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The health of plantation workers

Plantations are no mere relics of Britain's colonial past. Indeed, many are large thriving agricultural institutions (producing commodities such as tea, tobacco, and rubber) that play a crucial part in their countries' economy. In Zimbabwe a fifth of the working population works on plantations; in Malaya and Sri Lanka the figure is 10%, in India 1%. Among the various definitions of plantation is the telling one of "a social institution that depends on the use of unfree labour." This is a clear reminder that the labour force often consists of the descendants of migrant workers whose rights are few, working conditions frequently grim, education minimal, and health poor—in many instances worse than that of similar workers outside the plantations. Appreciable improvements in the health of the workers on some plantations have been made over the past few years, and this was the theme of a recent conference held at the London School of Hygiene and Tropical Medicine.

The meeting concentrated on new health programmes that have been introduced in plantations run by the United Planters Association in southern India, those managed by the Sri Lanka Planters Cooperation, and farms in Zimbabwe that have participated in the Bindura Farm Health Worker Scheme. An overview of plantation workers in Malaya was also given and yielded the surprising statistic that, although Malaya is by far the richest of the four countries considered, about 55% of the workers on the large estates still live below the absolute poverty line. (Details of the programmes discussed are available from the Evaluation and Planning Centre for Health Care.)

Geographical and cultural differences between the countries have dictated different approaches, but certain factors hold true. Firstly, many of the old plantation labour laws need to be updated. Secondly, the medical services on plantations have tended to be exclusively curative, with the doctors often unaware of the conditions under which their patients live and work. Thirdly, the energy and enthusiasm of a handful of people—provided that they have the cooperation of the plantation owner or, if the plantation is state run, the cooperation of key top officials—can achieve impressive improvements in health.

Most schemes have focused on preventive care and maternal and child health. Subsequent improvements in their health have, in some instances, benefited the plantation owners too because often the women do most of the work. The measures that have had most impact include providing antenatal care, building creches near the fields so that women can breastfeed with minimal disruption, and providing supervised preschool care for the under 5s. These leave mothers physically and emotionally more free to get on with their work and provide an opportunity to screen the children for health problems. Thus whether it is undernutrition or scabies, for example, the families may be approached and advised about feeding practices and treatment.

Crucial to the success of these schemes is the trained farm health worker or linkworker (a variety of names are applied) and midwife, who are trusted members of the community and after a short period of training are well able to give advice on topics such as basic hygiene, family planning, antenatal care, the use of oral rehydration fluids, and immunisation.

Though standards of health may be raised by such methods with minimal expenditure, further improvement—for example, providing a continuous supply of piped water to the workers' houses, a latrine for every family, better schools, new and upgraded accommodation, fairer and regularly increasing wages (all essential if workers are going to obtain autonomy and a reasonable standard of living)—is costly. The improvements described in the health and social status of the plantation workers in Sri Lanka clearly owe much to outside funding from organisations such as the World Bank, the Asian Development Bank, and the Dutch, Norwegian, and British governments.

In a day dominated by the achievements of a few in improving the health and social status of many, several questions were unanswered: what is the true cost of implementing and maintaining such schemes; do they continue to work when the key figures move on; to what extent, if any, are Western ideas of health integrated with indigenous systems of medicine; is the framework for evaluating the success of such health care projects adequate?

By implication the answer was no—we cannot claim to have an ideal framework in Britain. Nevertheless, most plantations keep scrupulous records, and the standard health indices are usually measured accurately. Talking to local people and holding focus groups among them to see how their ideas and expectations have changed also provide some measure of the success of a programme.

Those who would like to know more about health policy on plantations should contact Dr Richard Laing, Institute of Development Studies, University of Sussex, Falmer, Brighton BN1 9RE, or Gill Walt, Evaluation and Planning Centre for Health Care, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT.

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