Van die Redaksie/Editorial

Hostels, health and the nation

The outbreak of violence on the Reef in 1990, and the dreadful loss of life it entailed, has focused attention on the conditions of life in the hostels of this country. Whatever the immediate causes of the conflict, there can be no doubt that social conditions in many hostels scattered across South Africa are conducive to violence and conflict. They are a national scandal.

Hostels — also called 'compounds' — have a long history in South Africa. Initially provided to house migrant workers on the mines, they became an integral part of the country-wide system which attempted to restrict African urbanisation through the imposition of influx control and replace this normal process with a system of oscillating and predominantly male 'temporary' migrant workers. These workers, shorn of their families, could be channelled according to the demands of the economy, housed inexpensively, and be returned to the rural areas when no longer needed.

Hostels have varied in quality, but many — particularly those erected by local authorities — have been grossly inadequate from the start. Generations of black workers have spent most of their working lives separated from their families, in crowded single-sex structures of the most rudimentary kind. Social scientists have documented both the inadequacy of the accommodation, and the far-reaching social consequences of this. In a survey in the early 1970s, for example, Professor Francis Wilson summarised some of the effects of the life-style associated with the migrant labour/compound system as: family break-ups, bigamy, prostitution, homosexuality, alcoholism, violence, corruption, venereal disease, tuberculosis, malnutrition and beri beri.[1] The violence already referred to is simply one example of the legacy of the system.

It can be argued that influx control and the migrant labour system were more harshly imposed in the western Cape than in other parts of the country.[2] The freeze on African family housing led to severe overcrowding in township and hostel alike, and the ideology of a 'temporary' migrant work-force allowed authorities and employers in many instances to build sub-standard hostel accommodation. The abolition of influx control regulations in 1986 in some ways exacerbated the hostel situation as a number of families joined their husbands in default of alternative accommodation elsewhere.

Recent work undertaken by the Department of Social Anthropology at the University of Cape Town, of which some of the papers in this edition of the Journal are a part, has documented some of the current conditions in the hostels run by local authorities. A disturbing picture has emerged of overcrowding, unemployment, poverty, violence and social dislocation. In a recent study of a hostel in Lwandle near Somerset West, for example, it was found that the occupancy rate was 3,3 people *per bed*, that the person-to-(bucket)toilet ratio was over 100:1, and that other facilities were minimal.[3] A medical report on the same asbestos structure showed it to be a slum within the context of the relevant legislation.[4] The same pattern of unhealthy, overcrowded and explosive conditions is repeated in many parts of the Cape, and in particular in the council-built hostels which are the focus of the papers which follow (pp. 697 - 720).

The research on hostel dwellers in Cape Town published here constitutes some of the first detailed work on the health status of this category of the population. The work presented is important not only for the basic documentation it provides, but also for the number of broader issues raised. Prime among these is the issue of methodology: the field of hostel dwellers is particularly difficult. Research was only possible after careful consultation with local structures and in the closest cooperation with local people. The work also shows the difficulty of reaching the poorest people, and of the need to be especially sensitive to differentiation within the black townships. Not only does one have to be careful about assumptions regarding official population classification,[5] but one has also to be aware of the potential significance of differentiation between, for example, township and hostel residents. Similarly, one has to avoid simplistic notions of behaviour determined by 'culture', 'tradition' or 'Third-World' standards — all of which have been shown to be problematic in understanding the dynamics of South African society.[6]

The research also shows importantly that hostel dwellers are by and large well aware of the health implications of their situation, and understand the basic socio-economic processes involved. This has clear implications for strategies of health-care delivery. In the western Cape hostel dwellers are beginning to organise in order to improve their lot. The obstacles and the challenges are formidable, and not least for the medical sector.

Martin West

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2. West ME. From pass courts to deportation: changing patterns of influx control in Cape Town. *African Affairs* 1989; **81:** 463-477.
3. West ME, Jones S. Report on Employees of ASLA Construction who were moved from Mbekweni to Lwandle during September 1989. (Unpublished — Department of Social Anthropology, University of Cape Town.)
4. Bachmann OM. Inspection report on accommodation of ASLA Construction employees and dependants, Lwandle. (Unpublished — Department of Community Health, University of Cape Town.)
5. West M, Boonzaier E. Population groups, politics and medical science. *S Afr Med J* 1989; **76:** 185-186.
6. Boonzaier E, Sharp J. *South African Keywords*. Cape Town: David Philip, 1988.

Adjuvant therapy now indicated for colorectal carcinoma

Colon cancer remains a major health problem, with many individuals afflicted annually. In resectable colon cancer treated with surgery alone there has as yet been no substantial improvement in national mortality figures. Early attempts to improve surgical cure rates with adjuvant cytostatic therapy failed. An intergroup clinical trial[1] recently established that adjuvant treatment with levamisole, a deworming agent, in combination with 5-fluoro-uracil, a standard anticancer drug, improves survival of patients with colon cancer.

Subsequently, a US National Institutes of Health Consensus Development Conference[2] recommended that levamisole/5-fluoro-uracil be considered standard therapy in patients with Dukes' C colon cancer. This combination now yields significantly improved results in the adjuvant treatment of advanced stage colon cancer. The death rate due to Dukes' C colon cancer should be reduced by as much as one-third by the use of levamisole and 5-fluoro-uracil. The results in patients with Dukes' B2 colon cancer are still too preliminary to allow firm conclusions.[3]

In order to further develop the adjuvant treatment of colon cancer an intergroup (Eastern Cooperative Oncology Group, Cancer and Leukemia Group B and South West Oncology Group) study is randomising patients with B2 or C adenocarcinoma of the colon to compare the efficacy of 5-fluoro-uracil/low-dose Leucovorin v. 5-fluoro-uracil/high-dose Leucovorin v. 5-fluoro-uracil/low-dose Leucovorin/levamisole v. 5-fluoro-uracil/levamisole.

Rectal carcinoma also remains a major health problem. There is little evidence that the response to chemotherapy of colonic and rectal carcinomas is different; however, the clinical course of patients with rectal carcinoma treated with surgery alone has been characterised by a high death rate (55% of patients die within 5 years) and pain and disability associated with pelvic recurrence of tumour. Radiation alone results in a modest reduction in local recurrence but has not been shown to have an influence on survival. Newly available information reinforces the observation that adjuvant chemotherapy benefits patients with rectal carcinoma. Although results of levamisole/5-fluoro-uracil adjuvant therapy in Dukes' B2 colonic carcinoma are still equivocal, such a benefit may well occur in patients with stage B2 (T3N0M0) rectal carcinoma. A combination of cystostatics, such as 5-fluoro-uracil and levamisole, plus pelvic radiation, may well be the optimal combination.[4] Preliminary results suggest a strong rationale for testing these chemotherapeutic approaches combined with radiation therapy as an adjuvant treatment for rectal carcinoma.

The three co-operative groups referred to above as well as the North Central Cancer Treatment Group and the Radiation Therapy Oncology Group are at present testing 5-fluoro-uracil plus radiotherapy/5-fluoro-uracil plus Leucovorin plus radiotherapy/5-fluoro-uracil plus levamisole/5-fluoro-uracil plus Leucovorin plus levamisole in rectal cancer.

It is now felt that, when possible, all patients with Dukes' C colon cancer and patients with Dukes' B2 and C rectal cancer should be entered into these trials of treatment, and that observation following surgery is not adequate. Ongoing clinical trials are providing crucial information for future generations of patients and an effective network of appropriate controlled clinical trials is essential for progress against cancer.

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1. Laurie JA, Moertel CG, Fleming TR *et al.* Surgical adjuvant therapy of large-bowel carcinoma: an evaluation of levamisole and the combination of levamisole and fluorouracil: the North Central Cancer treatment group and the Mayo Clinic. *J Clin Oncol* 1989; **7:** 1447-1456.
2. NIH Consensus Conference on Adjuvant Therapy of Patients with Colon and Rectal Cancer. *JAMA* 1990; **264:** 1444-1450.
3. Moertel CG, Thomas RF, MacDonald JS *et al.* Levamisole and fluorouracil for adjuvant therapy of resected colon carcinoma. *N Engl J Med* 1990; **322:** 352-358.
4. US Dept of Health and Human Services — Clinical Announcement. Adjuvant therapy of rectal cancer. NCI, 14 March 1991.

Calling a spade a personalised earth-moving implement

'When *I* use a word', Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean, — neither more nor less.'

— Lewis Carroll, *Through the Looking Glass*

Once upon a time, words carried their own sense of meaning, and great store was set upon teaching children these specific meanings, if only to encourage clarity of thought and expression. After all, language, as Thomas Carlyle pointed out, is the flesh-garment, the body of thought, and if words do not carry specific meanings, then we are in a pretty pickle indeed. It was George Orwell in his book *1984* who highlighted the fact that although playing about with the meaning of words in order to change their meaning would not occur to most normal, decent people, it can most certainly be done, and few who read this book will forget the convolutions of 'doublethink' and 'newspeak', the latter being a language specifically designed to abolish concepts by abolishing their means of expression. 'Good' stayed as it was, but 'bad' became 'ungood'. Something very bad

became 'plusungood' and something very bad indeed became 'doubleplusungood'. Something so bad that it could not even be contemplated became 'doubleplusungoodthinkful'.

All this might appear vaguely amusing to those who have not thought its implications through, and who feel that it has no relevance to the real world. Unfortunately, it has a great deal of relevance indeed. During the worst years of Stalin's reign over the USSR, considerable attention was paid to the science of linguistics, which was certainly not being studied for the pure advancement of knowledge, but with the aim of changing and controlling the Russian language. Although it is not being done in such a blatant fashion, there are forces at work in our world today that try to manipulate language by distorting the meaning of words deliberately rather than allowing language to evolve naturally as it has done through most of history. Advertising is one area in which meanings can be subtly manipulated to the advantage of the advertiser, although advertising standards authorities usually keep a watchful eye on advertising content to ensure that the process does not go too far. In one of Cary Grant's earlier films, in which he plays a Madison Avenue advertising executive, he is challenged that he is making a living by lying to people. 'Advertising does not lie,' was the bland response, 'it merely employs the expedient exaggeration.'

The lastest example of linguistic meddling has come, sadly, from our own Department of National Health and Population Development, which issued a 'Glossary of AIDS-friendly words' at a recent conference on AIDS. Thus 'promiscuity' is out, 'multi-partner lifestyle' is in. 'Prostitute' is out, 'commercial sex-worker' is in. 'Gays, homosexuals' are out, 'men who have sex with men' is in, and so on through the whole muddle-headed, misconceived list. At a time when AIDS is one of the greatest health threats to the entire world, one would have thought that something a little more practical in the way of positive action plans for its containment would have been more appropriate than this trivial exercise in semantics. If we are to have any chance at all of dealing with the menace of AIDS, we are going to need all the clarity of thought and precision of expression that we can muster. This exercise in linguistic manipulation merely distracts attention from the main issue. The profession will doubtless treat it with the level of attention it doubleplusungoodthinkfully deserves.

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