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**AN ANALYSIS UPON VARIOUS PSYCHOLOGICAL
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CHILDREN'S: A REVIEW**

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An Analysis upon Various Psychological and Physical Hazardous Work Faced by Children's: A Review

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Abstract – Child labour is a worldwide phenomenon but more focus is required on developing countries. The policy framework of International Labour Organization (ILO) to eliminate child labour is based on United Nations (UN) Declaration of Fundamental Principles and Rights at work (1998). Over 170 million children worldwide still work in order to sustain their basic needs. About 22000 working children die due to occupational hazards every year, as per ILO estimates. Indian population has more than 17.5 million working children in different industries (Child Labour in India 1994; Tiwari 2005), and maximum are in agricultural sector, leather industry, mining and match making industries etc. As per provisions in the Constitution of India, “the State shall direct its policy towards protection of childhood and youth against exploitation and they shall not be employed to work in any factory or mine or engaged in any hazardous employment”; but unfortunately India has the largest number of urban and rural child workers in the world (Fyfe, 1994)) India being a developing nation is faced with traditional public health problems like communicable diseases, malnutrition, poor environmental sanitation and inadequate medical care. However, globalization and rapid industrial growth in the last few years has resulted in emergence of occupational health related issues. The major occupational diseases/morbidity of concern in India are silicosis, musculo-skeletal injuries, coal workers' pneumoconiosis, chronic obstructive lung diseases, asbestosis, by sinuses, pesticide poisoning and noise induced hearing loss.

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INTRODUCTION

Bad habits and poor hygiene, persistent behavioral risks, poor basic sanitation, and new and emerging diseases are contributing to a deadly mix that is changing the classic picture of healthy youth. Despite the obvious international epidemiological demographic shifts and certain policy improvements, the state of programme delivery and research in the field of adolescent and youth health is scarcely adequate to make the world “fit for children” as foreseen by the twenty-seventh special session of the General Assembly on Children in 2002. Many young people bear the burden of poor health owing to the effects of accidents and injuries including those caused by insecurity, war and occupation. In all countries, whether developing, transitional or developed, disabilities and acute and chronic illnesses are often induced or compounded by economic hardship, unemployment, sanctions, embargoes, poverty or poorly distributed wealth. The cumulative toll of violence, HIV/AIDS and now tuberculosis on youth is adding to the already heavy price still being paid by child victims of malaria and vaccine-preventable

diseases. All of this exists in stark contrast to the many gains made through the efforts of national authorities, young people themselves and the local communities in which they live, supported by the achievements of international development agencies working to ensure that the special needs of this important population and their right to good health are understood and met.

Children are the wealth of tomorrow. A child is unique individual; he or she is not miniature adult, not a little man or woman. The childhood period is vital because of socialization process by the transmission of attitude, custom, and behaviour through the influence of the family and community, children are vulnerable to disease, death, and disability owing to their age, sex, place of living, social economic status and a host of other variables. They need appropriate care for survival and healthy development. The term “child labour” refers to the engagement of children in prohibited work and activities; that is, work and activities by children that are socially and morally undesirable. The “worst form of child labour” is an appalling category of child labour which has been

defined to include all forms of slavery, child trafficking, and child soldier, and commercial sexual exploitation, hazardous child labour and using children in illicit activities. Eliminating these worst forms of child labour should receive the most urgent attention, according to the 171 countries that have ratified ILO Convention 182. Recent figures from the International Labour Organisation (ILO) show that; globally, 1 in 6 children work, 218 million children aged 5-17 are involved in child labour worldwide, 126 million children work in hazardous conditions. The highest number of child labourers in the Asia/Pacific region, where there are 122 million working children. The highest proportion of child is in Sub-Saharan Africa, where 26% of children (49 million) are involved in work. Rural working children, for example, are mainly engaged in agriculture activities and collecting water, fuel and fodder. In many countries, poor girls work as domestic servants for richer families.

Child Labour accounts for 22% of the workforce in Asia, 32% in Africa, 17% in Latin America, 1% in U.S, Canada, Europe and other wealthy nation. The proportion of the child labourers varies greatly among countries. Thus many families, especially those in developing countries need extra income or cannot afford to send their children to school, so they send them to work. "Historical growth rate suggest that reducing child labour through improvements in living standards alone will take time. If a more rapid reduction in the general incidents of child labour is a policy goal, improving educational system and providing financial incentives to poor families to send children to school may be more useful solution to the child labour problem than punitive measure design to prevent children from earning income". Child labour is a social problem and needs special attention from all levels to eliminate the basic causes behind it. Child labour is still common in some part of the world. A sizeable number of growing children of poor socioeconomic class especially in rural areas are known to be inducted as child labour. Studies have shown that labour at very young age can have dire consequences on the child's development, both physical and mental. Child labourers always had lower growth and health status compare to their nonworking counterparts, besides exposure to occupational hazards at a very young stage in their lives. It is now difficult to abolish child labour in the present situation of our country, but these children can be protected from health hazards, abuse and exploitation. Working condition for these children can be improved and regulated. Regular health check- up and early detection of health problems with necessary treatment should be arranged for them. Elimination of child labour can only be possible with combine effort of parents, community, government, nongovernment and voluntary agencies. Creation of awareness about the evil is the prime responsibility to prevent and abolish it. The global total includes 115 million children fewer than 18 engaged in "hazardous work" which could threaten their safety or health. The remaining 100 million child labourers are those under 15 whose tasks are not hazardous but are more substantial than

"permitted light work". Almost all child labour occurs in developing countries, with about 60% engaged in agriculture. Other occupations include domestic service, factory production and backstreet workshop. In one recent large survey undertaken at the national level reveals that out of a total of 3.67 million economically active children in the country, more than 60% (or 2.21 million) were exposed to hazardous conditions which included biological (19% of all working children), chemical (26%) and environment (51%) hazards during their work. Because of large majority of children most of those exposed were boys (approximately 70% of the total working boys and girls. Of the total exposed children of 2.21 million, there were more than 87,000 children (39%) whose suffered injuries or illness-divided almost equally. 49% of them were injuries and the other 51% were illness. The number of boys who suffered was considerably larger than that of girls. (72% versus 28% of the total suffers). Close to 3 quarters (74%) of the injuries and illness were in the rural communities and the rest (26%) in the urban areas. Numerically, the most frequent injuries were cuts/wounds/punctures which total close to 600,000 (or 69% of all injuries). However, there were also injuries which were serious though their occurrence were less frequent-for example, burns (57,500 equivalent to 7% of the total injuries), dislocation/fracture/sprains (45,900, or 6%), crushing injuries (29,800 or 3%) and even amputation (1,100 or 1/10 of 1%)—for a total of 134,300, equivalent to more than 15% of the total injuries and about 4% of the total working children. The type of child labour is the most important determinant of the incidence of work-related injuries. An estimated 6 million work-related injuries occur among children annually, which results in 2.5 million disabilities and 32,000 fatalities every year. In developing countries, children often work under hazardous conditions in the manufacturing and agricultural sectors. These children are at risk of both physical injuries and chemical hazards. Theoretically the relationship between occupation and health has been recognized for a long time. According to Dunton (1919) "Occupation is a basic human need as essential as food, drink and the air we breathe." Health flourishes when people's occupations give meaning and purpose to life and are publicly valued by the society in which they live and also organizes the behavior. Health is strongly influenced by having choice and control in everyday occupations. Health and well-being is influenced by the ability to engage in life's occupations. According to Yerxa (1998) "People make choices about the occupations they engage in to create a routine or daily pattern." Withdrawal or changes in occupation can lead to increased dependency, lack of confidence and depression. Conversely, to restore an individual's ability to function independently and exercise choice and control over his/her daily activities increases productivity and life satisfaction. So the person needs to engage in occupation that should not cause any harm to their health.

PHYSICAL AND PSYCHOLOGICAL HAZARDS

Hazard analysis is a process in which individual hazards of the workplace are identified, assessed and controlled as close to source as reasonable and possible. Thus hazard control is a dynamic program of prevention. Hazard-based programs also have the advantage of not assigning or implying the acceptable risks in the workplace.

Occupational health and safety has a greater scope in the heavy industry sector. Skills required to manage occupational health and safety are compatible with environmental protection and these responsibilities are bolted onto the workplace health and safety professionals like occupational health nurse. Occupational health nurse is accountable for occupational health programming and services, promoting workplace health and wellness within the guidelines and requirements of relevant Occupational Health and Safety legislation, consults with experts to provide the breadth and depth of programming necessary for a wide spectrum of occupational disease prevention, health promotion and education. Occupational health nurse frequently co-ordinates multi-disciplinary activities employing the knowledge, skill and experience of professionals from human resources, safety and services for persons with disabilities, mental health, infection control and public health. An effective awareness program about occupational hazards and first aid management helps to reduce the number of injuries and deaths, property damage, legal liability, illnesses, workers compensation claims, and missed time from work. It is important that new employees to be properly trained and embraces the importance of workplace safety as it is easy for seasoned workers to negatively influence the new hires. In India, occupational health is not simply a health issue, which includes child labor, poor industrial legislation, vast informal sector, less attention to industrial hygiene and poor surveillance data. As per the Director General of Factory Advisory Services and Labor Institutes Report (1998) there were 300,000 registered industrial factories and more than 5000 chemical factories in India, employing over half a million workers. Approximately 8.8 million workers were employed in various factories. With increasing economic growth, the problem of occupational hazards and conditions at work places is significantly increased apart from the health and safety. World Health Organization report has underscored that India could incur losses of \$237 billion by 2015 due to a sharp rise in lifestyle diseases such as diabetes, stroke, cancer due to increasing unhealthy work practices. The major occupational diseases morbidity of concern in India include silicosis, musculoskeletal injuries, coal workers pneumoconiosis, chronic obstructive lung diseases, asbestosis, sinuses, pesticide poisoning and noise-induced hearing loss. A study conducted by Kyle Steenland, Petra Macaskill and James Leigh, the annual incidence of occupational disease was between 924,700 and 19,02,300, leading to over

121,000 deaths in India. According to a survey of injury incidence in agricultural industry in Northern India, an annual incidence of 17 million injuries per year (2 million moderate to serious events), and 53,000 deaths per year was estimated. In a study, an extensive health survey of 573 lime kiln workers of Maihar and Jhukehi region of Madhya Pradesh was done for impact assessment of occupational and environmental health hazards" exposure on their health behavior. Various physical and physiological disorders of workers were screened with the cooperation of physicians and consultants. Among the observed health anomalies, eye disorders with 39.08% were ranked the highest, followed by respiratory disorders (20.06%), cardiovascular disorders (17.44%), skin disorders (15.70%), and gastrointestinal disorders (7.64%). Health illness was observed to increase with aging and length of hazard exposure.

Ayyappan R, Sankar S, Rajkumar P, Balakrishnan K (2009) conducted a Cross-sectional study in Chennai among automotive industries to illustrate the prevalence of work-related heat stress in multiple processes of automotive industries and the efficacy of relatively simple controls in reducing prevalence of the risk through longitudinal assessments. 400 measurements of heat stress were made over a 4-year period at more than 100 locations within 8 units involved with automotive manufacturing. The result shows that many processes in organized large-scale industries have to control heat stress-related hazards. 28% of workers employed in multiple processes were at risk of heat stress-related health impairment. The above finding shows that there is a need for recognizing heat stress as an important occupational health risk in both formal and informal sectors in India.

Lingard H (2002) conducted an experimental study among construction industry employees to assess how first aid training affects the motivation in avoiding occupational injuries and illnesses and its effect on their occupational health and safety behavior. Participants' motivation to control occupational safety and health risks was explored during in-depth interviews before and after receipt of first aid training. The result shows that first aid training had a positive effect on the occupational safety and health behavior of participants. First aid training appeared to reduce participant willingness to accept prevailing levels of occupational safety and health risk and increase the perceived probability that they would suffer a work-related injury or illness. Participants expressed greater concern about taking risks at work after receiving first aid training. From the above findings the study suggests that first aid training can have a positive preventive effect and could complement traditional occupational health and safety training programs and also there may be benefit in providing first aid training to all employees rather than limiting

the training to a small number of designated first aider Children who are in risky job fields have no opportunity to build their natural psychosocial health. Long working hours breed their feeling of frustration and inadequacy. Their involvement in risky work resists eventually in building their emotional cognitive skills and they become withdrawn, introvert and uncommunicative. A significant portion of the children working at construction and welding sector are suffering from psychological immaturity and overall 40 percent child laborers are affected by abnormal psychological growth. They are also deprived of the special care that would be required for their psychological effects. Child laborers are typically paid less than adults in all varieties of jobs even though they perform the same work and have to work beyond normal working hours.

TOBACCO HABIT, ITS HAZARDS AND WILLINGNESS

Human beings have been using tobacco since 600 A.D. Columbus who came to know about it from the Caribbeans during his historical journeys introduced it in Europe. The Portuguese introduced it in India. Harmful effects of tobacco have been recognized over the last 1000 years. Historically, three contemporary rulers, King James I of England, Shah Abbas of Persia and the Mughal emperor Jahangir of India in 16th century had noticed the harmful effects of tobacco and tried to ban it. Tobacco use is one of the leading preventable causes of premature death, disease and disability around the world. An estimated 4.9 million deaths occurring annually can be attributed to tobacco use. This figure is expected to rise to about 10 million by the year 2020, if the current epidemic continues and more than 70% of these deaths are expected to occur in developing countries.

Globally, cigarette smoking is the dominant form of tobacco use. In the Indian context, tobacco use implies a varied range of chewing and smoking forms of tobacco available at different price points, reflecting the varying socio-economic and demographic patterns of consumption. Tobacco is consumed in a variety of, both smoking and smokeless forms, e.g. bidi, gutkha, khaini, paan masala, hookah, cigarettes, cigars, chillum, chutta, gul, mawa, misri, etc. Tobacco is also a part of the socio-cultural milieu in various societies, especially in the Eastern, Northern, and Northeastern parts of the country. India is the second largest consumer of tobacco products and third largest producer of tobacco in the world. In order to facilitate the implementation of the tobacco control laws, bring about greater awareness regarding harmful effects of tobacco and fulfill obligation(s) under the WHO Framework Convention on Tobacco Control (WHO FCTC), the Government of India launched the National Tobacco Control Programme (NTCP) in the country.

Several strategies have been shown to reduce tobacco use. However, more than 50 years after the health dangers of smoking were scientifically proven, and more than 20 years after evidence confirmed the

hazards of second-hand smoke, few countries have implemented effective and recognized strategies to control the tobacco epidemic. International efforts led by WHO resulted in rapid entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC), which has 168 signatories and more than 150 Parties. Achievement of tobacco control goals will require coordination among many government agencies, academic institutions, professional associations and civil society organizations at the country level, as well as the coordinated support of international cooperation and development agencies.

As per India's Cigarette and Other Tobacco Product Act 2003 (COTPA), selling tobacco to minors or selling of tobacco by minors (under the age of 18) is legally forbidden and violation of the same is a punishable offence. Same applies to selling of tobacco containing items within 100 yards radius of any educational premises.

HEALTH HAZARDS OF JUNK FOODS

Food is an important part of a balanced diet. It is something everyone needs, every day. Life can be sustained only with adequate nourishment. Man needs food for growth, development and to lead an active and healthy life. Food is a substance, usually composed of carbohydrates, fats, proteins and water that can be eaten or drunk by an animal or human for nutrition or pleasure.

Junk food is the term given to food that is high in calories but low in nutritional content. In adolescents both boys and girls undergo several physical and psychological changes which make them to become partly responsible for their own health and welfare. Junk foods have no or very less nutritional value and irrespective of the way they are marketed, they are not healthy to consume. Psychological development of adolescents such as independence and acceptance by peers may affect adolescent's food choices and nutrient intake, which places them to adopt unhealthy eating behaviors like addiction to junk foods. Coming to Indian junk food, locally called, "chat", these mostly include the Samosas, Kachoris, Panipuris /golgappas are fried items with various filling within an outer layer made of refined flour. In India even Chinese food sold in road side stalls is Junk food, because they contain high amount of Monosodium Glutamate (MSG) which is a flavour enhancer & this MSG is recognized as a health hazard if taken in larger quantities because it causes headache, nausea, weakness, wheezing, edema, change in heart rate, burning sensation & difficulty in breathing. The finding of a new study out of Oxford University in the U.K. which revealed that processed junk food consumption can lead to aggression, irritability & even violent tendencies. The most common bad effective obesity which has become very common even amongst children aged as low as 3-5 years & causes many other chronic diseases of hormonal imbalances in the obese person. Nutrition experts have researched the bad effects of junk foods

& come to the conclusion that junk food manufacturing companies are fooling the people by showing deceptive advertisement that market show junk food as healthy. We must substitute junk food with healthier food like fruits & vegetables.

CONCLUSION

Children, with the compulsion of taking up work at early age 12 do not get the proper developmental environment. Many working children, especially girls, are also subjected to sexual abuse and harassment. Risky child labor also creates an obstacle for their future growth. While it is difficult to pinpoint the issue of risky child labor to the children's physical and mental deteriorations, it is worth mentioning that most child laborers are illiterate and unskilled due to early joining the employment sector. Concern for risky child labor is gaining global recognition, leading many times to calls for the elimination of all child labor. It is imperative to explore a multitude of approaches in order to eventually reach the coveted goal of eliminating child labor and preventive measures for their health.

Working children are from different age, race, income or health-status groups. The nature of work, its hazards and possible health effects, the situation in which children work are important aspects with respect to predictive short and long term effects of physical, mental and chemical work exposure on the health development of child labour in social system. Children are more prone and at high risk than adults because of rapid skeletal growth, development of organ and tissues, greater risk of hearing loss, developing ability to assess risks, greater need for food and rest, higher chemical absorption rates, smaller size and lower heat tolerance due to their physiological and immunological aspects., psychological effects and distress of child labour, occupational cancers, neurotoxicity, injuries, exposure to adverse physical factors, skin ailments, Carpel Tunnel Syndrome (rapid trigger movement of fingers) etc.

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