Medical Matters 1937*, p. 40. BNA S392/7/1.

[92] Letter from Dr D. Drew, Principal Medical Officer, Bechuanaland Protectorate, to Dr A.J. Orenstein, Johannesburg, 16th September 1937, p. 2. BNA S438/2/1 Tuberculosis in the B.P., 1938–39.

assistance from the British Colonial Development Fund.[93] While the Chamber did make a small donation towards the purchase of an X-ray machine, after much delay the request to the Development Fund was deferred indefinitely because of the war.[94]

During the Second World War the management of tuberculosis was complicated by soldiers returning from the African Auxiliary Pioneer Corps. Chiefs complained to the administration: 'When our men came back from the army we noticed that many of them were afflicted'.[95] The disease was alarmingly common and accounted for almost half of the deaths of Tswana soldiers who had served in the Middle East. In contrast to the management of repatriated miners, specialist tuberculosis shelters were built at various medical centres to contain the threat to public health.[96] The Deputy Director Medical Services, Dr Mackenzie, suggested that if those soldiers were kept in quarantine, the problem solved itself as most would soon die. 'This may seem an inhuman viewpoint, but it certainly compares favourably with that of allowing an African with tuberculosis to return and infect others—notably women and children of his own family group'.[97]

At a conference on post-war development held at Mafeking in January 1946, the delegates agreed on the urgent need for a tuberculosis survey. The nine years since Sir Harry Johnson's original recommendation for such survey had seen 'a menacing increase' in the incidence and distribution of the disease.[98] When the newly created World Health Organization

[93] Memorandum, Dominions Office, 12th July 1938. BNA S392-7-2 Health & Medical Position in Bechuanaland Protectorate, 1937.

[94] Letter from Resident Commissioner's Office, Mafeking, to His Excellency, The High Commissioner, Pretoria, 26th September 1939. BNA S438/2/1 Tuberculosis in the B.P. 1938–39.

[95] Mushingeh, A History of Disease and Medicine in Botswana, p. 194.

[96] Minute from G. Nettleton, Government Secretary, the Resident Commissioner's Office, Mafeking, to the Administrative Secretary to the High Commissioner, Pretoria, 9th November 1945. Subject: Tuberculosis in the African Pioneer Corps. BNA S438-2-2 Tuberculosis in B.P. 1940–1953.

[97] Memorandum from D.J.T.M. Mackenzie, Deputy Director Medical Services, Mafeking, to the Government Secretary, 3rd November 1945. BNA S438-2-2 Tuberculosis in B.P. 1940–1953.

[98] Memorandum from D.J.T.M. Mackenzie, Deputy Director Medical Services, Mafeking, to The Government Secretary, 4th August 1946. BNA S438-2-2 Tuberculosis in B.P. 1940–1953.

(WHO) Expert Committee on Tuberculosis met in Geneva in February 1948, it issued a set of policy guidelines for tuberculosis control. The Committee noted the importance of nutrition, housing and occupational health, and stressed that any prevention programme must include after-care and rehabilitation. Prevention was best done by identifying and isolating cases. Sample surveys using tuberculin testing and mass radiography were also recommended.[99] As always, the Committee emphasised the importance of education to inform patients and their families about hygiene and prevention.[100]

Under the Bechuanaland Public Health Act tuberculosis was a notifiable disease, and medical practitioners were required to immediately inform the local authority of new cases. Those authorities were in turn required to transmit weekly lists of cases to the Chief Health Officer.[101] In theory, the local authority was to take adequate measures to prevent the spread of the disease, including providing accommodation, maintenance, nursing and medical treatment. In practice the lack of funds and capacity meant none of that happened. During 1948, there were 932 tuberculosis cases reported in Bechuanaland, almost double the number from four years earlier. According to the Medical Director: 'There is little useful comment that can be made at this stage. The disease is apparently on the increase, but the true state of affairs is obscure'. Funding for a survey was finally approved in 1948.[102]

At a Cape Town meeting in February 1949, the South African Secretary for Health agreed to assist Bechuanaland by providing staff and a mobile X-ray unit.[103] In preparation, a pilot study using tuberculin testing, and

[99] Savingram [circular] from the Secretary of State for the Colonies, London, to the Officer Administering the Government of [Colonial Governments including B.P.], 20th December 1950, Annexure 1. Subject: Control of Tuberculosis-WHO. BNA Med 7/2 Tuberculosis, 1947.

[100] World Health Organization Supplementary Report, Tuberculosis, 22nd April 1948. Report on the Second Session of the Expert Committee on Tuberculosis held at Geneva, 17th–20th February 1948, p. 4. BNA Med 7/1. TB General, 1944.

[101] Memorandum, T.B. Control, May 1955. BNA Med 7/5 1955. Medical: Tuberculosis.

[102] *Annual Medical & Sanitary Report*, 1948. Bechuanaland Protectorate. BNA S397/1/3, 1948 & 1949, Annual Medical, pp. 2; 10.

[103] Memorandum from D.J.M. Mackenzie, Director Medical Services, Mafeking, to The Government Secretary, 11th February 1949. Subject: Yellow Fever and TB Surveys Scheme D.1037. BNA S438-2-2. Tuberculosis in B.P. 1940–1953.

mass radiography was carried out by the South African specialist Dr Dormer and a team of four. The pilot began well, with large numbers attending for examination at the Kanye Hospital. Unfortunately, public support collapsed with the deaths of a number of children following pneumonia and whooping cough vaccinations.[104] After several delays, in September 1952 a tuberculin testing and mass X-ray survey using a mobile X-ray unit was conducted in rural communities.[105] As most young male adults were on the mines, of the 21,270 examined 13,540 were females, an imbalance which compromised the results. A total of 273 abnormalities were diagnosed as 'active pulmonary tuberculosis', suggesting there was a significant problem.[106]

The Schechter Survey was an important step. However, it appears that its results underestimated the incidence of tuberculosis. In March 1953 Dr A.M. Merriweather, of the Scottish Mission Hospital at Molepolole, asked the government to help with the cost of medication. His hospital was treating patients with streptomycin and para-aminosalicylic acid (PAS) but lacked the resources to deal with the large numbers presenting. Most patients were asked to pay £10, a huge sum for a family, and this in any case did not cover the full cost of treatment.[107] The Director of Medical Services agreed that the government should pay for medication, providing the Mission bore the cost of hospital care.[108] Six months later, Dr J.A. Hay of the Seventh Day Adventist Mission at Kanye made an

[104] Dr D.J.M. Mackenzie, Director of Medical Services, Mafeking, 5th May 1949, Notes on a Discussion with Dr Dormer on 4th May 1949 Regarding a Tuberculosis Survey. BNA, Med. 8/1/1, TB Survey 1952.

[105] The survey was led by Dr M. Schechter from Durban. See M. Schechter. 'Mass X-Ray Survey: Bechuanaland Protectorate 1952'. *The South African Medical Journal,* Vol. 28, No. 4, 24th April, 1954, pp. 351–356.

[106] Schechter, 'Mass X-ray Survey: Bechuanaland Protectorate 1952', pp. 351–356.

[107] Letter from Dr A.M. Merriweather, Superintending Missionary, Scottish Livingstone Hospital, Molepolole to Dr Freedman, Director of Medical Services, B.P. Government, Mafeking, 17th March 1953. BNA MED 8/1/2. Medical TB Survey 1952.

[108] Letter from Dr Freedman, Director of Medical Services, Medical Department, Mafeking, to The Government Secretary, Mafeking, 10th April 1953. Subject: Tuberculosis, BNA MED 8/1/2. Medical TB Survey 1952.

urgent request for government assistance. The cases identified by the Survey had reported for treatment, but so many additional cases were presenting weekly with positive X-rays and sputum that the hospital was overwhelmed. Dr Hay had recently ordered a 12-year-old girl with open pulmonary tuberculosis to stay away from school. He was certain that many like her were a menace to their classmates.[109] Hay asked the government to consider building lying-in shelters to isolate infectious cases. The lack of capacity meant that many patients were turned away from hospitals because there were no beds.[110]

In response to a request from the government, the WHO carried out a Tuberculosis Survey in Bechuanaland in 1956. The survey confirmed the findings of a similar project undertaken with South African equipment in 1952. It showed that between 1 and 2 per cent of the population—almost double the official South African rate—had open tuberculosis.[111] In a territory with around 300,000 people, it was estimated that there were 3000 highly infectious cases. The Director of Medical Services considered that tuberculosis was the greatest public health problem. The vastness of the country posed serious difficulties. Most of the population lived in large villages which were several days' walk from their fields. Government policy was to isolate and treat as many infectious cases as possible, and it had spent more than £40,000 on specialist wards. While those 288 dedicated beds were essential for dealing with advanced patients, it was only possible to isolate a small proportion of the estimated pool of 3000 cases. Out-patient care using combined chemotherapy was provided by most hospitals, but patients often ceased treatment before they had recovered.[112]

[109] Letter from Dr J.A. Hay, Seventh Day Adventist Mission, Kanye, to J.C.E. Bowen, District Commissioner, Kanye, B.P. 29th September 1953. BNA S438-2-2. Tuberculosis in B.P. 1940–1953.

[110] Extract, Divisional Conference—Southern Protectorate, October 1955. BNA, Tuberculosis in the Bechuanaland Protectorate, 1960–1963, S438/2/3.

[111] Minutes, 31st July 1958. Subject: Tuberculosis Control. BNA S439/1/1 Tuberculosis in Bechuanaland Protectorate Assistance from the WHO 1955.

[112] Report on Visit to Bechuanaland by WHO Tuberculosis Consultant Anton Geser, 4th–7th June 1958, pp. 1–2. BNA Med 8/4 Medical: TB Surveys & Reports 1959.

Independence from Britain

Political independence in 1966 brought rapid economic and social change. The British Protectorate of Bechuanaland became Botswana, and the capital was moved from Mafikeng in South Africa to Gaberones (now Gaborone). The following year, diamonds were discovered in a remote region of central Botswana. While the country gradually developed a number of small enterprises, diamond mining became the dominant industry and accounted for most of the 30-fold increase in Gross Domestic Product, which occurred between 1967 and 1983.[113] Within 25 years, almost half of Botswana's population were urban dwellers.

However, South Africa's mines remained a major source of employment, and tuberculosis continued to pose profound challenges to the country's health system. In 1960, the 10,000 wage earning jobs in the Protectorate provided work for just 2 per cent of the resident population. In 1962, the total of remittances and cash inputs from migrant labour amounted to around £2 million per annum.[114] After independence the flow of labour continued. In 1970 there were at least 55,000 Batswana employed on the gold mines and in other sectors of South Africa's economy.[115] The flow of labour south peaked at 40,390 in 1976.[116] According to the 1991 Census, the vast majority of Batswana abroad were men working on contracts in South African mines, and tuberculosis was the major cause of morbidity and mortality in Botswana. A central Tuberculosis Register had been kept since 1962, but it did not provide reliable data. In the same year, a pilot BCG vaccination campaign began, but was not sustained. A comprehensive National Tuberculosis Programme based on BCG vaccination, case finding and treatment was finally launched in 1975 in collaboration with the World Health

[113] John Taylor. 'Some Consequences of Recent Reductions in Mine Labour Recruitment in Botswana'. *Geography,* Vol. 71, No. 1, 1986, pp. 34–46.

[114] Wazha G. Morapedi. 'Migrant South African and the Peasantry in the Bechuanaland Protectorate, 1930–1965'. *Journal of Southern African Studies,* Vol. 25, No. 2, June 1999, p. 203.

[115] Francis Wilson. *Migrant Labour in South Africa: Report to the South African Council of Churches Johannesburg.* The South African Council of Churches and SPRO-CAS, 1972, pp. 115–116.

[116] Taylor, 'Some Consequences of Recent Reductions in Mine Labour Recruitment in Botswana', p. 41.

Organization. In the early months of 1981, a tuberculosis prevalence survey was undertaken with the assistance of the South African Medical Research Council. There was a stigma attached to tuberculosis, and the results were compromised by the low numbers who presented for screening. In addition, the survey was conducted after people had migrated to their lands for agricultural work. Despite these problems, the survey uncovered an epidemic of tuberculosis. The Southern Health Regions of Lobatse, Gaborone and Molepolole had the highest reported incidence, usually around 500 cases per 100,000.[117] In the early 1980s, tuberculosis was joined by HIV/AIDS. The high volume of migrant labour, and the compounding effects of TB, silicosis and HIV/AIDS, resulted in Botswana having one of the highest HIV prevalence rates in the world. Botswana National Policy on HIV/AIDS (1998) provided a framework for a multi-sectoral response to the epidemic. However, it did not mention migrant or mobile populations.[118] The settlement of the miners' class action in 2019 gave many workers the first meaningful access to compensation for their occupational injury. As of 25 August 2022, about 1585 claims for compensation have been lodged, but none have so far been paid.[119]

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[117] Maganu, 'Botswana National Tuberculosis Programme', p. 10.

[118] *Briefing Note on HIV and Labour Migration in Botswana*. IOM International Organization for Migration, 2005, p. 5.

[119] https://www.tshiamisotrust.com/information/progress-report/.

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