Education of Tubercular Children in Northern Ireland, 1921 to 1955

Susan Kelly*

Summary. This paper looks at the education of tuberculous children in Northern Ireland from 1921 to 1955. It shows that there were regional differences and deficiencies in the extent of provision in Northern Ireland. Although rates of tuberculosis were higher for Irish children than their English counterparts, the Irish School Medical Service was not developed until at least 16 years later than in England and Wales. Other regional differences are revealed in the paucity of open-air education. This was considered the ideal but places were available for comparatively few children. Many continued to attend the same school as before their diagnosis whilst others were nursed at home and did not receive any schooling. We can obtain a much deeper picture of the impact of these deficiencies on tuberculous children and their families by supplementing the documentary sources with evidence obtained from oral interviews.

Keywords: tuberculosis; child health; education; Northern Ireland; oral history

Literature with regard to education of the tubercular child tends to focus on the category of pre-tubercular child rather than those children who became ill with the disease. The pre-tubercular child was defined in 1907 when the von Pirquet test was developed. It revealed those individuals who were infected with the tubercle bacillus but not suffering from active disease. As these children could then become ill with tuberculosis at a later stage in life, much of the anti-tuberculous movement focused their resources on these pre-tubercular children.1 On an international level, this led to the open-air school movement, the preventorium and health camps, which hoped to build up the resistance of sickly children and prevent them from becoming actively ill with tuberculosis. A number of books have been written on the subject.

Linda Bryder considers the British open-air school movement, and the emphasis placed on the key tenets of fresh air and nutrition.2 Frances Wilmot and Pauline Saul look specifically at the history of six open-air schools in Birmingham, including memories of past pupils and information about their day to day timetables.3 Margaret Tennant studies health camps in New Zealand and Cynthia Connolly considers the American preventorium.4 These schemes had as much to do with furthering the health of the nation as

*Centre for the History of Medicine in Ireland, University of Ulster, Shore Road, Newtownabbey, Co. Antrim BT37 OQB, UK. Email: SK.Kelly@Ulster.ac.uk

Susan Kelly is an associate member of the Centre for the History of Medicine in Ireland. Her PhD was entitled “Suffer the Little Children”: Childhood Tuberculosis in the North of Ireland 1865 to 1965. Her research interests include history of child health, tuberculosis, polio and oral history. She is currently working as a freelance researcher.

1Kelly 2008.
3Wilmot and Saul 1998.
4Tennant 1994; Connolly 2008.
they did with recognition of the individual’s right to health. They were a product of the era and support of these schemes came from both social hygienists and eugenisists. Articles on the subject again focus on the systems developed for the pre-tubercular child. 5 These works do not specifically consider the tubercular child within institutions such as sanatoria or the general school system. 6 One recent book that does record sanatorium life is by Ann Shaw and Carole Reeves. It uses oral history to record the memories of children in a Welsh tuberculosis sanatorium between 1922 and 1959. The first-person accounts bring the sanatorium experience alive although the interviewees rarely mention education. Carole Boyce, a patient in the 1940s, comments ‘there appeared to be no plan or system of education, and the little work we did was collected without comment and never returned’. 7

In the works mentioned, there are key ideas that are relevant to this paper, such as children who escaped historical scrutiny. In the Northern Irish system these ‘missing’ children were tuberculous but were not in sanatoria or schools and often not recorded statistically. There are various reasons for this, such as lack of beds, places and funding. Notable absences were also a feature of the health camps and preventoria in New Zealand and the United States of America. Tennant comments that although Maori children had, in 1935, a rate of tuberculosis ten times higher than the Pakeha population, they were not targeted as recruits for the health camps. 8

This was, however, in line with the mid-century ideal of New Zealand as a ‘classless raceless society’. 9 With regard to the United States, Connolly comments that ‘the lack of beds for children of colour [is] particularly notable given the higher mortality rate from tuberculosis among black children’. She attributes this to segregation and a lack of ‘interest in the health of African American children’. 10 As with any group with access to scarce resources, decisions were made as to who was the most ‘deserving’ of a place. In the United States, selected preventoria children tended to be ‘white, poor and often immigrant or first-generation American’. A selection process automatically meant ‘missing’ children who were excluded. This was also the case with the non-residential open-air school in Belfast. This paper, however, considers the education system in Northern Ireland, which was supposed to cater for all children, tuberculous and otherwise. This broad aspiration meant therefore that all the children not included might be regarded as ‘missing’. The issues of efficiency and expense are themes considered in much of the writing regarding open-air schools. Whilst this paper does not consider efficiency, the idea of the expense of these schools is developed regarding the impact they had on the budget allocated for the treatment of all tuberculous children in the province.

The literature on the history of public health provision for children, such as the School Medical Service, has included the tubercular problem but not focused on it. 11 Some recent work on school health has concentrated, in the words of Gleason, on ‘school medical

6Kelly 2008.
7Shaw and Reeves 2009, p. 43.
10Connolly 2008, p. 79.
inspection as a window on the social process of “constructing” healthy children.12 Bernard Harris, writing in 1995, said ‘the School Medical Services of Scotland and Northern Ireland … their story must be told elsewhere’.13 Jacqueline Jenkinson discusses ‘the health of [Scottish] school-age children and the nutrition controversy’ in a chapter of her book.14 Ruth Barrington briefly discusses the role of County Medical Officers of Health in the School Medical Service in Ireland but not in relation to tuberculosis.15

This paper attempts to build on the works listed by looking at tubercular children in the general school system within Northern Ireland and comparing the situation with that in England. The influence of the School Medical Service is also considered. Koch’s discovery of the infectivity of tuberculosis in 1882 and, later, the results of the von Pirquet test drew attention to the latent tuberculosis infection many children carried. Mortality figures, however, showed that tuberculosis affected the British Isles unevenly. In England and Wales, there had been a steady decline in the mortality figures from around 1850 whilst in Scotland the epidemic peaked in the 1870s.16 In Ireland, however, the disease peaked around the turn of the century.17 This affected all ages, including children. The Registrar-General for Ireland, in his Annual Report for 1905, drew special attention to tubercular disease. He showed that whilst it had fallen elsewhere in the British Isles, in Ireland it had remained stationary or increased. For example, this meant that, when mortality figures for children aged 10–15 were compared in the later years of the nineteenth century, there was a 27 per cent fall in England and Wales, a 32 per cent fall in Scotland but a 19 per cent rise in Ireland.18 Whilst mortality figures were available at this time, there were no systematic morbidity figures across the British Isles for children.

The Beginnings of the School Medical Service

A number of enquiries into the health of schoolchildren occurred in the early twentieth century. They showed that unexpectedly large numbers were suffering from undiagnosed conditions such as heart problems or tuberculosis. In 1902, the Royal Commission on Physical Training in Scotland, after examining children in Edinburgh, estimated that 700 children had undiagnosed pulmonary tuberculosis.19 Another school medical examination of children in Leith, Scotland in 1906 showed that 1.74 per cent exhibited signs of pulmonary tuberculosis.20

One of the hopes for a School Medical Service was that children with the early signs of tuberculosis would be noticed and their health built up by ‘wholesome food, fresh air, and breathing exercises’ before their condition became serious.21 In January 1908, the School Medical Service was inaugurated in England and Wales. Scotland appointed School Medical Officers the same year. The Scottish service was almost totally suspended during the First World War and only became active again in 1919.22 The Annual

---

13 Harris 1995, p. 4.
15 Barrington 1987, p. 103.
16 For further comparison of the British epidemic differences, see Kelly 2008.
18 Barr 1953, pp. 60–5.
20 For a detailed account of the School Medical Service in England and Wales, see Harris 1995.
21 Robertson 1907, p. 460.
Report for 1911 of the Chief Medical Officer of the Board of Education showed that, of children examined in England and Wales in 1908, 1.02 per cent had tuberculosis. This dropped to 0.75 per cent in 1909, to 0.67 per cent in 1910 and 0.59 per cent in 1911.\(^\text{23}\) In 1913, the School Medical Service of Scotland found 1,489 tuberculous children in school. As stated, Irish children were known to suffer from tuberculosis in larger numbers and there were many calls for a similar School Medical Service to be established in Ireland. In 1908, the Belfast Health Commission stated that ‘systematic medical inspection of the pupils in the National Schools would be of great value’.\(^\text{24}\) In 1907, at a series of lectures organised by the Women’s National Health Association, Sir Robert Matheson, the Registrar General for Ireland, and Dr John McCaw, the President of the Ulster Medical Society, added their support.\(^\text{25}\) School medical inspections were not initiated in Ireland at this stage, although in theory they had ‘the complete assent of all parties’.\(^\text{26}\)

Irish Nationalist MPs may have had misgivings about a School Medical Service for two reasons. The first was the anticipation that the introduction of a School Medical Service would put increased financial strain on Ireland when Home Rule was implemented.\(^\text{27}\) Secondly, Irish MPs may have been swayed against the School Medical Service by the influence of the Catholic Church. Later reports give a clear indication of the Hierarchy’s stance on the issue. In 1919, Cardinal Logue commissioned a report into the proposal for a Medical Treatment of Children Bill for Ireland ‘to form a reliable estimate of the dangers which may arise’ from such a bill becoming law. The subsequent report revealed concerns over the influence of the Eugenics Society in the establishment of the service in England. It was resolved that school managers should insist that parents give written permission before examinations were made, and that these would only be carried out in the presence of a parent, with girls only being examined by a ‘lady doctor’.\(^\text{28}\)

Politicians such as Augustine Birrell, President of the Board of Education, continued to call for a School Medical Service in Ireland. In 1907, with regard to the medical inspection of school children, he said ‘I am sorry it does not exist here in Ireland. … I assure you the Government will do its very best to give effect to your recommendations at the earliest possible time ….\(^\text{29}\) Medical experts, such as Dr Coey Bigger, also called for inspections.\(^\text{30}\)

In 1917, he felt it unfortunate that in Ireland:

\[\text{there is no system of medical inspection of school children as there is in England … [as] periodic inspection reveals such defects as carious teeth, enlarged tonsils, adenoids, ring-worm, rickets, early tuberculosis, eye diseases &c, which when detected early, may be remedied or at least alleviated, but which if left uncare for are liable to become much more serious and to detract from the child’s future usefulness or even imperil his life. … Ireland, whose infantile death-rate is lower than that of England,}\]

\(23\)PP 1911 Cd. 5925 xvi, Chief Medical Officer 1911.

\(24\)Belfast Health Commission 1908, pp. 89–94.

\(25\)Gordon (ed.) 1908, p. 42.

\(26\)Hansard, Mr Daniel Wilson, Unionist Member of Parliament for West Down, 1918–1921, debate on Medical Treatment of Children (Ireland) Bill, 24 March 1919.

\(27\)For example, the fiscal transfer created by the 1908 Old Age Pension Act was 1.6 per cent of the Irish National Income. O’Grada 2000, pp. 3, 6.


\(29\)Gordon 1908, p. 150.

\(30\)Dr E. Coey Bigger was Medical Commissioner of the Local Government Board for Ireland and Crown Representative for Ireland on the General Medical Council.
loses this advantage in the school-going period. ... [Figures show] the steady increase in the children’s death-rate in Ireland as compared with England, and makes evident the necessity of having a system of medical inspection of school children.\textsuperscript{31} 

A Public Health (Medical Treatment of Children) (Ireland) Bill was finally introduced in 1919. The upheavals in Irish political life in the early 1920s meant little action was taken and it was not until 1924 that assessment of the problem of tuberculosis in Northern Irish schools began. The School Medical Service in the Irish Free State did not begin to develop until 1927.\textsuperscript{32}

**Tuberculosis and the Service in Northern Ireland**

In 1923, Belfast County Borough became the first area in Northern Ireland to draw up a scheme (under the Public Health (Medical Treatment of Children) Act, 1919) for the medical inspection of school children. It came into operation in 1924. In the first year, almost one in every hundred children inspected was found to have pulmonary tuberculosis whilst more than one in a thousand (0.1 per cent) had tuberculosis of the bones or glands.\textsuperscript{33} Figures available up to 1948 can be seen in Table 1.

Table 2 is a comparison of the percentage of children with tuberculosis in Belfast with those in England. These figures appear to reflect the higher rate of tuberculosis in Belfast. Lack of standardisation of School Medical Service assessments meant that not everyone accepted the figures produced. In 1927, Dr George M’Gonigle argued that ‘the absence of standards … seriously limited the[ir] usefulness’.\textsuperscript{34} Comparative studies show, however, that in the period 1891–1900 mortality figures for school-age children were much higher in Ireland than in England and Wales, and Scotland.\textsuperscript{35} Throughout the first half of the twentieth century, mortality figures from tuberculosis for all ages in Ireland remained higher than in England and Wales and Scotland.\textsuperscript{36} This lends validity to the comparison of figures shown in Table 2, though it is also possible that larger numbers of tuberculous children remained in the school system in Belfast. The numbers of Belfast children with both non-pulmonary and pulmonary TB increased in 1933, 1935 and 1936. The rise in pulmonary TB cases in these years is partly due to increased referrals for X-ray.\textsuperscript{37}

Whilst other areas in the north of Ireland, outside Belfast, did not yet have a School Medical Service, some systematic examinations of children were conducted. On 8 November 1927, at a meeting of the Londonderry and Limavady Education Committee, Dr Mary Long reported on the findings of the ‘Health and Well Being Scheme’ (Table 3).\textsuperscript{38} It is interesting to note that, whilst the percentages of children with non-pulmonary tuberculosis are low, these are considerably higher than in Belfast. It is not known, however, whether all the school children of the Londonderry/Limavady area were examined or if this was a particularly vulnerable section of the school population. The higher rate of non-pulmonary tuberculosis in the areas outside Belfast reflects the much lower percentage of pasteurised milk available in these areas.

\textsuperscript{31}Bigger 1917, p. 66. 
\textsuperscript{32}Barrington 1987, p. 80. 
\textsuperscript{33}Belfast Education Committee, 1924, p. 73. 
\textsuperscript{34}Harris 1995, p. 108. 
\textsuperscript{35}Barr 1953, pp. 60–5. 
\textsuperscript{36}North Ireland Tuberculosis Authority (hereafter NITA), Annual Report, 1956, p. 27. 
\textsuperscript{37}Chief Tuberculosis Officer, Belfast 1935, p. 13. 
\textsuperscript{38}Belfast Newsletter, 8 November 1927, p. 5. The article gives no further detail about the scheme.
In 1926 it was reported at the Belfast Education Committee that 88 children who were considered to have non-infectious but active pulmonary and gland TB remained at public elementary schools in Belfast—they were not kept at home, moved to sanatoria or open-air schools. Dr T. Fulton, Chief School Medical Officer for Belfast, observed that this was 'extremely dangerous because at present it is impossible to definitely say when...

Table 1. Results of examinations by the Belfast School Medical Service, 1924–48

<table>
<thead>
<tr>
<th>No. of children examined</th>
<th>No. with pulmonary TB</th>
<th>% of total</th>
<th>No. with non-pulmonary TB</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924</td>
<td>10,702</td>
<td>100</td>
<td>0.93</td>
<td>16</td>
</tr>
<tr>
<td>1926</td>
<td>10,748</td>
<td>82</td>
<td>0.76</td>
<td>23</td>
</tr>
<tr>
<td>1927</td>
<td>12,056</td>
<td>75</td>
<td>0.62</td>
<td>22</td>
</tr>
<tr>
<td>1928</td>
<td>12,167</td>
<td>69</td>
<td>0.56</td>
<td>11</td>
</tr>
<tr>
<td>1929</td>
<td>13,033</td>
<td>103</td>
<td>0.78</td>
<td>26</td>
</tr>
<tr>
<td>1930</td>
<td>14,298</td>
<td>75</td>
<td>0.52</td>
<td>9</td>
</tr>
<tr>
<td>1933</td>
<td>13,840</td>
<td>110</td>
<td>0.79</td>
<td>19</td>
</tr>
<tr>
<td>1935</td>
<td>15,758</td>
<td>128</td>
<td>0.81</td>
<td>34</td>
</tr>
<tr>
<td>1936</td>
<td>16,663</td>
<td>100</td>
<td>0.60</td>
<td>20</td>
</tr>
<tr>
<td>1937</td>
<td>16,544</td>
<td>88</td>
<td>0.53</td>
<td>15</td>
</tr>
<tr>
<td>1938</td>
<td>15,998</td>
<td>63</td>
<td>0.36</td>
<td>—</td>
</tr>
<tr>
<td>1947</td>
<td>16,568</td>
<td>24</td>
<td>0.14</td>
<td>12</td>
</tr>
<tr>
<td>1948</td>
<td>17,065</td>
<td>18</td>
<td>0.10</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Belfast Education Committee, County Borough of Belfast Education Committee Reports 1924–48.

Table 2. Comparison of the percentage of children found by the School Medical Service to be tuberculous in England and Belfast, 1924–37

<table>
<thead>
<tr>
<th>Year</th>
<th>Belfast Pulmonary TB</th>
<th>% of total</th>
<th>London and representative areas of England Pulmonary TB</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924</td>
<td>0.90</td>
<td>0.93</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>1932/33</td>
<td>0.79</td>
<td>0.04</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>1937</td>
<td>0.53</td>
<td>0.53</td>
<td>0.01</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Note: Figures for Belfast are for 1932 and for London 1933.

In 1926 it was reported at the Belfast Education Committee that 88 children who were considered to have non-infectious but active pulmonary and gland TB remained at public elementary schools in Belfast—they were not kept at home, moved to sanatoria or open-air schools. Dr T. Fulton, Chief School Medical Officer for Belfast, observed that this was 'extremely dangerous because at present it is impossible to definitely say when...

Belfast Education Committee, 1926, p. 86. The area that became Northern Ireland had a number of sanatoria. Forster Green opened in 1880, Throne Children’s Hospital (for bone and joint tuberculosis) in 1874, Whiteabbey Municipal Sanatoria in 1906, Armagh Sanatorium in 1916, Dungannon and County Tyrone Sanatoria in 1918, Graymount Municipal Hospital for Tuberculous Children opened in 1921 and moved to Greenisland in 1941, and finally Crawfordsburn Sanatorium for children with pulmonary tuberculosis opened in 1946.
a case becomes infective. The numbers of children with active, non-infectious pulmonary tuberculosis at public elementary schools were even greater in many other years, with 578 in 1930 and the peak of 775 in 1938 (according to available figures). There were also between 91 and 533 children with non-pulmonary tuberculosis attending school each year. Since this form of tuberculosis tended not to be infectious, they were not seen as a threat to other children. As Dr Fulton pointed out, however, the ‘atmosphere of the ordinary school is not such as to assist the cure of these cases’.

Dr Fulton appealed for two more open-air schools for tuberculous children (over and above Graymount Open-Air School which was supposed to be for children who did not have active tuberculosis). He commented that although children with pulmonary tuberculosis were categorised as non-infectious, colds or flu might make them infectious to their classmates. In 1930, Fulton added ‘many of these children are of superior intelligence but owing to irregular school attendance they reach the higher standard too late to be able to compete for scholarships and once more are penalised in comparison with their fellows’.

Other counties in Northern Ireland were slower to start School Medical Services and in 1926 the Ministry of Education drew attention to their statutory obligation in this matter. By 1929, however, Armagh County Authority was the only one in Northern Ireland making no provision. Where school medical officers were present they carried out a ‘general inspection’ of each child. This involved a rapid but searching observation of hands, head, eyes and mouth. The rapidity of the observation and lack of stethoscopical examination would, however, have made it difficult to diagnose tuberculosis. Children experiencing the pain of tubercular pleurisy would have been apparent but many others could not have been diagnosed in this rapid assessment. ‘Particular Inspections’ were detailed medical examinations with completion of a record card, and were carried out if a child was reported by a parent, teacher or school nurse to need one. All new children and those leaving before the next inspection also received one.

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of children examined</th>
<th>No. with pulmonary TB</th>
<th>% of total</th>
<th>No. with non-pulmonary TB</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magerafelt</td>
<td>4,472</td>
<td>65</td>
<td>1.45</td>
<td>14</td>
<td>0.31</td>
</tr>
<tr>
<td>Coleraine</td>
<td>3,723</td>
<td>35</td>
<td>0.94</td>
<td>15</td>
<td>0.40</td>
</tr>
<tr>
<td>Limavady &amp; Londonderry</td>
<td>3,823</td>
<td>54</td>
<td>1.41</td>
<td>28</td>
<td>0.73</td>
</tr>
<tr>
<td>Belfast</td>
<td>12,056</td>
<td>75</td>
<td>0.62</td>
<td>22</td>
<td>0.18</td>
</tr>
</tbody>
</table>

Source: Belfast Newsletter (8 November 1927) and Belfast Education Committee, County Borough of Belfast Education Committee Annual Report for the year 1927.

40 Belfast Education Committee, 1927, p. 93.  
41 Belfast Education Committee, 1927 to 1948.  
42 Belfast Education Committee, 1926, p. 87.  
43 Graymount School was established in 1921 with a day and hospital section.  
44 Belfast Education Committee, 1927, p. 94.  
45 Belfast Education Committee, 1930, p. 83.  
47 Local Government Services N.I. 1930–1, p. 79.  
48 Ibid.
1930, Belfast School Medical Officers also included a personal history sheet filled in by the parents of children being examined (95.2 per cent complied).\(^{49}\) It seems likely that these would have included information about tuberculosis. Some regions used Dispensary Medical Officers instead of School Medical Officers but government sources felt this was unsatisfactory. By 1931, the Ministry of Education was able to report that ‘such indifference and hostility as had been manifested [by parents] on the initiation of this work has now disappeared’.\(^{50}\) By 1930, officers from all counties sent in annual reports of the number of children they examined and their principal ailments.\(^{51}\)

**Open-Air Education**

In Belfast, an open-air school opened in Whiteabbey Sanatorium in 1913 and at Graymount Sanatorium in 1921. There were no others elsewhere in Northern Ireland. Graymount had a section for day pupils and another for hospital patients. The numbers of children attending the sanatoria open-air schools fluctuated. They had approximately 100 beds between them, the maximum number of special places available for tuberculous children. The actual number attending would have been less, however, due to a shortage of teachers and the inability of acutely ill children to take part in lessons. Additionally, 100 is a small number when compared with the tuberculous children attending Belfast schools, which at certain points exceeded a thousand.\(^{52}\)

The day section of Graymount catered for the majority of children in Northern Ireland educated in the open air. The figures ranged from 70 to 200 children attending in some years. However, there was a lack of clarity as to who the school places were for. At its opening, the children in the ‘hospital section’ had tuberculosis of the bones whilst the children in the day section were classed as ‘physically defective’. The majority of the children at Graymount were in the sub-category ‘delicate children’, which meant they had pre- or latent tuberculosis, debility or anaemia.\(^{53}\) The emphasis on what needs the school should address changed from year to year. The many varieties and stages of tuberculosis may have led to this lack of clarity from government sources. In 1929, Graymount was described as being for children ‘not in fact themselves tuberculous, although in danger of becoming so’.\(^{54}\) In 1933, it was described as ‘Graymount School for tuberculous children’.\(^{55}\) In 1934, it was described as being for ‘children who are living with tuberculosis cases’.\(^{56}\) The *County Borough of Belfast Education Committee Report* of 1947 stated ‘although chest conditions tend to predominate, they do not get preference’.\(^{57}\) The report the following year appears to be an attempt to clarify the situation:

> the impression has gained ground that this is a school for tubercular children. Such is far from being the case. In fact, we have to try to ensure that no child with active tuberculosis is permitted to enter as he would be then a source of danger in that all who are in attendance are debilitated and therefore potentially liable to any

\(^{49}\)Belfast Education Committee, 1930, p. 65.  
\(^{50}\)Ministry of Education NI, 1931–2, p. 18.  
\(^{51}\)Ibid.  
\(^{52}\)Belfast Education Committee, 1938, stated that 1,008 children with active tuberculosis attended Belfast Public Elementary schools.  
\(^{53}\)Belfast Education Committee, 1933, p. 67.  
\(^{54}\)Local Government Services N.I. 1929–30, p. 66.  
\(^{55}\)Local Government Services N.I. 1932–3, p. 53.  
\(^{56}\)Local Government Services N.I. 1934–5, p. 122.  
\(^{57}\)Belfast Education Committee, 1947, p. 70.
such infection ... as it so happens a high proportion of those admitted have had the disease which has been ‘arrested’.  

It would therefore seem that the majority of the pupils at Graymount had a connection with tuberculosis but importantly the places were not for those children with active pulmonary tuberculosis.

### A School for Tubercular Children?

Throughout its history, the Belfast Tuberculosis Committee wanted more than one non-residential, open-air school. In 1919, the Chief Tuberculosis Officer (CTBO) suggested estimates be made ‘sufficient to build, equip and maintain two such schools’. The most advanced plan for a bigger school was put forward in 1936. The CTBO for Belfast obtained an allocation of land to build a large open-air school for Belfast. This would accommodate the Graymount pupils (about 130) plus places for 70 more children. The Belfast plans came to nothing when the education committee decided that only ‘when the demand for normal elementary school accommodation had been met [would they] proceed with a scheme for the erection of open-air schools for delicate children of school-age’. Charles Thomson, the Medical Superintendent Officer of Health, issued a report in 1938 where mention was made of ‘the four Open-Air Schools I have previously asked for’. It is not clear, however, whether these proposed schools were to be for delicate or actively tuberculous children. The matter may have been influenced by the decision of the Board of Education for England and Wales in 1931 that a sanatorium was the best place for a tuberculous child. In theory, however, if a child was discharged from a sanatorium and was no longer infectious but not yet fit for an ordinary school, a place would be found for them in an open-air school. In reality, the number of places needed were simply not available.

In October 1943, open-air schools became the responsibility of the Education Committee of Belfast County Borough Council rather than the tuberculosis committee. Attitudes to the open-air school appear to have been changing at a national level during this period. Between 1949 and 1950, a survey was made of all open-air schools in England and Wales by four medical officers of the Ministry of Education. They concluded that, while there was a need for special schools for delicate children, the Spartan open-air conditions of some should cease. The Annual Report for the years 1952 and 1953 commented that in ‘the last report the open-air schools came in for some outspoken criticism ... this has been widely studied and discussed, and a great deal of fresh thought has been and is being given to the subject’. When an increased budget became available...
after the Second World War, money was spent on new hospital buildings at Greenisland Orthopaedic Hospital for children with tuberculosis of the bones. Northern Ireland, therefore, never built a day open-air school for children with active tuberculosis.

Much of the previous historiographical debate with regard to open-air education has evaluated the merits of the system, questioning whether it ‘marked a new era in preventive medicine’.69 This paper does not consider the success or otherwise of the open-air aspect of the regime. It does, however, consider the availability of it as this was the only specific education offered to tubercular children. Therefore, the medical and educational success of Graymount will not be considered here, but how the financial issues impacted on the availability for tubercular children.70 Open-air education was expensive, the majority of the day-to-day money being spent on food. It was this cost that prevented the development of many more open-air schools. In 1926, Sir George Newman, Chief Medical Officer to the Education Board, calculated that the cost per annum of open-air education came to £30 per child, which compared with only £12 in an ordinary elementary school.71 The figures for 1925 for Preston Open-Air School reveal that 38 per cent of the education welfare budget went to the school, which educated only 0.7 per cent of the children.72 The amount spent on food by Graymount Open-Air School is not known as it was included with that of the Municipal Hospital for Tuberculous Children.73 It seems likely, however, that it was as high as in other similar establishments. This meant that running costs had to be considered as well as the building costs.

It is difficult to assess whether Northern Ireland’s provision of open-air education was better or worse than in the rest of Britain as provision was so uneven. In 1915, there were open-air schools in London, Barnsley, Birmingham, Darlington, Halifax, Kettering, Lincoln, Norwich, Reading, Sheffield and Murthy in Scotland.74 Some cities went on to open several. Thirteen were developed in London, six in Birmingham and three in Sheffield.75 As in Graymount, however, these did not all accept children with active pulmonary tuberculosis. By 1931, there were 80 day and 45 residential open-air schools in the United Kingdom. Of these, eight day-schools and 37 residential schools were specifically for children with pulmonary tuberculosis.76 The day schools were, however, re-designated as schools for delicate children in 1931 (except those in London).77 In 1949, only 72 of the 146 local education authorities in England and Wales provided (open-air) schools for delicate children.78 Northern Ireland, as stated, never had an open-air day school specifically for children with pulmonary tuberculosis.

70For discussion of the medical and educational value of open-air schools, see Kelly 2008; Bryder in Cooter (ed.) 1992; Turner 1972.
73PRONI, LA7/9AE/6.
75Fox 1991; Wilmot and Saul 1998; Turner 1972.
76Henderson 1975, p. 22.

77In 1931, the Board of Education (England and Wales) decided to reclassify the day TB schools from Type P, for children suffering from pulmonary TB, to Type D schools for delicate and debilitated children. The six TB day schools in London managed to remain open for active TB cases until 1939. See Fox 1991, pp. 260, 271.
78Ministry of Education 1952, p. 105, in chapter XIII, ‘Schools for Delicate Children (“open-air” schools)’.
Absence from School

The problem of tuberculous children missing out on their education had been apparent for many years. In 1911, a study of 14 patients at the Royal Victoria Hospital School showed that their average absence from school before admission was eight months.\(^7\)

There was no consensus about how to deal with this but it would appear that financial constraints were usually the limiting factor with regard to education for the tubercular child. Inevitably, there were many children with tuberculosis in Northern Ireland who were not in any institution, school or hospital, but were simply kept at home. Figures for tuberculous children in Belfast not attending an institution are available from 1924 to 1948.\(^8\) These figures are, unfortunately, of limited use. They are only for Belfast and information is not given as to how they were calculated. Therefore, it is unclear whether they represent children who were absent at one point in the year or a yearly total of absences. Do they include children who were sent home from sanatoria to die? How lengthy an absence from school was required to be counted in these figures? The numbers only account for children younger than 14, so children who expected to maintain their education past this age are not included. There is great variation from year to year and it is difficult to believe that in 1933 only eight children in Belfast missed school due to tuberculosis. In addition, the rapid drop from 79 in 1928 to 14 in 1929 is strange. However, regardless of the anomalies, these figures do reveal that the authorities were aware of this problem but that they could not produce clear numbers on the subject.

In contrast to Northern Ireland, England and Wales did produce figures of school absences due to tuberculosis, although it is possible that these figures experienced the same definitional problems as Belfast. The Annual Report by the Chief Medical Officer of the Board of Education for 1924 tabulates 2,206 children with non-pulmonary tuberculosis who did not attend school or other institution. There were also 2,547 children with infectious tuberculosis and 4,089 with non-infectious tuberculosis. The report for 1929 states that there were ‘6,774 children of school age suffering from various forms of tuberculosis who were not attending school’.\(^8\) This indicates that in England and Wales absences due to tuberculosis were submitted by the Local Education Authorities and collected at a national level.\(^8\) After 1930, they were not, however, included in the Annual Reports of the Chief Medical Officer to the Board of Education (England and Wales), which also no longer mentions the problem specifically regarding tuberculosis.

In 1931, as mentioned, the Board of Education decided that specific schools for the tuberculous were no longer required, as the proper place for tuberculous children was a sanatorium. Best practice would therefore have meant that children diagnosed with tuberculosis would have instantly been given a place in a sanatorium and kept there until they were fit for school or a place was available for them in a ‘special school’. In 1948, as a compromise, due to bed shortages in Northern Ireland, it was suggested

\(^7\)Goss and Sutherland in Sutherland (ed.) 1911, p. 147.

\(^8\)County Borough of Belfast Education Committee reports, 1924–1948.
that sanatorium treatment did not need to be prolonged and ‘progress towards recovery may be well maintained at home’. A sanatorium waiting-list of 121 patients with tuberculosis of the bones. The majority of these would have been children and there was no facility for schooling them. This meant there were many children who on diagnosis of tuberculosis had a long wait before their treatment and others who were discharged before they were fit to attend regular school. Special school places were available for very few children who needed them in Belfast, let alone the rest of Northern Ireland.

**Oral Histories and Educational Experience**

Due to the lack of archival information about many aspects of childhood tuberculosis, and in particular the incomplete figures with regard to education, it was felt that oral history interviews might help to fill these deficiencies. The author created an archive of oral history interviews to study all aspects of childhood tuberculosis in Northern Ireland. Letters were placed in various newspapers asking for volunteers who had experience of childhood tuberculosis to come forward for interview. In total, 53 interviews were recorded. Some of these were with educators, health professionals, relatives of the tuberculous or people who had tuberculosis as young adults. Twenty-eight were with people who as children had first-hand experience of tuberculosis. Interviewees were promised anonymity and therefore pseudonyms have been used. The interviewees ranged in age from 44 to 100, with experiences in all decades from 1910 to the 1960s. The best-represented decade was the 1940s (38 per cent). Most interviewees had lived in Belfast at the time of their tuberculosis (68 per cent). With regard to education, oral history was used to access the experience of tuberculous children nursed at home and to ascertain how common an occurrence this was within the group. Interviewees were asked about all aspects of their education or lack of it in their tuberculous years. This included, sanatoria education, school education, open-air or otherwise and any that occurred in their periods at home.

One interviewee nursed at home was May (b. 1918). She felt home nursing was so common at the time that perhaps the reason they were admitted to hospital was because their mother had died. Indeed, with fewer hospital beds and greater numbers of tuberculous, this situation was a more frequent occurrence in the earlier decades of the twentieth century. She and her brother had tuberculosis of the lungs and glands in 1926 when they were seven and eight. They were nursed in a sanatorium and then sent home. May recovered quickly but her brother was not so well:

They sent him out because they thought they couldn’t do anything. And the doctor said, ‘Ah well you know, sorry nothing we can do’. … They sent him home because that was it. He was dying. … We had a housekeeper. A very nice lady, she was. She was a Christian, and thought you know, these motherless children. … So she looked after my brother. … There was no follow up for my brother because he was supposed to be ‘going’ and there was no point looking after him. … [He did however eventually recover] … we just went back to the school around the corner. There was nothing special, there was no special treatment because it was so common.

83 NITA, Annual Report 1948, p. 21. 84 Ibid.
You know they couldn’t get everybody any kind of special treatment. You just got it, either you stayed home and got better eventually or you went into hospital as we did and em… I suppose because we hadn’t got a mother we got into hospital, perhaps. Perhaps if we’d had a mother we’d have stayed home.85

Sally (b. 1920) spoke of her 14 year-old cousin who had tuberculosis in 1936. Fred was in a sanatorium but after a while he gave up. He felt ‘sure wouldn’t I be better away than suffering all this?’ At this stage, he was taken home where he spent two years before he died:

He was in a room, in fact what we had was, in those days in a small kitchen house we had a wee room [kitchen] and then you had another room off it. And my aunt had him in there. So that he was near to the sink and all, you know what I mean, like. … And that was a good arrangement. And that’s what we had. The rest of them were up the stairs. But he had a special room on his own. And she tried to keep the other family out of it as much as she could. You know. They would have looked in through the door to him, looked in, you know … he lasted two years … it was a horrible way to go.86

These were two children who were expected to die. Others less ill were nursed at home for long periods without any formal education. Henry (b. 1929) had tuberculous pleurisy in 1941 when he was aged 12:

I got my first bout of pleurisy. I don’t remember feeling ill. I must have had chest X-rays but I don’t think I had any fluid, any significant amount of fluid, pleural fluid. And during that time I was off. I missed school of course. We had a nurse who was with us, who the family had found and she was with us most of that year, as far as I remember. And I was kept in bed but getting gradually more fresh air and exercise. And after that year, as far as I can remember, I went back to school…. I had a year there and came back with further evidence of pleurisy … so at that stage I had, I must have had further X-rays and I was certainly managed in bed, for say six months, nearly all the time doing little but reading with some homework. After that I went for a third term of the year, academic year to a public elementary school. And had a term there, and then went on … and had no further trouble for the rest of my life.87

Anne (b. 1931) remembers in 1941 being nursed at home for six months after discharge from the sanatorium as:

they didn’t like you to go to school then when you’d been diagnosed because then that was going to spread it. So for about six month … I wasn’t really getting any education. My brother would have done this and that and he was ten years older … he was trying to give me a bit of education.88

Betty (b. 1945) was aged five when she had tuberculosis of her abdominal glands. She had only a little family-provided education at home when she got out of hospital:

85OH17. 86OH18. 87OH2. 88OH35.
I was taken home in a wheelchair. ... I'd been going to the village school [in Belfast] but I never went back. ... I had schoolbooks but I never remember any contact with the school, any school or any teachers. Must have been towards two years without school.\textsuperscript{89}

These are examples of five children from 1926 to 1949 who were kept off school for reasons relating to their tuberculosis. It seems likely, from oral history evidence, that the figures provided by the County Borough of Belfast Education Committee may have been only the tip of the iceberg.\textsuperscript{90} We have no figures at all for the rest of Northern Ireland. Other tuberculous children were in-patients at various sanatoria or hospitals but received no education as their institution did not have a school.

Some conscientious teachers sent work up to the hospital but many more children missed out altogether. This affected all age groups of children. Younger children went back to the school on discharge labelled ‘backward’. They did, however, have a chance to catch up. As one woman (b. 1950) remembers ‘when I went back to school I actually went in two years below ... so I never picked up. ... [My education] really suffered. I call myself the dummy in the family’.\textsuperscript{91} Another woman (b. 1945) said:

I do remember coming back to school and going into the class lower because I’d missed so much. But then I caught up anyhow which was, everyone was quite surprised. ... I mean I lost out in schooling but I caught up. ... I can remember the teachers being very encouraging.\textsuperscript{92}

Another woman (b. 1942) spent six months in Armagh Sanatorium in 1956 at the age of 14. She then spent a further nine months at home, all with no education. When she went back to school she joined the younger class and felt that this meant that she ‘lost interest a bit’ in education.\textsuperscript{93} For older children, however, it could simply mean their education had stopped years before planned. This obviously had a knock-on effect on their job prospects and future earnings.

One oral history interviewee describes the educational difficulties she faced and overcame. Joan (b. 1938) was a patient for over a year at Armagh sanatorium at the age of sixteen. Her tuberculosis had been diagnosed between junior and senior certificates. She missed out, therefore, on receiving her final school qualifications. On leaving hospital she led a restricted life at home for the next three years with her hours out of bed being gradually increased. During this time, however, she managed to complete her education. Joan takes up the story.

My school pal decided I should be doing something useful. She decided that she would teach me what she learned at school. The library was very helpful in providing me with any books I needed. And so the adventure was under way. Obviously I could only undertake one subject at a time so I studied English Literature—a great love of

\textsuperscript{89} OH46.
\textsuperscript{90} It is not possible from oral evidence to collect complete figures regarding the numbers of tuberculous children who missed school. However, of 28 interviewees who had tuberculosis while of school age, six mentioned long absences from school. This would suggest that official figures under-estimated the extent of this problem.
\textsuperscript{91} OH45B.
\textsuperscript{92} OH25.
\textsuperscript{93} OH27.
We were almost scuppered before we’d begun. Not only was I allowed up for just an hour a day but I would not be allowed to sit in an exam hall with other students. It seemed as if I was never going to get away from the stigma of having TB. But Dad came to the rescue. The nuns in St Clare’s convent took exams from London. Not only was I allowed to sit the exam one subject at a time but I could sit the exam in a huge room on my own with one supervisor. … These exams—unheard of when I was at school—were ‘O’ levels and how I loved them!94

Obviously, Joan was a very resourceful woman and with a lot of support from family and friends she was able to achieve her educational goals. Family income and motivation with regard to education were influential factors. There were many tuberculous children whose education was interrupted, and who would not have been able to match Joan’s achievements. With some effort, teenagers who came from better-off families managed to make up for the missing school years as they were able to continue their education beyond the age of 14. For children who were expected to start earning as soon as possible this was not an option.

There was recognition from government sources regarding the impact that sickness could have on education. The Ministry of Education Acts of 1927 and 1947, in an attempt to maintain hospitalised children’s educational standards, stated that ‘it shall be the duty of every Local Education Authority to ascertain what children require special education treatment’.95 The creation of the National Health Service in 1948, which covered the whole of Northern Ireland, could have tackled this problem in a systematic fashion and the Transfer of Functions Order meant that the school medical officers became servants of the health service rather than the education system.

In 1955, however, a report by the Advisory Council for Education in Northern Ireland, concerning special education, commented that there was still ‘a lack of integration between the health and education services’. However, it described the new innovation of home tuition ‘for children who cannot be educated in ordinary schools’. It was ‘to be given by teachers from special schools released for a few sessions a week’.96 However, figures are not available for tuberculous children who benefited from this. By 1955, after the introduction of anti-tuberculous drugs, tuberculosis was diminishing throughout the British Isles. Even in 1963, however, 1,198 school children in England and Wales had their education disrupted by tuberculosis.97 The situation for sick children at the end of the twentieth century was different. Figures for 1998 indicate that at any point there were several hundred children in Northern Ireland whose general education was at risk due to prolonged hospitalisation. In 1998, the Royal Belfast Sick Children’s Hospital had between 130 and 140 children on their daily register. Approximately 30 per cent of these children were educated at home.98 Currently the Education and Library Board must provide the education a child needs, ensuring that whether at home or in hospital it is similar to that provided at school.99

94OHA.
95Love 1998, p. 163.
97Ministry of Education 1963.
Conclusion

This paper shows the difference in regional implementation of health policies. At a time when Ireland had higher rates of tuberculosis and malnutrition than the rest of the British Isles, policies such as the School Medical Service were inaugurated in England and Wales whilst the sick school-children of Ireland remained undiagnosed. The responsibility for this seems to lie both with local political ineffectiveness and with Westminster politicians who allowed it to happen. Some Irish politicians hoped that by not implementing the School Medical Service in 1908 they could pass a later Public Health Bill that would be more far-reaching. Others may have worried about future financial implications and the opposition of the Catholic Church. As a result, the School Medical Service of Ireland was delayed by 16 years and more so in the Republic. Regional differences are apparent also in provision of open-air education. From its creation in 1921 to the late 1940s, Northern Ireland was fiscally challenged and conservative in nature. It was not innovative. Open-air education was an expensive choice. This meant that even whilst open-air education was accepted as the best option for educating tuberculous children, Northern Ireland appears to have fewer of these schools than many other similarly populated areas of England, and no day open-air schools specifically for tuberculous children. No other solution was attempted. This article recovers the experience of children not embraced by the system and shows that many tuberculous children in Northern Ireland were nursed at home for long periods of time and had long spells without education. This was the case even though the aim of the authorities was to have tuberculous patients nursed in sanatoria and tuberculous children educated at open-air schools. It is not known to what degree this pattern would be repeated in regions of England without further research but comparison of numbers in hospitals across the United Kingdom might suggest this is the case. This illustrates the limitations of looking at the history of childhood tuberculosis purely in public health terms.

If we review the education provided in Belfast for tuberculous children between 1921 and 1955, we can conclude that the majority remained in the public elementary school system. A minority of children spent periods in sanatoria schools and others periods at the open-air school. However, the largest—though unknown—number of children were nursed at home and simply disappeared from the system. The authorities appear to have had a very poor record of the number of tuberculous children who were not at school or hospital. Figures for Northern Ireland, as discussed, only refer to Belfast and these are incomplete.

Oral history gives a variegated picture of the consequences of this diverse educational experience. No firm conclusions can be drawn from a small number of interviewees.

100 The creation of the Northern Irish State (1921) coincided with economic collapse. The government of Northern Ireland attempted to follow Westminster in terms of social spending (such as unemployment and sickness benefit) but they had less revenue to support this. Imperial government did not transfer funds from the treasury until 1945. This lack of funds may have impacted spending on open-air schools. The historian D. S. Johnston, however, puts the slowness of development down to ‘the lack of the necessary desire to improve conditions which stemmed from the conservative nature of public representation at both governmental and local level’. Kennedy and Ollerenshaw 1985, p. 213.

101 They were not accounted for in any official records if they were discharged from hospital and not fit for school, or nursed at home privately and not waiting for a place in a sanatorium.

102 Figures for England and Wales appear to have been collected at least for the years previously mentioned.
compared with the number of tuberculous children. While its use predominantly in this case is to reconstruct historical phenomenology, it contextualises the experience of those children revealed to have been nursed at home. It illustrates the variety of reasons why tubercular children were not attending any institution, such as being nursed at home, sent home to die and those not allowed back into their previous school. It restores a much wider and personal dynamic to research on illness, such as tuberculosis, which is often written from a public health perspective. It appears that some children did manage to catch up with their education. Many others with less home support must have had ‘the handicap of impaired education being added to the handicap of impaired health’.103 The Education Authorities in Northern Ireland appear to have neglected the children who were unfit for school, could not find a bed in a sanatorium, or a place at an open-air school. In stark contrast to those children fortunate enough to attend the open-air school, these children had no money spent on them at all and the majority did not even appear on official figures. From 1921 to 1955, it would appear therefore that the vast majority of tuberculous children, who were not in sanatoria, were either in the public elementary school system or absent from school and receiving no education. Special education catered for very few children.

Acknowledgements
This paper was discussed with colleagues at CHOMI, University of Ulster and I acknowledge their help.

Bibliography

Primary sources
Public Records Office of Northern Ireland, Belfast, Northern Ireland.
Interviews undertaken by the author and Caroline McSherry between April and November 2004.
Belfast Newsletter.
Belfast Education Committee 1924–1948, County Borough of Belfast Education Committee Annual Reports, 1924–1948.
Chief Medical Officer 1910, PP 1910 Cd. 5426 xxiii, Annual Report of the Chief Medical Officer of the Board of Education for 1909.
Chief Medical Officer 1911, PP 1911 Cd. 5925 xvii, Annual Report of the Chief Medical Officer of the Board of Education for 1910.
Chief Tuberculosis Officer Belfast 1924–35, City and Borough of Belfast Tuberculosis Department. The Report of the Chief Tuberculosis Officer (1935).

103 Fox 1991, p. 36.


North Ireland Tuberculosis Authority, 1948, Northern Ireland Tuberculosis Authority Annual Report.

Secondary sources


Jones G. 2001, ‘Captain of all these Men of Death’: The History of Tuberculosis in Nineteenth and Twentieth-Century Ireland, Amsterdam and New York: Rodopi.


