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Health Status of Women Workers in Plantation Industry in a Select Area

Sherly Kurien

Introduction

The contribution of the women to development is seriously underestimated and socially unrecognized. The value of women's unpaid housework and community work is estimated at between 10 per cent and 35 per cent of the GDP Worldwide, and in 1996 it amounted to 12 trillion and in developing countries the women make 31 per cent of the official labour force and produce more than 55 per cent of all food grain. But still we see that the role of women in building a just and developed society through their remunerated and unremunerated work in almost all countries of the globe has been seriously underestimated (Singh, 2005).

Women constitute nearly half of the world population, receive two-thirds of the world's income and own less than a hundredth of the world's property. In India, 90 per cent of women are employed in the unorganized sector, without fair wages and occupational amenities.

Indian women, constituting nearly half of the total population, play a crucial role in the domestic sphere and also in the rural field, particularly in the agricultural sector. Yet, our traditional attitude is to treat women as second-class citizens. This is so in spite of the fact that women have proved their mettle in every walk of life. Their contribution is not given due credit. According to an ILO estimate, the value of unpaid household work constitutes 25 to 39 per cent of the GNP.

The largest number of working women in India is engaged in farming operations either as cultivators or as agricultural labours. They take up a wide variety of activities like sowing of seeds, transplanting, weeding, harvesting, preparation of compost and manure pits, application of manures, storage of seeds and food grains. An active farm women spends eight to nine hours on farm during the peak agricultural season.

Conditions of Women Workers

In the developing world, women are responsible for 50 per cent of total food production. In Tanzantu, women work an average of 2600 hours a year in agriculture, while it is only 1800 hours a year for men. In Africa as a whole, 60 per cent of all agricultural work, 50 per cent of animal husbandry, and 100 per cent of food processing is done by women. Millions of women in the third world cook and clean, sew and wash, plant and weed, care for the old and bring up the young and their working about 16 hour a day is not uncommon. The enormous work coupled with inadequate and unbalanced diet results in poor health and subsequent illness. The traditional notion of women being confined to the home, without exposure to the outside world has resulted in being deprived of proper health and other facilities. In the light of these facts an attempt was made to study the status of women in plantation work in a selected area.

The area selected for the study was Hosatti in Kilkotagiri. Kothagiri derives its name from the traditional habitat of tribal community Kotas. In fact Kotagiri was a small town which expanded because of plantation activities. Kotagiri is a town well connected both the with district headquarters and other important places within the district and with the nearest town in foothills, and about the same distance from the district headquarters Ootacamund. The northern part of taluk is covered with temperate forests and the rest of the area is covered mostly by tea plantations and vegetable.

The major plantation crop is tea which is grown extensively throughout the region. Tea gardens, small and large, lay enchantingly spread over the steep hills and deep valleys in the Nilgiris. The tea plantations here account for about 10 per cent of the total tea production in South India. In these tea gardens, also known as tea estates, several thousands of women are employed to pick tender leaves from the bushes. They traverse acres and acres of tea fields, day in and day out, to selectively pick only two leaves and a bud and collect the harvest either in jute bags or baskets slung over their back. The nimble fingers of the tea pickers work like machines and make no error about the type of leaves required for the manufacture of quality and flavor-rich tea.

Hosatti is a small village surrounded by hills and the weather is chill

throughout the year which allows tea plantation activity to flourish. There are nearly 100 households and for the purpose of the study the investigator selected only 60 women who were actively engaged in plantation activity. The important characteristics of these households are that they have small holdings and their meager incomes are derived from the casual employment in tea plantation.

Socio-economic Background

The general socio-economic background of the selected women is depicted in the following section. All the households had a small piece of land to be called as their own or in the words of Amartya Sen they had an entitlement of land. The land area was very meager, to the tune of ½ acre to 1 acre. In this small plot they grow tea. In their tea estate the women work for 2-3 days a week and the rest of the days they cultivate various vegetables like carrot, beetroot, potato, cabbage etc. in a small measure. Many men in this area are not seriously involved in any work and they just while away their time in the nearby shops or community hall or in market place. The bread winners are the women. They work hard and earn a living and sustain the family. Bases on the data collected we have classified women on the basis of their income as follows and this is depicted in Table 1.

Table 1

Income-wise classification of women

Income/month (In Rs.)	Number	Per centage
Less than 5,000	20	33.3
5,001-10,000	35	58.3
Above 10,000	5	8.3

More than half of the sample size are in the income group which ranges from Rs. 5,001- 10,000 per month. Only eight per cent of the sample population had more than Rs. 10,000 as their monthly income. This reveals that all the families come below the poverty line.

Health Status

The current study probed into the health status of these women. It was revealed that nearby 90% of the women have skin diseases. This may be due to the fact that, day in and day out these women are exposed to shine and rain for their work and they work inside the tea estates or in very close contact with these plants. The other serious illness found among these women were asthma and TB. Long hours of work in the chill weather affect the lungs in the long run. All the

households have the traditional way of cooking, i.e., by using firewood, they cook. The smoke which emits out of kitchen is also one reason which affects the lungs. This coupled with the climate and improper diet leads to all kinds of lung infection and finally resulting in TB. In the initial stages of asthma and TB they do not realize the seriousness they casually take it as a cold or fever and with the help of domestic medication it will be arrested temporarily. But in due course of time it appears again and again and the person loses her immunity and is prone to such serious illness. These women do not give due importance of health and this is the reason they do not approach a medical practitioner right in the beginning nor do they go to a hospital. As a last resort only they go to a Doctor and by then it becomes too serious to be treated. Hence the poor health status of the women.

The staple food item is rice and all of them take tea or coffee so frequently and this may be a reason why again whooping majority of the women are found to have diabetics. Since this is also not detected early, they land in serious illness. A disease called a sickle cell is now-a-days found among these plantation workers. It is nothing but reduction of White Blood Cells. This is mainly due to nutritional deprivation or this is the state of being anaemic. The prevalence of anaemic among women poses risk to women at various stages of her life. She will be easily susceptible to diseases and reduces the energy to do her daily chores.

Poverty condition also prevents them from meeting or consulting a doctor. If they do not work there is food in the family. Even if the husband's work he hardly brings anything to home. They are addicted to drinks and this takes away a major share of their income. Hence women have to work and definitely take care of the family. As long as they can, they continue to work and this leads to poor health. As Sathyamala (2006) points out a chronically starving population is highly susceptible to disease but is unlikely to seek early and/or adequate treatment because of cost incurred. For people who make a living by selling their physical labour on a daily basis, the high indirect cost of treatment in terms of loss of wages acts as an important determinant in medical care seeking behavior. In rural areas there is the added factor of distance and transport cots. The poor have little or no surplus to spend in terms of money, food or body stores.

The identification by the World Health Organisation (WHO) of poverty as the greatest single killer is less platitudinous than it sounds. India's mortality and morbidity profile remains overwhelmingly, dominated by poverty related infectious diseases, malnutrition and, hunger. It is well established that the calorie deprivation in rural areas has increased in the period between 1991-92 and 2002-2003. The absorption of food grains per head has fallen sharply to an abysmally low average annual level of 151 kg. By the pre-drought year 2000-01 (Patnaik, 2004). More than half the women between 15 and 49 years of age and three-

fourths of the children are anaemic. Severe and chronic under-nutrition affects 18 per cent of the children. Close to 2 million children and 1,10,000 women die every year, the latter from causes related to pregnancy and childbirth. In rural India, one woman dies every five minutes while giving birth. In addition, communicable diseases continue to fester like lesions on the body of the public health structure. Together, they are responsible for the death of 2.5 million children and an equal number of adults annually (Prasad, 2006).

The frequency of incidence of common illness and the course of treatment was examined and is presented in the following table:

Table 2

Incidence of Sickness

Sickness	(Frequency (Number reporting)			
	Regularly	Once in a Month	Once in 6 Months	Rarely
Fever	25	5	7	10
Cold	35	5	-	20
Backpain	40	20	-	-
Headache	25	30	5	-
Viral fever	-	5	10	25

The major health problem that affects these women seems to be back pain. This is because they always bend down to pluck the tea leaves. Further there is bag resting at their back in which the leaves are collected. Further the exposure to the cold climate often troubles them with fever, cold and head ache. It was noticed that 50 per cent of the women go to private hospitals for treatment while 30 per cent receive medical help from government hospital and the rest of the group still takes domestic medicine. The older generation believes in the traditional treatment. Many elderly women grows medicinal plants and herbs which are very effective and they do use it regularly. But the younger women prefer to go to private doctors for fast recovery.

The cost of treatment, was reported to be Rs.100-200 for 30 women while it was more than 200 for 10 women, for a month. Though in absolute terms it looks a trivial amount, for the poor women it is a big sum of money. This is one reason for refraining themselves from attending a medical practitioner. Also a day's labour is lost. In the case of delivery, many women now seek medical help from trained health staff or admit themselves in hospital. But there were a handful that still believed in traditional system of health care delivery and would not avail outside assistance. They do not want to incur any extra cost of delivery in an

institution when the birth can be conducted at home at minimal expense. This is in tune with a study done by Ramachandran (2008) on women's health in Kanyakumari District.

Health is acknowledged to be a complex issue which has strong linkages with nutritional intake, environmental sanitation, availability of safe drinking water, education and awareness and the access to preventive and curative health care. These variables were analysed for the plantation women workers too. The nutritional intake was found to be highly inadequate. They start the work very early in the morning. They go to the estate and start plucking tea leaves very early, without taking any food. This is continued till afternoon and then they take lunch. But this is an unbalanced diet. Solar also is the case with dinner. They consume lots of tea in between the work and this to a great extent nullifies their appetite.

Environmental sanitation is not very satisfactory. Personal hygiene also needs improvement. They refrain from having daily bath due to the chill weather. Drinking water is a telling indicator of good health. In this village there are two wells - one for drinking water and another one for other purposes. All the households get water from this common well. The drinking water is consumed directly and 35 women do not boil it. It seems to be safe as the well is cleaned periodically.

Health problems of plantation women are mostly work-related. Many illness or health problems arise out of infections, exposure to chill weather, psychological stresses, poor environment lack of personal hygiene and sanitation and high rates of malnutrition.

Steps towards Better Health

Surviving through a normal life cycle with good health, helps one to lead a happy and productive life. Human beings are the most productive factor of any economy. This factor needs to be healthy so as to be fully exploited to churn out much wealth in an economy. Improvement in the health status of the people has been one of the major thrust areas for the social development. The dream of healthy India can only be achieved when women's health is taken care and given priority. A holistic approach to women's health which includes nutrition, environment, sanitation and health services should be adopted. In the case of plantation women worker's special efforts should be taken to protect themselves from extreme weather conditions which would affect their health. It is a sorry state that when the price of tea goes down these poor women are at a loss. Government should give them incentive or some relief measures should be initiated to iron out such eventualities.

Education is the most powerful and potent factor for changing women's position. Most of the plantation workers have had only basic education and some are illiterates. They are not aware of their rights. Many of the Government programmes do not reach them. Women should be educated to fight for their rights. Education on nutrition and hygiene is very important as this forms the core of health. Steps should be taken to remove drudgery of women both at home and work place. Provision of health services which are easily accessible to women at affordable prices should be promoted.

Conclusion

The contribution of women to economic development is enormous and this is more so in the case of working women in unorganized sector. There is a growing number of women who work in plantation sector but their health status in sadly very poor. They live and work in unhygienic conditions which increase their susceptibility to chronic diseases and infection. Malnutrition coupled with poor health and lack of awareness are critical issues faced by poor women in plantation fields. On account of their poverty they are preoccupied with their daily battles for survival. It is therefore important to bring health care to the centre-stage in the development agenda. Also women should be educated and enlightened to realize their rights. All provisions should be made available by the government to provide adequate health services at affordable cost, so that women in the remote and backward areas can have access to it and thereby lead a healthy life. A healthy woman would make a healthy family and a healthy society.

The innovative manner in which the Chinese went about building their health services in the rural areas is well documented. Their primary emphasis was on ensuring that the basic needs of the population were met, and it is upon this base that preventive campaigns were launched. Health services were developed in a phased manner beginning with primary level care followed by secondary and tertiary levels. However, most writings on China do not give adequate attention to the factors that fell beyond the scope of health services and were far more influential in improving the health status of populations. The reason for citing the Chinese experience is to emphasise the relative role that health services play in contributing to health security and restating the access to basic needs for health improvement (Acharya, Baru and Nambissan, 2001).

The Rise of the Welfare State and Health Services

Until the late nineteenth century period health care was a private and individual responsibility in Europe. The beginnings of state responsibility are seen during the late 1800s when Bismarck introduced a social insurance scheme for workers

in Germany. This was then an example that other European countries also followed. State financing and provisioning of health services is a post Second World War phenomenon in Europe that was guided by principles of universality and equity. The world over this period witnessed the rise of the state as key actor in the social sectors. The sixties were the period of growth of welfare states during which state investments grew in several parts of the world. However, the seventies witnessed a world recession and it was the social sectors which suffered from cutback in expenditures.

During the eighties and nineties, there has been an acceleration of privatization throughout the world. This has been due to cutback on public expenditure and expansion of the private sector. These trends were clearly visible in the Indian context when the private sector expanded during the eighties and nineties. In addition to the growth of the private sector, the restructuring of the secondary and tertiary levels of care in the public sector is also a part of the privatization process. If one examines the structure of provisioning at the primary, secondary and tertiary levels of care, then one finds that there is a substantial private sector at the primary level consisting of individual practitioner, both formal and informal. The public sector has sub-centres and primary health centres but its availability and accessibility is variable across states. At the secondary level, the private sector consists of nursing homes with bed strength ranging from 5 to around 50. These institutions are confined to the better-developed states, urban areas and, in some cases, to rural areas. The tertiary sector is confined to the cities, and some of them are corporate enterprises that offer a range of specialist services. Thus, individual practitioners are rendering the bulk of out-patient care in the private sector in in-patient care is mostly by the secondary level institutions. The tertiary sector is being accessed mostly by the upper and middle classes while at the secondary level it is a mixed picture (Baru, 1998).

The high direct and indirect cost of health care often prevents an informal sector worker from seeking treatment, which may result in a worsening of her state of health. The poorest quintile of Indians is 2.6 times more likely than the richest to forego medical treatment when ill, and despite higher rates of illness, is only one-sixth as likely to undergo hospitalization (Peters, et.al, 2001). Poor health, when it results in lost wages and/or health care expenditures, leads to indebtedness, loss of assets and further poverty.

They live and work in unhygienic conditions and are susceptible to many infectious and chronic diseases. A vast majority of them have no fixed employer-employee relationships; nor do they get any statutory social security benefits. Workers in the informal sector do not get health care benefits, nor paid leave for illness, maternity benefits, insurance, old age pension or any other benefits. They

receive very low wages, and, as own-account or self-employed workers, they obtain meager piece-rated earnings. At the same time, most workers in the unorganized sector are not members of unions or associations. They thus remain without any representative organizations, which could otherwise help them fight against the many injustices they face everyday. They also do not have the bargaining power or collective strength to demand just policies and laws, including the laws for social protection and social security (Ahmad, et.al., 1991).

Considering the economic conditions of the country, universal coverage or even majority coverage cannot be achieved by either or both the health insurance systems and the government has to continue to play an important role both in terms of financing and delivery, especially for the lower income people and those in the rural areas. However, some resource pressure can be eased from the government by expanding the coverage under both the private and social insurance systems and especially under the latter.

If health security means equitable distribution of health care and low levels of morbidity and mortality, the state has a long way to go. While the health map of Andhra Pradesh, on most indicators, compares poorly with the rest of the southern states, on the reforms front, Andhra Pradesh is in the forefront with significant shifts in health policy. An in-depth assessment of the reforms in the health sector is still early, yet the patterns are discernible. For ensuring health security in Andhra Pradesh, the urgent need is for the state to play a more proactive role in being the major provider of health care services to its people, in both rural and urban areas. Health has to be considered a right and the state has to bear the responsibility of ensuring the well-being of its people.

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