

Chronic kidney disease spreads in rural Sri Lanka

W. A. Sunil
5 March 2014

Chronic kidney disease (CKD) has become a major health problem in rural Sri Lanka. Previously confined to North Central and Uva provinces, it is now prevalent in the Northwestern, Eastern, Southern and Central provinces, and parts of the Northern provinces.

Most of those living in these poverty-stricken districts are paddy and chena (slash and burn) cultivators. Many of the victims are male farmers and agricultural labourers. Growing numbers of cases, however, are being reported among women and children.

According to the World Health Organisation (WHO), more than 15 percent of the population aged 15–70 years in the North Central and Uva provinces are affected with CKD. Over 22,000 deaths from the disease have been recorded in the Anuradhapura district in the North Central Province since CKD was first identified in 1991.

Over 1,100 CKD patients are hospitalised per month in Sri Lanka and 300 deaths recorded per year. The death rate, however, is actually higher than this because many of the victims die at home.

Despite the increasing spread of CKD, its root cause has still not been definitely established. Some researchers argue that it is caused by water polluted with “unique hydro chemicals.” Many small farmers use large quantities of low-quality fertiliser and toxic agro-chemicals to boost their harvests and compete against larger producers.

WHO believes that the cause is multi-factorial. According to Dr. Shantha Mendis, WHO’s senior coordinator on chronic disease prevention and management, the factors include poor diet, chronic exposure to cadmium or kidney-damaging pesticides, arsenic and lead, genetic susceptibility to kidney failure and the use of ayurvedic or indigenous herbal remedies containing the Sapsanda plant.

The failure over the past two decades to identify the source of the CKD epidemic is an indictment of successive Sri Lankan governments and the private profit system. Hundreds of lives could have been saved utilising new developments in medical science.

WHO has recommended several measures to control the disease and provide some relief for its victims. These include regulating fertilisers and agro-chemicals and the provision of safe drinking water to the CKD-affected areas, better health facilities and financial support for the victims. Mendis has called for immediate “multi-sectoral measures” to reduce people’s, especially children’s, exposure to suspected toxins as a “top priority.”

President Mahinda Rajapakse’s government received several reports from WHO, including in 2009 and 2012. The reports were not published or made widely available, and their recommendations were largely ignored. The government banned some low-quality fertilisers containing glyphosate and carbofuran in 2011 but then lifted the ban under pressure from agro-chemical companies.

Lack of clean drinking water and extensive use of low-quality fertilisers are regarded as major factors in CKD’s spread. Only 40 percent of Sri Lanka’s people have access to pipe-borne water, with 15 out of 25 of the country’s rural districts still dependant on ground water.

Professor Sunil J. Wimalawansa, who has researched the issue for the past 15 years, recently called for additional funding for water-related infrastructure in the North Central Province. He warned that it would take 50 years to build the required infrastructure under the current allocation.

Another key factor in the spread of CKD is the desperate lack of medical equipment and specialist

doctors and nurses. In 2007, health authorities estimated that Sri Lanka needed at least 1,000 dialysis machines. Currently there are only 178 machines in public hospitals and eight haemodialysis centres and two transplant centres. Colombo's National Hospital has only six consultant vascular and transplant surgeons and nine consultant nephrologists.

Addressing a kidney disease seminar last December, Dr. Rajiva Dissanayake, an Anuradhapura hospital nephrologist, revealed the lack of facilities at his hospital. The kidney unit, he said, needed at least 18 doctors and 36 nurses to function properly but only had 8 doctors and 12 nurses.

Sri Lankan doctors performed only 699 kidney transplants from 2007 to 2011. Private sector treatment is expensive and virtually impossible for poor farmers or workers to afford. Dialysis treatment at a private hospital, for example, is over 8,000 rupees (\$US61) per session, with critically ill patients requiring at least two sessions a week. A kidney transplant costs over one million rupees (\$7,647)—a fortune for Sri Lanka's working people.

WSWS reporters spoke to several CKD sufferers from the villages of Thalava and Siyabalangamuva in the North Western Province's Kurunegala district. The villages have about 600 families, and 90 people are suffering from CKD. Seventeen people have died from the disease in the two villages over recent years.

Most of those living in the area are poor paddy farmers, with some chena cultivators. They all use well water for drinking and cooking. The prevalence of CKD in this area has been blamed on excessive amounts of fluoride in the drinking water.

B. M. Sisira Kumara, 46, from Siyabalangamuwa said he started suffering from CKD three years ago. "I had to spend more than 20,000 rupees for medical tests. When there are no drugs in hospital I have to purchase them outside, which costs 1,500–2,000 rupees every time," he said. "I have no permanent job and do odd jobs, and also have to look after my old mother. All this makes this ailment difficult to manage."

H. M. Bandaranayake, 61, a farmer from Siyabalangamuwa, said he was diagnosed as a CKD patient eight years ago but is now in a critical condition. "I had to get most medical tests from outside and paid thousands of rupees. When I was admitted to Kurunegala hospital in a critical condition they sent me

to Kandy [about 80 kilometres away] for dialysis because they had no adequate facilities. The doctors recommended a kidney transplant but I don't have enough money for that. I've no other choice but to wait for death."

W. M. G. Somarathne, from the same village, was the father of three children. He died from CKD in November 2012 at the age of 48. His wife said he had been diagnosed in August 2012. "By that time, the disease had reached a critical level and there was no time for a transplant. Three months later he died," she said.

The only medical facility in this area is the Nikawewa base hospital. It has no proper facilities for CKD treatment. Serious patients have to travel to hospitals in Kurunegala, Anuradhapura or Kandy, 46, 76 and 80km away respectively.

The terrible level of CKD across the country is the direct responsibility of successive governments that have refused to provide properly-equipped health facilities and staff, and failed to take any serious measures to prevent the disease. Like its predecessors, the Rajapakse government is indifferent to the desperate needs of small farmers and peasants.



To contact the WSWS and the Socialist Equality Party visit:

wsws.org/contact