Poor health care for Sri Lankan tea plantation workers

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On October 3, a female worker, Marudai, from the Stockhelm Plantation at Maskeliya in Sri Lanka suddenly fell ill, fainted and was unable to speak. Workers demanded an ambulance from the management to take her to hospital at around 7am. Receiving no response by about 11 am, workers threatened to go on a strike. Only then a lorry, not an ambulance, was provided to take the patient to hospital.

On April 10, another female worker, Pushpanathan, from Ingestry Plantations at Dick-oya belonging to the Kelani Valley Plantations died, along with her newly born baby, because management failed to provide a vehicle to send her to hospital in time. Next day workers went on a strike demanding better health facilities. Management promised to implement their demands. But, as of early October, nothing had been done and the health conditions on the estate remain just as bad as before.

These are just two of the tragic incidents that have happened to Tamil-speaking plantation workers due to their lack of access to proper health facilities. One could pile up many more. Under British colonial rule, indentured labourers were brought from southern India to serve as cheap labour for the island's profitable tea and rubber plantations. Today their descendants are among the most oppressed layers of the working class in Sri Lanka.

One of the most striking examples of class discrimination in Sri Lanka is the virtual exclusion of the estate workers from the national health service. As in colonial times, the plantation companies continue to employ substandard medical practitioners without proper qualifications to provide either preventive or curative health care to workers. These practitioners are entrusted with community medicine, family planning, maternal, child health, immunisation, ante-natal and post-natal care.

In the rest of the country, only doctors trained in the university-level State Medical Colleges or medical practitioners, who have passed the Apothecaries Examination and undergone a long apprenticeship in state hospitals, are allowed to practice medicine. But on the estates, health care is in the hands of Estate Medical Assistants (EMA), who have passed only the pharmacist's examination and a special test, devised for the plantations by the Sri Lanka Medical Council. They are trained in private hospitals, which lack uniform standards.

The Hatton area is in the heart of the tea-growing estates in the central hill country of Sri Lanka. There are 69 plantations owned by seven companies on which over 170,000 people live. Yet there is only one company which provides a single hospital. The rest of the plantations are served only by one or two dispensaries and many lack even an Estate Medical Assistant. The dispensaries are staffed by pharmacists, apprentice pharmacists or untrained laymen.

Bogawantalawa Plantation Ltd (BPL) has the one hospital, 13 dispensaries and three EMA staff for its 11 plantations with a population of 31,148. On the seven estates owned and operated by Horana Plantations Ltd (HPL) there are no hospitals, 12 dispensaries and only one EMA for the population of more than 18,000 people.

Medical supplies are provided to the state hospitals by the government medical supplies department, but the plantation dispensaries are supplied by the Plantations' Housing and Social Welfare Trust (PHSWT). Its head office is in Colombo with regional offices in the main plantation centres: Hatton, Nuwaraeliya, Badulla, Ratnapura, Kegalle, Galle and Kandy. Plantation management dominates the PHSWT with 50 percent of the representatives—government officials comprise 30 percent, and the plantation workers unions have the remaining 20 percent.

As a result, only a few standard items are provided for the dispensaries: Paracetamol, iron tablets, Benzyl Benzoate (B.B cream), Mebandazole, Ergometrine injections, Penicillin tablets, Tetracycline capsules,

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Cotrim-oxazole tablets, Vitamin A & D capsules, and Jeevanee (an oral rehydration solution), and disposable syringes. The quality of drugs supplied is low, the quantity is inadequate and many essential medicines are not provided at all.

There is also a lack of other medical personnel and facilities. There are only 31 trained midwives and 28 untrained ones for 48,571 women of child-bearing age in the Hatton area. There are only 42 maternity wards—each with no more them two beds, poorly equipped and mostly staffed by under-qualified EMAs. In cases where pregnant women have complications they are sent to government hospitals at the last moment.

Of the creches available, only 311 are provided with electricity, water, toys and pictures—by UNICEF, not the government or plantation management. The vast majority are no different from the earlier *pulle madams* or baby care centres, which employed untrained and retired female employees. Crude hammocks made from pieces of cloth with the ends tied to the roof beams are used as the cradles. For children not old enough to attend school these are virtual penitentiaries. Often the creche attendants cannot speak Tamil, the mother tongue of the children, and look down upon their charges as the children of coolies.

The ambulances provided by UNICEF for plantation workers are often appropriated by the superintendents for their own use. They are rarely used to transport an ailing worker to hospital. Even women in labour pains are transported by lorries. To get a vehicle from town, one has to spend about 500 rupees or the equivalent of a week's salary.

Plantation workers are among the most economically deprived and therefore the most vulnerable to disease and ill-health. Malnutrition produced by insufficient and low quality food is so widespread that the average physical height of plantation workers is discernibly much less than that of the better-fed sections of the population. Anemia is common, especially the women and is invariably aggravated by pregnancy. The plantation districts have the highest mortality rates in the country for all age levels. The levels for maternal and infant deaths as well as still births are the worst.

The normal meal of a plantation worker consists of a roti (unleavened bread) with some chilies and salt ground together. The daily wage of a plantation worker is no more than 95 Sri Lankan rupees (Rs) or about $US1.25 but even a kilogram of the cheapest quality rice is Rs 30 and a kilogram of wheat flour is Rs 20. A coconut costs Rs 15 and a kilogram of potatoes is more than Rs 25. Protein rich food is almost out of question as a kilogram of beef is Rs120, mutton Rs 180 and chicken Rs 200. Dried fish, once a main source of proteins among poor Sri Lankans, now ranges from Rs 20 to Rs 40 for just 100 grams, according to quality.

The vast majority of plantation workers live in what are known as “line rooms” that are dirty and unhealthy, congested, with poor ventilation and lighting, damp and cold. These line rooms, each 12 feet by 10 feet, are built like barracks in two double rows back to back, accommodating 24 households—one family for each room. They have thin walls of a single layer of brick, roofs covered with corrugated iron sheets and mud floors.

There is only one window for the eight to 10 persons who share the room. Lighting is by bottle lamps—unsafe kerosene lamps made from empty bottles. Families cannot afford much furniture, and people usually sleep on the bare floor on thin sheets of cloth. The only privacy for married couples is often just a bed sheet hung from the ceiling. Since 48 percent of plantation homes have no toilet facilities, open drains are often used by children. The adults resort to the shade provided by tea bushes or glades.

For over 100 years, plantation workers produced the tea and rubber, which were the chief source of profits and foreign exchange, first for the British colonialists and then for the Sri Lankan bourgeoisie. The poor wages, grossly inadequate accommodation and lack of decent health care are an indictment of the companies that have exploited the plantation workers, as well as the government and the state apparatus.

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