

Health status of hostel dwellers

Part I. Introduction, methodology and response rates

M. A. RAMPHELE, M. HEAP

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Migrant labour and the resultant material and physical impoverishment provide the social context for this study. The hostel dwellers as a migrant or mobile population presented certain research challenges. The working concepts, including the notion of the 'bedhold', employed in this study to address the mobility of the population are outlined. The methodology describes how the range of criteria selected to measure health status was investigated in a single survey. The response rates suggest that surveys carried out in the urban location of a migrant labour situation do not access the poor in the broader migrant labour situation. Findings are treated with caution for what they infer for the broader migrant population.

S Afr Med J 1991; 79: 697-701.

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A cross-sectional survey of the health status of the residents of the council-built migrant hostels outside Cape Town at Langa, Guguletu and Nyanga was carried out during October - November 1987. The survey is part of a larger project which investigates the conditions of life in the hostels of the western Cape.⁷⁻⁹ The project was initiated at the request of the hostel dwellers. It provides the hostel dwellers with the necessary database for their current campaign to upgrade their accommodation to family housing.

Health status is measured on the basis of a number of criteria (see Appendix A), which vary for the different age and sex groupings of the hostel population and are appropriate to the social conditions. Criteria to measure health status were selected by biomedical practitioners in consultation with the hostel dwellers. The hostel dwellers were consulted for popular health concerns. The introductory background to the survey is provided here and the methodology and response rates are discussed.

The health status of the urban migrant worker hostel dwellers must be seen in the context of the peculiarities of the South African migrant labour system.^{10,11} Usually migrant labour leads to eventual permanent urban settlement for the worker and his family.¹⁰ Permanent urban settlement has the potential for improvements in health status.^{12,13} However, South African government policy has long restricted black permanent urban settlement. Despite the recent repeal of the 'pass laws', it appears that many restrictions still remain.¹⁴ Oscillation between rural home-base (eastern Cape or Transkei/Ciskei for the hostel dwellers of this study) and urban workplace is the norm for migrant workers and their dependants.

Hostels are a direct outcome of influx control, a cornerstone of apartheid.¹⁵ Influx control was particularly stringently applied in the western Cape,^{16,17} where the effects of legal constraints to permanent urban settlement have been compounded by the coloured labour preference policy and the more insidious social controls. For example, no land or housing was made available for blacks from the time of the establishment of Guguletu in the early 1960s until the opening of Khayelitsha in the 1980s.¹⁸

Hostels, which may be employer- or council-built, were originally designed to provide minimal and temporary barrack-type dormitory accommodation for single male migrant workers near the urban workplace for the period of a work contract. Some local hostels were located (Fig. 1) at Cape Town docks (until very recently), in the townships of Langa, Guguletu and Nyanga, at the Strand, Kuilsriver and in Brackenfell.^{19,20} This survey was carried out in council-built hostels because they are more accessible to outsiders than employer-built premises.

The concept of the hostel or labour compound is as old as migrant labour in southern Africa, which dates back to the last century. The Old Flats in Langa is one of the oldest of the hostel complexes in Cape Town, having been built in the 1930s, shortly after the opening of this township in the 1920s. The Breakwater Prison, which was built in the last century, has until very recently also provided hostel accommodation.

Hostel dwellers comprise a significant proportion of the population. In the western Cape (old Western Cape Development Board area, which approximates the Western Cape Health Services Region),²¹ there are 1 084 hostel complexes (G. Stamatidis, CPA — personal communication). In Cape Town, the council-built hostel dwellers comprise approximately 11% of Cape Town's black population and include men, women and children.⁸ Despite the single male sex design and former severe legal restrictions women and children have always resided in the hostels. The demographic survey, which preceded the health status survey, provided evidence of the following conditions in the hostels: severe overcrowding (2,8 persons *per bed*); poor and inadequate basic amenities (117

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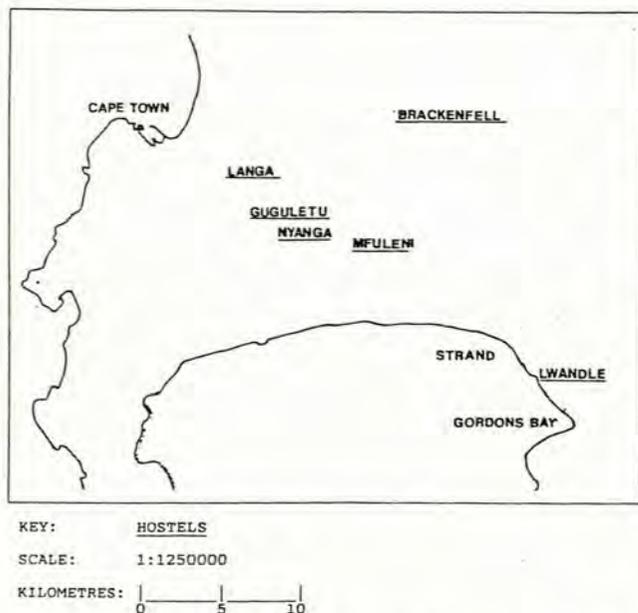


Fig. 1. Map showing geographical location of some council-built hostels in the south-western Cape.

persons to 1 tap, 133 persons to 1 working lavatory); an average weekly cash income of R100 for the needs for both rural and urban dependants.⁷⁻⁹

Working concepts

The unit of study is a social group — migrant labourers. In other words, the human study population is defined in the social sense. Categorisation by population classification is insufficient to address the poverty or oscillation of the migrant lifestyle. The hostel dwellers cannot be defined by geographical location alone. In Cape Town hostel dwellers are located across the townships of Langa, Nyanga and Guguletu. They do not have the same rights to permanent urban residence as the township residents. This is an important factor in determining their mobility.

The population cannot be distinguished into rural and urban categories. There is a continuous movement between the home-base and the urban workplace. Patterns of movement vary over the long- and short-term, on the basis of age and gender. This interdependence of the home and workplace dimensions cannot be discounted, particularly with regard to health. The home-base population is dependent on the cash earned at the workplace for basic physical survival.^{22,23}

The 'bedhold'^{8,9} is the unit of analysis for the 'conditions of life' project. The concept reflects the physical layout of the hostels where a block 'houses' between 2 and 16 economically independent bedholds and where average bed occupancy is 2,8 persons. The notion of the bedhold is based on, and directly related to, the definition of the research population, as migrant labourers in the southern African context. It describes the urban dimension of the divided migrant household. The household conceptualises the domestic group and its economic interdependence and mutual responsibilities for members as a process over time and place.²⁴ The 'urban' bedhold includes the individual in whose name the hostel bed is rented (the formal bedholder), his/her dependants, male and female, adult (≥ 17 years) and children (0-16 years), resident in the Cape Town hostel at the time of the survey.

The combined cash wage income of the 'bedhold' serves as the gradient for material differentiation in this study. The

conventional social class indicators are inappropriate in the hostel context, where unskilled labour is the common work category. Physical survival in conditions of severe poverty depends not on individual income but on combinations of resources and mechanisms for redistribution of cash wage incomes.^{22,23}

Data collection

Data for the health status of hostel dwellers were gathered by administering questionnaires as well as certain screening techniques, which served primarily as a validation for the questionnaire responses. The question schedule was divided into three parts: a demographic profile of the bed population; a health status of children (0 - 5 years); and a health status of adults (≥ 17 years). These are the major age groupings among the hostel dwellers.⁹ For individuals aged 6 - 16 years some flexibility was exercised by the research team and in practice the 'child' questionnaire was administered to individuals 0 - 10 years and the 'adult' to individuals ≥ 11 years.

Question schedules were administered by trained Xhosa-speaking interviewers. The interviews were conducted from a central location in the different hostel complexes to provide some privacy in the overcrowded hostel living conditions as well as to accommodate the screening measures. Two trained nurses were responsible for the blood pressure and blood sample taking. The interviewers had no biomedical training; they were Xhosa-speaking women, with between 8 years and 10 years of schooling and literate in English and their mother tongue. They were not from among the hostel dwellers. Few hostel dwellers who were available during the day admitted to being literate in English and Xhosa. Facilitators were drawn from among the hostel women; they assembled the people selected for the survey and assisted with the testing of urine and weighing. Both facilitators and interviewers received pre-research training. The training covered interviewing techniques and how to weigh, take height measurements and test urine.

Participation in the health interview section was entirely voluntary. Proxy reporting on health matters was not considered acceptable except in the case of children. In practice not all the individuals who comprise a 'bedhold' volunteered for the health section.

Screening techniques included blood pressure (taken with a mercury baumanometer in the sitting position) to screen for hypertension; random non-fasting urine examination to screen for diabetes; a blood sample for VDRL to screen for syphilis; a blood sample for γ -glutamyltransferase to screen for ethanol abuse. Height and weight measurements were carried out on all participants.

Data gathering was carried out from Monday to Friday between 08h00 and 16h00. The research team worked some Saturday mornings and some evenings to survey hostel dwellers in formal employment.

Sampling procedure

The initial target of a 10% cross-sectional random sample of the hostel bedholds (1200 bedholds comprising an estimated population of 3360 persons) was not achieved.²⁵ The survey achieved a 3% sample of the hostel bedholds (Table I). Of this bedhold population (928 individuals), 60% (555 individuals) volunteered for the health interview (Table II).

The age profile of the bed and health samples (Figs 2 and 3) reflects that of the hostel population.⁹ It also reflects the age profile of the urban workplace dimension of a divided migrant labour population. The elderly and schoolgoing children tend to be proportionally higher at the home-base.

TABLE I. TOTAL HOSTEL BEDHOLDS, TARGET SAMPLE BEDHOLDS AND BEDHOLD SAMPLE ACHIEVED, BY PLACE

| Geographical area | Total beds | Target bed sample | Bed sample | % total beds achieved |
|-------------------|---------------|-------------------|------------|-----------------------|
| Nyanga | 2 744 | 250 | 38 | 1 |
| Guguletu | 2 752 | 250 | 151 | 5 |
| Langa | 7 332 | 700 | 133 | 2 |
| Total | 12 828 | 1 200 | 322 | 3 |

TABLE II. HOSTEL HEALTH SCREEN — RESPONDERS BY PLACE

| Place | Bed sample | Health sample | Response rate (%) |
|--------------|------------|---------------|-------------------|
| Langa | 359 | 195 | 53,4 |
| Guguletu | 414 | 272 | 65,7 |
| Nyanga | 155 | 88 | 56,7 |
| Total | 928 | 555 | 59,8 |

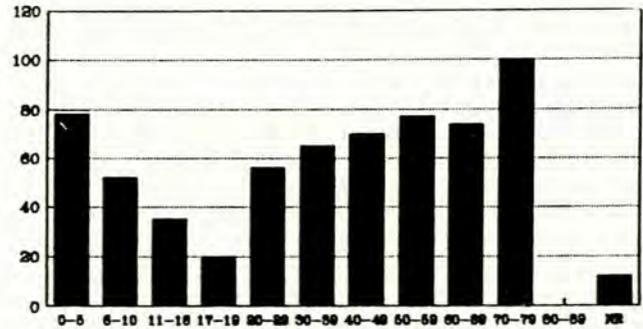


Fig. 4. Percentage response by age — hostel health screening (NR = not recorded).

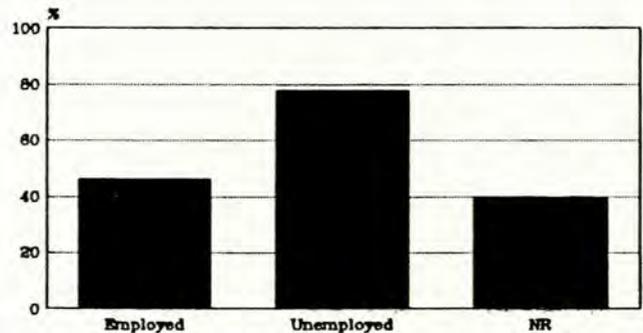


Fig. 5. Percentage response by employment — hostel health screening (NR = not recorded).

wage earners 46%) (Fig. 5). Among the employed responders, response was highest (71%) from bedholders with average weekly income > R100.

Discussion

The investigation of a number of health criteria, rather than a single index, distinguishes a health status survey. The urgency of the upgrading scheme necessitated that the criteria selected to measure health status for this project were investigated in a single survey, rather than as separate studies as in the case of the Mamre study.^{26,27} This survey is therefore best described as a screen for health status. It identifies overall health status trends for a migrant population and should be assessed as such.

The research procedure was planned to suit the limited time available. The research procedure, among other factors, affected response. The central location was not uniformly convenient. A site-to-site survey using questionnaires only has been shown to elicit a better response rate.^{9,28} Men are under-represented in the study. Their employment commitments effected the lower response rate, despite the research team making themselves available after working hours. Women, being largely unemployed, were more readily available during the day.

A strict adherence to the principle of voluntary participation also affected the response rate. A number of individuals refused the health interview. Men, in particular, were uneasy about the screening measures. Women, as mothers and the primary household health care providers, seem more acquainted with the routine diagnostic procedures of antenatal clinics, such as weighing, blood tests, urine examination and blood pressure readings.

The higher response from Guguletu may reflect the better organisation of the Hostel Dwellers' Association in this area as

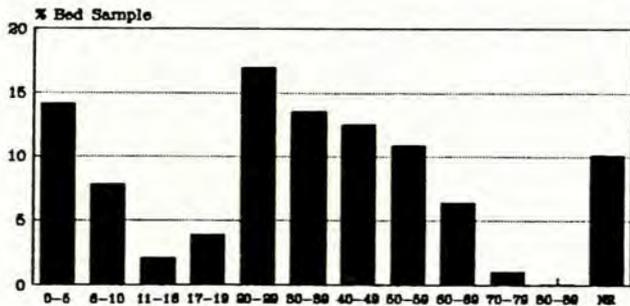


Fig. 2. Percentage bed sample — age profile (N = 926; NR = not recorded).

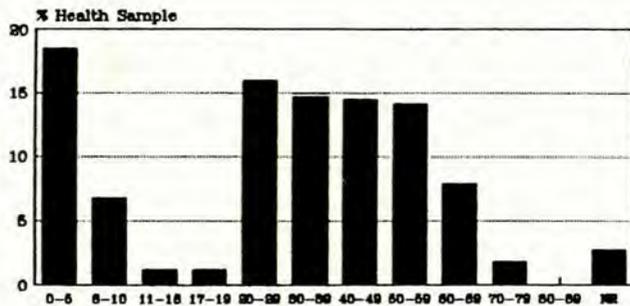


Fig. 3. Percentage health sample — age profile of responders (N = 555; NR = not recorded).

The response was highest from Guguletu (Tables I and II). For children response was highest among the 0 - 5-year-olds (0 - 5-year-olds 78%; 6 - 10-year-olds 52%; 11 - 16-year-olds 35%) (Fig. 4). This is the major child grouping in the hostel population. Response was higher among those > 40 years (Fig. 4).

The response rate was higher from women (72%) than men (48%). This reflects the higher response from adult dependants (dependants 66%; bedholders 53%), where females are among the majority. Female response rates are also reflected in the higher response from the unemployed (unemployed 78%; cash

well as the more closely knit physical layout of this hostel complex.

In Nyanga where response was poorest, the council-built hostels are unevenly dispersed among the employer-built hostels. Residents were suspicious of strangers who wandered around with official-looking clipboards, talking to some people and not to others and who appeared to be 'counting' hostels. Much of the Nyanga accommodation has been sold. This has placed severe constraints on the already overcrowded accommodation. Response at Nyanga was also affected by the conflict among local leaders at the time of the survey. In an effort to diffuse any perceived close association with a particular faction, the research team moved away from the Hostel Dwellers' Association 'structure' where research in this area was started. Response did not improve and, on the advice of a neutral party, to avoid any unpleasantness we left the area.

Health status surveys are in-depth investigations, epidemiologically as well as socially. This hostel health status survey in its design and choice of unit of analysis attempted to complement both epidemiological and social research. The definition of health status for this study took into account the poverty of the hostel environment and the age and sex groupings of the urban hostel population. These were identified during an earlier demographic survey.⁹ The population profile reflects a population divided across two geographical areas. The working age category ($\geq 17 - 65$ years) was the major grouping among adults. Among those < 17 years of age, children 0 - 5 years were the major category. The questionnaires addressed these major groupings. However, this left a proportion of the population where some flexibility with the administration of questionnaires had to be exercised — in this case the 6 - 16-year-old age category.

The concept of 'bedhold' relates the individual, the unit of medical analysis, to the social context of migrant labour. The individual is a member of a 'bedhold'. The bedhold is the urban dimension of the divided migrant household. Via the 'bedhold' and the household, a unit of social analysis, the individual is related to the broader oscillating migrant labour situation.

Final remarks

The demographic survey that preceded this health survey and the notion of the bedhold as a central research tool allowed for a detailed analysis and description of responders and non-responders. Findings were interpreted against this background. But this study did not reach the extremely poor. In the broader context of a migrant labour situation, the hostel dwellers as cash wage income earners comprise the minority of materially more advantaged households. It is on these wage income earners that the broader migrant population is dependent for cash and physical survival.

The findings on non-response among the poor reflected the situation of the extremely poor more generally. Extreme poverty results in withdrawal.²⁹ The extremely poor are the least visible members of a society,³⁰ which also makes them less visible to research and health care.²³ These response rates suggest that a certain caution is necessary when interpreting findings on the urban poor and when making generalisations to the broader migrant population from data collected in one or other of the geographical locations of the migrant labour situation.

Our sincere thanks to the hostel dwellers of Cape Town for the opportunity to carry out this project; to Dr Derek Yach of the Centre for Epidemiological Research in Southern Africa of the South African Medical Research Council; to colleagues in the

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Appendix A

Criteria for investigating health status of the residents of the council-built hostels of Langa, Nyanga and Guguletu:

1. Overall health status
 - (a) Infant mortality rate
2. Adult (≥ 17 yrs) health status
 - (a) Disease prevalence
 - Tuberculosis
 - Syphilis
 - Diabetes
 - Hypertension
 - Other conditions (i.e. those for which a respondent was seeking treatment at the time of the survey)
 - (b) Injuries
 - (c) Habits
 - Smoking
 - Alcohol consumption
 - Diet
3. Child (6 - 16 yrs) health status
 - (a) Disease prevalence
 - Tuberculosis
 - Other conditions
 - (b) Injuries
 - (c) Habits
 - Smoking
 - Alcohol consumption
 - Diet
4. Child (0 - 5 yrs) health status
 - (a) General
 - Birth weight
 - Place of birth
 - Immunisation record
 - Current height and weight
 - (b) Disease
 - Diarrhoea
5. Additional
 - (a) Contraception in women
6. Therapy sought in the event of disease and injury
 - (a) The survey in addition to measuring health status also investigated hostel dwellers' therapy-seeking activities

REFERENCES

1. West ME. Confusing categories; population groups, national states and citizenship. In: Boonzaier E, Sharp J, eds. *South African Keywords: The Uses and Abuses of Political Concepts*. Cape Town: David Philip, 1988: 100-110.
2. Bradshaw D, Botha H, Joubert G, Pretorius HP, Van Wyk R, Yach D. Review of South African Mortality. (Technical Report No. 1). Parow, CP: Institute of Biostatistics of the South African Medical Research Council, 1987.
3. Ramphela M. Health: a mirror of South African power relations. Paper presented to the Smithsonian Institute, Washington, DC, USA, April 1988. (See also: Benatar, SR. Medicine and health care in South Africa. *N Engl J Med* 1986; 315: 527-532.)
4. Boonzaier E, West ME. Population groups, politics and medical science. *S Afr Med J* 1989; 76: 185-186.
5. Rip MR, Keen CS, Woods DL. Intra-urban variations of neonatal and post-neonatal mortality in a developing city. *Soc Sci Med* 1987; 25: 889-894.
6. Prothero RM. Disease and mobility: a neglected area in epidemiology. *Int J Epidemiol* 1977; 6: 259-267.

7. Thomas E. Conflicts and their resolution in Guguletu migrant hostels: a study of the role of the Western Cape Hostel Dwellers Association. Thesis for the degree B. Sc. Hons, Department of Social Anthropology, University of Cape Town, 1987.
8. Ramphela M. The dynamics of gender politics in the hostels of Cape Town: another legacy of the South African migrant labour system. *J S Afr Studies* 1989; 75: 393-414.
9. Segar J. Living in anonymity — life in the hostels of Cape Town. Paper presented at the Annual Conference of the Association of Anthropologists of Southern Africa, Rhodes University, Grahamstown, 7 - 12 September 1988.
10. Wilson F. *Migrant Labour in South Africa*. Johannesburg: South African Council of Churches and SPRO-CAS, 1972.
11. Murray CG. *Families Divided*. Cambridge: Cambridge University Press, 1981.
12. Yach D. Urbanisation in South Africa — consequences for health (Editorial). *S Afr Med J* 1988; 74: 479-480.
13. World Health Organisation. *Urbanisation and its Implications for Child Health: Potential for Action*. Geneva: WHO, 1988.
14. Murray CG. Displaced urbanisation. In: Lonsdale J, ed. *South Africa in Question*. London: African Studies Centre, University of Cambridge in association with James Currey and Heinemann, 1988: 110-133.
15. Peskin M, Spiegel AD. Urban hostels in the Johannesburg area. In: Mayer P, ed. *Migrant Labour: Some Perspectives from Anthropology*. Vol. 7 of typescript. Grahamstown: Rhodes University Migrant Labour Project, 1976.
16. West ME. From pass courts to deportation: changing of influx control in Cape Town. *African Affairs* 1982; 81: 463-477.
17. Savage M. Pass laws and the disorganisation and reorganisation of the African population. Paper presented at the Second Carnegie Inquiry into Poverty and Development in Southern Africa (No. 281). Cape Town, 13-19 April 1984.
18. Elias C. A housing study: legislation and the control of the supply of urban African accommodation. Paper presented at the Second Carnegie Inquiry into Poverty and Development in Southern Africa (No. 157). Cape Town, 13-19 April 1984.
19. Selvan D. Housing conditions for migrant workers in Cape Town. SALDRU Working Paper No. 10, 1976.
20. Seleokane M. Nyanga East Men's Hostel: The Condition of Migrant Workers. University of Cape Town, SALDRU Working Paper No. 62, 1985.
21. Yach D. Tuberculosis in the Western Cape Health Region of South Africa. *Soc Sci Med* 1988; 27: 683-689.
22. Spiegel AD. Migrant labour remittances, the developmental cycle and rural differentiation in Lesotho community. Dissertation submitted for the degree M.A., University of Cape Town, 1979.
23. Heap M. Health and disease in south-eastern Lesotho: a social anthropological perspective of two villages. Centre for African Studies, University of Cape Town Communications, No. 16, 1989.
24. Murray CG. Keeping house in Lesotho: a study of the impact of oscillating migration. Dissertation submitted for the degree Ph.D., Cambridge, University, 1976: 54.
25. Ramphela M. The myths of participatory research. *Social Dynamics* 1990; 16: 1-15.
26. Jacobs M, Joubert G, Hoffman M. Anthropometric assessment of children in Mamre. *S Afr Med J* 1988; 74: 341-343.
27. Marshall RAS, Yach D. Management of hypertension in Mamre women. *S Afr Med J* 1988; 74: 346-348.
28. Hoffman M, Yach D, Katzenellenbogen J, Pick W, Klopper JML. Mamre Community Health Project — rationale and methods. *S Afr Med J* 1988; 74: 323-328.
29. Townsend P. *Poverty in the United Kingdom. A Survey of Household Resources and Standards of Living*. Harmondsworth, Middx: Penguin, 1979: 31.
30. Hill P. *Rural Hausa: A Village and a Setting*. Cambridge: Cambridge University Press, 1972: 148.