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A STRANGE CASE OF MEDICAL TOURISM: TRAVELLING WITH TUBERCULOSIS IN SOUTH AFRICA

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Abstract: This study represents a historical contribution to the niche of medical tourism. The context is South Africa during the late nineteenth-century, a period when flows of 'invalids', mainly from Britain, were encouraged to travel to the country in search of a 'climate cure' or relief from the ailment of tuberculosis or, more correctly, what at that time was known as 'consumption'. South Africa's climate was viewed as healthy which underpinned its emergence as a medical tourism destination. Arguably, the flow of consumptive invalids as medical tourists to South Africa was part of an international response associated with climatotherapy which was given status and recognition in the nineteenth century. The challenges and difficulties that confronted consumptive invalids in South Africa are discussed. These included the need for improved standards of accommodation and local food as well as opportunities for gainful employment. Invalids travelling to colonial South Africa in the nineteenth century had to be prepared for rough conditions and to an experience which would be much different to those visiting the health resorts of Europe. The research uses archival sources, traveller guidebooks and historical reports by medical specialists which build up the reputation of South Africa as a favoured destination for 'invalids'. With improved medical knowledge, especially through Robert Koch's discovery of the aetiology of the disease, climatotherapy and the 'open-air treatment' was no longer the recommended treatment for sufferers of tuberculosis. Accordingly, this early episode in medical tourism in South Africa was closed. Overall, this paper extends the growth of recent scholarship exploring the historical geography of tourism development in South Africa.

Keywords: medical tourism, historical geography, tuberculosis, climatotherapy, guidebooks, South Africa

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INTRODUCTION

The niche of medical tourism, travel for the purpose of seeking medical treatment and improvement in health, continues to expand on a worldwide basis. Correspondingly, a burgeoning literature has consolidated around a range of issues in medical tourism straddling the critical nexus of health, tourism and disease (Balaban & Marano, 2010; Chaudhary et al., 2024; Clement et al., 2024; Connell, 2006, 2011; Datta, 2020; Hall, 2012; Haykowsky, 2017; Lubowiecki-Vikuk & Białk-Wolf, 2025; Mathijsen, 2025; Ntais et al., 2024; Syah et al., 2022; Tosun et al., 2025). Arguably, most of the international scholarship about medical tourism is concentrated around recent or *contemporary* issues of both international and domestic flows of medical tourists search for improved health. Nevertheless, travel "as an escape from or cure for disease is an ancient phenomenon" (Langum, 2025: 133). It is well-documented that people have been travelling for purposes of enhanced health for millennia such that medical tourism can be considered as one of the oldest niche forms of tourism (Connell, 2011).

Unquestionably, the existing literature concerning the historical dimensions of medical tourism is limited (Rogerson, 2026). Against this backdrop the novel contribution of the paper is to document what might be viewed as a 'curious' historical case of medical tourism. The focus is on tuberculosis, an ancient deadly disease that has ravaged global populations for centuries (Bynum, 2012; Chakraborty & Jayawickrama, 2025; Mousavi-Sagharchi et al., 2025). Tuberculosis is one of the world's deadliest infectious diseases and estimated to kill at least two million people every year (McMillen, 2015). It remains one of the most significant public health problems worldwide with 8 to 10 million new cases on an annual basis. Since the 1980s there has been a resurgence of the disease in developed countries with the appearance of new bacterial strains resistant to various anti-tuberculosis drugs. In Europe and North America this resurgence of tuberculosis is associated with the spread of AIDS, drug abuse, homelessness and poverty. Another consideration for this re-emergence and growth in tuberculosis is inseparable from increased human mobility, including through tourism (Hall, 2006). Across the Global South the disease has been an ever present feature of life because it was never eradicated in poorer parts of the world. In 1993 the re-emergence and increasing surge of the disease prompted the World Health Organisation (WHO) to declare a global health emergency (Roberts & Buikstra, 2003). Current WHO estimates are that

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deaths from tuberculosis annually are 3 million and that as much as one-third of the world's population is infected with the tubercle bacillus (Barnes, 2023). The setting for this investigation is South Africa which ranks globally among the top 30 high-burden tuberculosis countries. The curable and preventable disease of tuberculosis currently continues to ravage the country's black African and coloured (mixed race) communities despite a century of therapeutic advances and numerous legislative instruments which were designed to prevent it (Mizrahi, 2024; Packard, 1989a, 1989b).

The COVID-19 epidemic introduced a further layer of complexities into the landscape and practice of tuberculosis treatment (Olivier & Luies, 2023). This historical investigation of medical tourism looks at South Africa during the nineteenth-century, a period when flows of 'invalids' (mainly from Britain) were attracted to the country in search of a 'climate cure' or relief from the ailment of tuberculosis or, more correctly, what at that time was known as 'consumption'. The historical period covered in this research begins in the 1870s and ends in 1910, the year when the two British colonies of the Cape and Natal amalgamated with the two Boer Republics of Transvaal and Orange Free State to form the Union of South Africa. At one level, the research represents a modest contribution to international literature on medical tourism. In addition, it is a study that adds to the undeveloped scholarship on the historical geography of tourism. Three further sections of material are presented. The next section situates the study within a literature on the changing knowledge about the aetiology and appropriate treatment of tuberculosis. Following a brief review of methods and source material the results section examines the critical challenges and search for health of British invalids who travelled to South Africa for a cure from their condition of pulmonary tuberculosis.

LITERATURE REVIEW

Tuberculosis is an infectious and contagious disease due to *Mycobacterium tuberculosis* "which usually lasts throughout the life course and determines the formation of tubercles in different parts of the body" (Barberis et al., 2017: E9). The history of the disease has been traced to the Stone Age Paleolithic era (Mousavi-Sagharchi et al., 2025).

For Herzog (1998) the earliest fossil records can be dated to about 8000BC. According to Migliori et al. (2022 :1) the history of tuberculosis, known also as 'White Plague', is of great significance for humanity "for the magnitude of morbidity and mortality it has generated over centuries". Chalke (1962: 301) notes that the "disease has had an incalculable influence on the history of mankind" and in the story of tuberculosis "apart from leprosy western civilization has known no communicable disease which may run such a protracted course, affecting almost any part of the body and giving rise to such long periods of ill-health and disablement". The work of Bynum (2012) is regarded as the seminal historical account chronicling the development of tuberculosis. In another influential study Daniel (2006: 1862) records that tuberculosis is "an ancient scourge" and has "plagued humankind throughout much of human history".

The terminology of tuberculosis only came into use in the mid-19th century with the earlier terminology that of consumption or phthisis. In the Middle Ages the disease was known in England and France as 'the king's evil' and it was widely believed that those infected could heal after a royal touch (Barberis et al., 2017). The disease reached epidemic proportions in Europe and North America during the 18th and 19th centuries earning the sobriquet 'Captain Among these Men of Death' (Daniel, 2006). Although consumption was considered an "horrendous condition", paradoxically for some individuals in the nineteenth century age of Romanticism it was a 'fashionable' condition (Lawlor, 2010).

During the time of the industrial revolution in Europe the disease was widespread because of risk factors such as poor social conditions, deprived work settings, badly ventilated work environments, overcrowded housing, dismal sanitation and malnutrition (Barnes, 2023). According to Lawlor (2007: 5) in the 19th century the disease of consumption "killed as many as one in four people in Western Europe and America".

Nevertheless, Bynum (2001) flags that historical scholarship is correct in asserting that whilst the incidence of tuberculosis in Western society peaked in the early decades of the nineteenth century, nobody actually died officially of tuberculosis as the condition was known as consumption. It was only after 1882 when Robert Koch discovered the *tubercle bacillus* that deaths from tuberculosis were formally recorded. "Before then, people died of consumption, phthisis, or some other disease with a collection of signs and symptoms that we now relate to tuberculosis" (Bynum, 2001: 676).

Knowledge and practice about the aetiology and treatment of tuberculosis has shifted markedly over time (Barberis et al., 2017; Bynum, 2012). At the beginning of the 19th century a major scientific debate raged as to its origins – whether it was infectious, or a hereditary disease, or a form of cancer. At the time most medical specialists considered the disease "to be hereditary or contracted by inhaling 'miasma' or corrupted air" (Karakousis & Mooney, 2025: 3).

The milestone in tuberculosis diagnosis was the discovery by Robert Koch of the aetiological agent in 1882. It was not until Koch discovered the tubercle bacilli that "western medical science acquired a means of clearly identifying the disease through its isolation" (Packard, 1989a: 24). Koch's demonstration of the bacteriological cause of the disease resulted in the award of the Nobel prize for Medicine in 1905 for "his elucidation of the aetiology of tuberculosis" (Daniel, 2006: 1864). Herzog (1998: 8) points out Koch's achievement was the production of "irrefutable evidence in 1882 that a specific microbe is the fundamental cause of tuberculosis". Further, as Barnes (2000: 431) asserts, Koch's demonstration that the tubercle bacillus was the true cause "established a new understanding of causation in medicine". It was a scientific breakthrough which set in motion an aetiological revolution with vast implications for the control of infectious disease including the laying of foundations for the subsequent development of new treatments for tuberculosis.

According to Murray et al. (2015: 1749) "of all achievements in modern medicine, the successful treatment of tuberculosis has had one of the greatest impacts on society". Nevertheless, following Koch's discoveries the development of treatments was slow and initially focused on the isolation of patients, rest and provision of quality nutrition (Migliori et al., 2022). The sanatorium served initially as a place of healing for patients with tuberculosis.

The first successful treatment against tuberculosis was the introduction of the sanatorium cure which involved both continuous fresh air, rest and good nutrition. Public health measures to combat the spread of the disease emerged slowly after the acceptance of Koch's demonstration of the disease's bacterial cause. In the late 19th century sanatoria were established for the treatment of patients. Among the pioneers of sanatoria was Hermann Brehmer who opened a sanatorium in Lower Silesia (now in Poland) in 1859 with open-air spaces and at an altitude of 500 m above sea level offering bed rest, a rich diet and structured physiotherapy exercises, a model that began to be replicated in many other countries. Sanatorium care displaced the so-called 'open-air treatment' which had been put forward by advocates of climatotherapy and held much credibility in the medical community prior to Koch's germ theory (Herzog, 1998). The sanatorium model became widely adopted and diffused across many countries for the treatment of the disease.

For the closing decades of the 19th century and into much of the early part of the 20th century "the sole substantial means of treating tuberculosis was through hospitalization in a sanatorium" which was a time-consuming process and with no guarantee of ultimate success (Pliatsikas et al., 2024: 246). Beyond the treatment of infected patients a range of prevention measures were implemented against the disease. Tuberculosis prevention included two main thrusts, namely vaccination and management of infection. Vaccination was targeted towards tuberculosis prevention by active immunity. It was applied widely following World War 1. Management of tuberculosis infection centred on individuals hosting the infection and killing the bacilli, including through antibiotics in order to prevent the occurrence of future cases. (Migliori et al., 2022). Developed by French researchers the application of Bacille Calmette-Guérin (BCG) vaccination began in 1921. Once again, initial acceptance was slow but a major roll-out occurred after World War II and vigorously was promoted by UNICEF. Debroyer (2023: 313) considers that the "introduction of antibiotics after the Second World War constituted a turning point in the history of tuberculosis, since the disease came to be perceived as a treatable one which was thereby thought to no longer pose a threat to public health". Arguably, the modern era of control was heralded by the discovery and application of streptomycin in 1944 and isoniazid in 1952 (Daniel, 2006). In addition, after World War 2 effective chemotherapeutic treatments were evolved for the treatment of tuberculosis. Although progress was made in containing the disease, proclamations about the 'end of tuberculosis' were premature as evidenced by its post-1980 resurgence.

MATERIALS AND METHODS

The study began by reviewing a baseline of international research concerning the history of tuberculosis and its impacts. As was demonstrated in the above discussion, it was revealed that marked changes have occurred in historical understanding of the causes of the disease and the most appropriate treatment practices. The central focus of analysis was upon the nineteenth century when climatotherapy and the advocacy of an 'open-air' treatment was widely acknowledged.

The research on the wave of tuberculosis travellers to South Africa during the nineteenth century represented an early example of medical tourism. The study applied the methods of historical geographers which include the use of primary source materials from archives as well as the collection of other evidence from secondary literature. As stressed by Withers et al. (2020) historical geography, a dynamic sub-field of modern geography, has no single universal definition that speaks across the ages. At its core the domain of historical geography can be viewed as "the study of the geographies of past times" and most often is archive-based albeit it may incorporate other research approaches (Jöns, 2020: 48). The tourism geographer Joseph Cheer (2024: 169) recently endorsed the merits for researchers following "an oft-unacknowledged historical geography perspective". The strengths of archival research for historical geographers are identified by Beckingham & Hodder (2022). The judicious application of historical methods, including of archival sources, can reveal patterns of change over time including for historical geographies of tourism.

In South African research, archival sources have been used successfully to reveal different facets of the historical geography of tourism variously for the segregation era of the 1920s and 1930s (Rogerson & Rogerson, 2023, 2024a, 2024b, 2025a) as well as the apartheid period from 1948 to 1991 (Rogerson, 2020, 2025a, 2025b, 2025c, 2025d; Rogerson & Rogerson, 2024a, 2025b). This case study of medical tourism is looking at tuberculosis and travel to South Africa and is situated during the period prior to the 1910 formation of the Union. The evidentiary base incorporates a range of primary documentary sources. For historical research in tourism, Mackenzie (2005: 34) maintains that travel "guide-books are an extremely rewarding source". This assertion is confirmed by the application of guidebooks variously to provide insight into Norway's emergence as a tourism destination (Drury, 2026), advertising for holidays at British resorts during the First World War (Page & Connell, 2025) and the construction of Bosnia-Herzegovina as a popular destination for upper-class British tourists during the late nineteenth and early twentieth century (Cameron, 2023). Guidebooks were one of the essential sources used by Buzard (1993) in the seminal study of the development of European tourism during the formative years of the nineteenth and early twentieth centuries. Distinctively, in this investigation, much use is made of travel guidebooks, including of special guidebooks produced in the nineteenth century for the use by 'invalids'. Other source material includes travellers' reports and research authored by medical specialists evaluating South Africa as a destination for consumptive invalids. The National Library of South Africa Cape Town depot is an important depository for much of the historical source material.

RESULTS AND DISCUSSION

Two sections of results and discussion are presented. The first relates to interpreting the mainstream or conventional medical wisdom of the nineteenth century for understanding the treatment of tuberculosis, namely climatotherapy and endorsement of 'the open-air treatment'. The second section turns to examine the growth and mobilities of consumptive invalids who travelled from Britain to South Africa in search of a cure for their condition.

Tuberculosis and Climatotherapy

Twenty-four centuries have elapsed after the appearance of the treatise by Hippocrates – the 'Father of Modern Medicine' - on environmental factors governing human health. Hippocrates work *On Airs, Waters and Places*, described the various ways that climate could impact health or the spread of disease and pointed to the benefits of clean water, fresh air and moderate climates (Pappas et al., 2008). Arguably, the Hippocratic corpus that climate was intimately related to health and disease guided Western medical thinking for many centuries (Craik, 2015). It was rendered obsolete from the 1870s by the march of bacteriology and evidence from germ theory that micro-organisms explained the occurrence of many diseases. Nevertheless, since the time of Hippocrates a considerable amount of writing emphasized the importance and potential of medical climatology with special reference to the therapeutic effects of certain meteorological environments on tuberculosis (Bashford & Tracy, 2012; Moriyama & Herrington, 1939). Rogers (1969: 1) observes that since the time of *Airs, Waters and Places,* "physicians have been interested in the role of climate in the incidence of disease and in the use of climatological therapy. Nowhere is this interest in the role of climate in the incidence of disease more prominent than in the climatotherapy of tuberculosis".

As the aetiology of tuberculosis was unknown for most of the nineteenth century, recommendations for changes of climate were the most important elements of physicians' therapeutic arsenal for treating pulmonary tuberculosis. In nineteenth century Britain the belief was widespread that climate was both a cause and potential cure for consumption (Langum, 2022). Medical practitioners in Britain showed considerable interest in the advantages and health benefits of non-British climates (Janković, 2006). Pemble (1987: 92) records "Victorian climate therapists discussed the effects of different climates on people's minds and bodies" and stressed the importance of selecting "the right climate for every ailment". But, beyond "climate, advocates of medical travel also proposed the travel in and of itself as health-giving"; the benefits of sea voyages, the novelty of new places and a change of air "persisted in regards to travel for consumption into the late nineteenth century" (Langum, 2022: 56). Accordingly, for Janković (2010: 120) during the nineteenth century "moving to better air became a more common practice, and eventually, an orthodoxy". Long term international travel, albeit with no guarantees of recovery, became one of the most popular forms of medical therapy (Janković, 2010).

Importantly, until the mid-19th century in Britain and across much of Europe the sickness of consumption was widely believed to be one disease which could benefit from rest and a change of climate (Langum, 2025). But, it was not only in Britain or Europe that ideas of climate therapy took root (Solis-Cohen, 1901). Gangstad (2023) shows that climatic cure, the prevention or improvement of physical or mental conditions through relocation to a particular climate, was a popular medical belief system in America during the 19th and early 20th centuries. It was stated that the practice of climatotherapy "proliferated in American medicine during the 19th and 20th centuries" (Gangstad, 2023: 3). Thompson (1971) highlights that the acceptance of climatotherapy was widespread among medical practitioners in California especially during the latter half of the nineteenth century. In 19th century California a form of medical treatment called 'wilderness cure' enjoyed considerable popularity (Thompson, 1976). This involved little more than an open-air stay in wild country, usually wooded uplands, and based on the belief that such spaces provided curative influences on sick persons, especially consumptives. Belief by medical specialists in the curative power of climate for American consumptives continued into the early decades of the 20th century. For example, Wilkinson (1902) asserted that in addressing the issue of pulmonary consumption: "in climate we have the cherished desideratum, experience proved that when properly selected and properly taken advantage of its power for good can be relied upon. Its benefits in phthisis are no longer a matter of speculation but one of fact. In the presence of its magnificent healthful possibilities, all other remedial agencies pale into insignificance" (Wilkinson, 1902: 372-373). Some American scholars wrote of climatotherapy in almost religious tones. For example, Bruns (1932: 24) implored that "When we speak of the climatic treatment of tuberculosis, we do so with reverence and divine faith for we are dealing with a treatment universal in its use and as old as the history of man, nature's most precious remedy, a gift from the 'Maker' of all things".

Although there existed a long history of the privileged classes travelling for health purposes including to spas and healing springs, technological improvements in travel in the nineteenth century, such as the innovation of steam powered trains and boats, opened up the options for medical tourism to a wider cohort of travellers (Langum, 2022). Much attention now focused on doctors' recommendations for patients to seek out a 'change of air' both for the air itself and for psychosomatic reasons of improving patients emotional and mental health (Langum, 2025; Morris, 2018).

Travel for health purposes expanded. Italy and France were popular health tourist spots and Madeira a major destination for British invalids, including of consumptives. With improved transport technologies invalids began to venture farther afield to other 'health destinations' such as China, Australia, Egypt, the American West, the Peruvian Andes, and South Africa (Carey, 2014; Langum, 2025; Solis-Cohen, 1901).

Consumptive Invalids in Search of Climate Therapy

The flow of consumptive invalids as medical tourists to South Africa therefore was part of an international response linked to the 'science' of climatotherapy which was given status and recognition in the 18th and 19th centuries. Packard (1989a: 38) reflects that in the history of tuberculosis in South Africa a significant role was played by "European consumptives, primarily from England, who came to South Africa in hopes that their health would benefit from its climate". South Africa's reputation as a health resort had been established in the early 19th century when the Cape Colony played a pivotal role in Britain's Indian Ocean world as supply depot for British troops heading to India (McAleer, 2013; Harrington, 2025). The territory was viewed as a healthy location and site of recuperation for Britain's India soldiers. The reputation of the Cape Colony as a health resort for visitors from Britain was furthered from 1857 by the establishment of regular mail ship services between England and Cape Town (Ferrario, 1978).

Building upon that reputation as a health destination, the Colony's potential for assisting consumptive invalids was buoyed by the subsequent reports produced by medical specialists and by the promotional messaging that was contained in several guidebooks that appeared in the 1880s and 1890s.

One of the earliest reports was developed from a presentation made by the English physician Dr Edmund Symes-Thompson (1873) to the Royal Colonial Institute in London on the value for invalids to travel to 'elevated health resorts in the Southern hemisphere'. South Africa was a specific focus of attention and accorded positive endorsement. A further leading influence upon South Africa as a medical tourism destination for invalids was the book produced in 1886 by Arthur Fuller titled *South Africa as a health resort with especial reference to the effects of the climate on consumptive invalids.*

In the preface to the first edition Fuller (1886: iii) made clear the promotional character of the guidebook with its objective "to bring home to the public the value of South Africa as a health resort". In addition, it was stated "the consumptive invalid should be informed, that in addition to the climatic advantages of the country referred to in these pages the voyage to South Africa is one of the finest in the world" Indeed, invalids were frequent passengers on the weekly mailships, described as "admirably appointed" from Southampton and London (Fuller, 1886: iv). Fuller's book, published in London, went through multiple editions and was highly influential in Britain. The guidebook sought to correct misconceptions and "incomplete descriptions" which existed about the improvement of travel in South Africa because of the expansion of the railway network and made recommendations about the best 'health resorts' that invalids might select. Likewise, other guides produced for use by invalids provided information in climate maps to enable "those ignorant of South African geography to readily distinguish the places most suitable" (Brown, 1893: 33)

In the decade spanned by the multiple issues of Fuller's guides, the preface to the fourth edition (1894) pinpointed that "large numbers have availed themselves of the health resources of the country and that "South Africa is far better known in England to-day than it ever has been, and as its health resources are more widely known they will be more fully appreciated". In the fourth edition Fuller (1894) clarified different places in South Africa seemed to suit 'invalids' and much depended on the period of the disease. It was observed as follows: "The choice of a climate is something like the choice of a wife, no categorical enumeration of characteristics without actual contact and experience can bring about a happy match in either case, and the invalid must be content if he finds one climate not agreeing with him to try another" (Fuller, 1894: 70). The various editions of Fuller's book drew upon material which appeared in a second report authored by Symes-Thompson who detailed South Africa's capacity for 'giving or restoring health'.

The central argument was "that South Africa is a Health Resort of no mean value is a fact that should be more generally realized" (Symes-Thompson, 1888: 1). Nevertheless, the report equally was not without criticisms.

The arrival destination of Cape Town for most invalids was not a recommended place to stay both because of its winds and from a sanitary point of view the town was "in a truly disgraceful condition". It was considered that until the situation improved the duty of the medical community in Britain should be "to see that invalids are not tempted to stay in the city" (Symes-Thompson, 1888: 13). With estimates of a mean humidity of around 75 percent the assessment was that "none of the coast districts, as regards climate, is an advantageous resort for all-the-year-round residence of phthisical patients" (Creswicke, 1903: 161). The recommendation was made that invalids should move on into the interior and seek out health resorts which were situated in higher altitude tablelands of the Karoo where the dry atmosphere and sunshine provided a basis for health restoration. For example, the small town of Aliwal North was lauded as one of the most valuable health resorts for phthisical patients and readers informed that Cradock with its rail access "is regarded in the Colony as one of its principal health resorts" (Symes-Thompson, 1888: 13).

Nevertheless, whilst endorsing the merits of South Africa for visits by consumptive invalids, it was added that the ability to adapt to new conditions and the character of patients, especially their readiness to enjoy a new life, was essential for success: "It is useless to send to South Africa a man or woman whose comfort depends on the luxurious surroundings of home life, and who will never cease to grumble when difficulties arise" (Symes-Thompson, 1888, p. 3). The report by Symes-Thompson (1888: 16) offered a caution about the Karoo that despite its climatic advantages "the comforts and conveniences of home are here still deficient" and suggested that those for "whom the delicacies of home life are so essential may find the monotony trying, and the coarse conditions of life intolerably irksome".

urthermore, it was advised that "no one should attempt such a life who is not content to put up with many inconveniences, and to renounce most of the refinements and avocations of English town life" (16).

Overall, Symes-Thompson (1888) was highly critical of the shortcomings of hospitality services provided in South Africa describing that "hotel accommodation is so deficient" and "the hotels in South Africa are, for the most part, unsatisfactory" (Symes-Thompson, 1888: 12). In addition, further criticism was directed at the poor quality of services: "the attendance is bad, and the conveniences few". All these cautions underscored invalids had to be prepared when venturing out to South Africa, for an experience much different from the health resorts in Europe. In reviewing the international experience of the climatic treatment of consumption James Lindsay (1887: 166) advised that the "fastidious traveller, who values luxury above health, and is offended by a hard bed or tough beefsteak, had better pass the Cape by". Correspondingly, "the traveller who sets before him health as his chief object, who is superior to petty discomforts, who can smile at a rough road, and is not rendered miserable by a disappointing dinner – such a traveller may gain much health and perhaps, in addition pleasure and instruction – by a well planned sojourn in Southern Africa" (Lindsay, 1887: 167).

The need for good hotels, improved accommodation and food standards was a constant refrain (Rogerson & Rogerson, 2021b). In several guidebooks appearing in the 1880s and 1890s, most notably Brown's guide which was produced for the use of 'tourists, sportsmen, invalids and settlers', the message was relayed that invalids would have to 'rough it' in the upcountry interior towns where luxuries were not readily available, there was lack of variety of food and in many instances

the food was undercooked. Quality of accommodation in small towns was a core problem as was made clear in the 1893 Brown's guide (Brown, 1893). Creswicke (1903: 162) lamented that "outside of a few towns, it is impossible to obtain good accommodation for the traveller, and still less for the invalid". In several of the guidebooks appearing in the 1880s and 1890s, most notably Brown's guide which was produced for the use of 'tourists, sportsmen, invalids and settlers', the message was relayed that invalids would have to 'rough it' in the upcountry interior towns where luxuries were not readily available, there was lack of variety of food and in many instances the food was undercooked. Scholtz (1897: 22) reflected that for many invalids "the great difficulty in South Africa has been to procure an easily digestible though not too abundant and rich diet". In the book recording his winter travels in South Africa in the 1880s, Sir Frederick Young argued that in order "to render the undoubted excellencies of the South African climate more attractive to invalids, who ought more largely to avail themselves of its advantages, it would be an excellent thing, as well as undoubtedly a paying speculation, if better hotels, fitted up in all respects with all modern European improvements, were established both at Cape Town, and at all the other principal towns up country, as well" (Young, 1890: 111-112).

South Africa therefore gained its reputation as a health resort mainly through the guidebooks and recommendations of medical specialists who considered the climate of the Cape Colony was "the chief factor in the treatment of pulmonary complaints" (Robertson, 1904: 435). This message was repeated in the almanac of the Cape Colony that appeared in 1907 which highlighted that the "excellent climatic conditions of the Colony render it an ideal health resort" (Burton, 1907: vi). Further, Burton (1907: 74) stressed the special climatic advantages of Ceres, namely that its altitude and protection by surrounding mountains was sufficient "to prevent the atmosphere from becoming humid and unhealthy". The town was hailed as blessed with plenty "of ozone for invalids who usually pick up very quickly in this lovely place" (Burton, 1907: 75). For Fuller (1894: 24) the climate at Beaufort West was rated as "salubrious and dry and should be good for invalids". The volume produced by Scholtz (1897) reiterated the importance of the 'open air' treatment for treating consumption and its administration through sending patients to a health resort like South Africa where they could spend the day in the open air and away from crowds allowing the body to "recover from consumption by using the climate as a form of medicine". This said, it was cautioned that as money was vital in the life of invalids the recommendation was that poor invalids should not come to South Africa as living costs were high and job prospects often limited (Scholtz, 1897).

As van Wyk (2013: 65) reflects, with the growth in popularity of South Africa as a medical tourism destination so did the flows "of invalids and tourists who came to visit South Africa in search of health". Within the guidebooks produced in the late 1890s and early 1900s evidence appears of some improvements taking place particularly in the provision of accommodation services. For example, the Karoo small town of Beaufort West was described as endowed with "two good hotels" and "often resorted to by persons with weak lungs who find the keen dry invigorating air very beneficial" (Burton, 1907: 253). Special praise was given once again to Ceres which, with its improved railway connection enjoyed good access to Cape Town, was the first town in South Africa to be publicly named a health resort. Scholtz (1897) highlighted the recent improvements in terms of quality of accommodation facilities available at Ceres to invalids in terms of hotels and boarding houses. In Brown's guide it was stated that "When away from the larger cities travellers in South Africa have never asked for luxury and very few hotels have offered it to them. Rough and ready manners and a liberal but coarse bill of fare were, until recently, considered rather the correct thing in this extremely republic country. The example set by the steamships and by most of the hotels in the leading towns is however rapidly effecting a great change, and the growing influx of pleasure and health seekers is compelling the landlords to think more of their guests and less of their bar" (Brown, 1893: 16).

Overall, according to medical specialists the disposition of the patient was an important factor in determining the health outcome of consumptive invalids choosing to travel to South Africa. In a guidebook produced for American patients by Solis-Cohen (1901: 24), a Professor of Medicine and Therapeutics in Philadelphia, the recommendation was "only the hardier class of consumptive patients should be advised to go to South Africa". The Colony was deemed as most appropriate for persons who "are accustomed to roughing it more or less in regard to food and accommodation; especially persons of strong constitution who have become infected with pulmonary tuberculosis during some temporary depression of the health and under specially bad hygienic circumstances" (Solis-Cohen, 1901: 24). Members of the British medical community proffered similar advice. For example, Robertson (1904: 437) averred that "those patients endowed with a strong will power and cheerful disposition do much better than those who are despondent".

The former "settles down to make the best of matters, gets accustomed to his surroundings, which gradually get a sort of fascination and the feeling of 'home-sickness' wears off". Importantly, such individuals might secure gainful employment. It was argued as follows: "It is necessary that every invalid coming out to South Africa should have a certain amount of money. If he is robust and only 'threatened' with pulmonary mischief, perhaps he may risk coming with a limited amount; but if the disease has got a fairly firm hold, it is absolutely necessary that he should have enough to keep him for a year at least. If he hasn't, the chances are that he will accept employment too soon, or employment that is unsuitable, and do himself harm in that way" (Robertson, 1904: 437).

CONCLUSION

The novel contribution of this paper is revealing a neglected dimension in the history of medical tourism. The results of this investigation build upon and extend a suite of related papers and book chapters which have been produced in recent years on the historical geography of tourism in South Africa. The focus was the late nineteenth and early twentieth centuries when South Africa emerged as a medical tourism destination for 'invalids'. This was a time when climatotherapy and the 'open-air treatment' for consumption were accepted wisdom and practice in British medical circles. Accordingly, increasing flows of patients were encouraged to make their way to South Africa "where they might spend time in the open

air, away from crowds and that they had exercise in the open air" in order "to help the body recover from consumption by using climate as a form of medicine" (van Wyk, 2013: 54). Overall, what South Africa could offer was 'pure unbreathed air', which could be accessed in the elevated plateau where there was high altitudes and thinly populated small towns.

The case of invalids travelling to and within South Africa confirms the assertion made by Michael Hall (2006: 159) over two decades ago that "the reality is that tourism is a major contributor to introduction of new diseases to populations as well as contributing to an increased spread of existing disease". Packard (1989a) presents compelling evidence for the 1890s to show that the arrival of consumptive immigrants from Britain seeking a climatic cure in South Africa contributed to the growth and spread of tuberculosis in the country. Oftentimes this occurred before invalids even reached the subcontinent for "they not infrequently infected their fellow passengers on shipboard" (Packard, 1989a: 38). Many consumptive passengers travelled second or third class and were accommodated in small cabins with poor lighting and ventilation wherein they infected several unaffected passengers. Beyond that channel of infection and spread, outbreaks of tuberculosis in the small towns of Aliwal North and Beaufort West, two popular health resorts for invalids, were clearly associated with the increasing numbers of visits and temporary settlement of British consumptive invalids. By the time of the formation of the Union of South Africa in 1910 the momentum of this early form of medical tourism was gone. The reason was the improved medical understanding of the aetiology of the disease which followed Koch's discoveries and correspondingly the reduced credibility of climatotherapy and 'open-air treatment' as an appropriate cure for tuberculosis.

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