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## **HAZARDOUS CHILD LABOR & PSYCHO-PHYSICAL AND ECONOMIC CONSEQUENCES: A STUDY IN SYLHET CITY, BANGLADESH**

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Mohammad Morad<sup>3</sup>

### **Abstract**

Children of developing countries, by and large, have been working in different kinds of economic activities either on territorial (urban/rural) distribution or on sectoral (formal / informal and / or organized / unorganized) allocation basis. They used to work in manufacturing plants, small factories, metal and construction works. The inductive study is based on social survey aiming at unveiling the physical and mental discomforts of children involved in hazardous formal and/or informal economic sectors. Decisive examination of both primary and secondary data was made for in-depth analysis. Around 90% children under survey were suffering from different psycho-physical diseases while above half of them availed Medicaid and care from locally self-trained physicians who possessed no recognized knowledge of medical care. In addition, child workers are less-paid than those of adults. The study concluded that working at an early age causes problems of health and safety; and thereby get impeded their intellectual development and natural growth which causes severe negative consequences on economic potentials.

**Key Words:** Hazardous Child Labor, Physical Health, Psychological Health, Economic Consequence, Sylhet City

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## **Introduction**

The issue of child labor has been a source of continued concern throughout the world particularly in the developing countries. Although its prevalence in Bangladesh is frequently attributed to acute impoverishment, other factors compel children to assume economic burdens along with adults. In the same vein, relevant discourses essentially depicted child-workers as helpless victims who required immediate need of protection and rescue. Bangladesh, as a small developing country of the South Asia, suffers from large population with more than 30% extreme poor. Families are unable to mitigate basic demands of children that force them to be involved in hazardous works from very early age. Although the issue of child labor has been addressed in various policy papers of the government, it has received only generic treatment in the policy formulation. The exercise of policies lacks of visions and sensitivity which encourages families as well job market to encourage children taking risky tasks. However, physical and mental discomfort of the children affect on the socio-economic development of the country at large extent. Though the government of Bangladesh has already ratified the convention on "Child Labor", it is now an obligation for the government to take necessary initiative for protecting children.

Children have got a priority within the development process for quite long time all over the world. In Bangladesh the issue has been noted in various plans, policies and laws by successive governments at times, the scenario is still similar. However, the level and pace of improvement depend on the extent of misuse and abuse of physical labor of the child workers. Khair (2005:1) has discussed of the 22.8 million have been surveyed in 1995-96 reported 21.2% to have had working children between the ages of 5-14 years. The corresponding figures in urban and rural areas were 16.8% and 22.5% respectively (Haleh (ed.), 1985: 4). The number of working children in the same year was estimated at around 6.6 million or 19.1% of all children aged 5-14 years, the proportion of working children was 18.3% (Ahmed and Quasem, 1991: 5).

The degree of the risks in the informal sector is similar to that of the formal sector where the psycho-physical soundness of child workers had almost always been compromised. Hazardous childlabor has a predominant impact on the psycho-social structure of children's development. The socioeconomic condition within the agrarian structure of the country compels the poor families to engage their children in risky jobs at an early age. They do not have interest in education as, they think, it has no real life necessity for them which is evident in similar

studies as Uddin, Hamiduzzaman and Gunter (2009) summarized by focusing on child labor and educational issues.

In Sylhet city, children are vulnerable particularly on account of their physical and mental immaturity since they engage themselves in tiresome, untrained and non-productive activities like rickshaw pushing and pulling, welding, etc but they do not get healthcare facilities even in case of workplace mishaps. Usually they face illness like skin infections, heat-stroke, somatic pains, eye-related problems etc. Compulsory take-up of risky jobs at an early age hinders their natural mental growth. Additionally, they are also ill-paid for long hours than that of normal ones.

The broad objective of this study is to examine the extent of hazardous child labor causing physical and psychological problems and socio-economic effects. Accordingly, the study specified to: (i) identify existing levels and forms of hazardous child labor; (ii) find out the key issues of physical and psychological discomforts; and (iii) develop insights of consistent impacts of child labor in the socioeconomic structure.

### **Review of the relevant literature**

Some of the core causes responsible for the expansion of child labor within a short span of time in Bangladesh are poverty, number of family members, economic safety for elders, mental torture on children and broken family (Emerson and Knabb, 2007).

Ahmed and Quasem (1991) said that children are not getting enough money to take proper nutrition though they are engaged in risky jobs like rickshaw or van pulling, construction or welding sector etc. Ali (2006), compared between National Child Labor Survey 1995-96 and 2002-03, in order to look at the nature and magnitude of child labor; and to find out influencing factors behind it; and concluded that education and occupational choice does matter in case of children's involvement in hazardous labor. Hazardous child labor hinders their natural growth due to nature of job they take creating overburden on their body and mind; consequently, it hampers their future work lives (Grant, 1993).

Another relevant study by Guendelman, Wyn and Tsai (2002) addressed the effects of early working age of children on their physical and mental health creating strong barriers to have access to health insurance and utilization of health care among working poor families. They also found from a survey that 32% working children of the poor families remained far behind to overcome barrier of access; and less likely to attend a registered physician.

A more relevant empirical study (Mamun, Mondal, Islam and Kabir, 2008) have investigated factors influencing health complications of child laborers and showed that increased working hours, more hazardous sectors, and engaging in an early age at work cause more health complications than others.

Guendelman and Samuels (2002) also found that working children of the poor families either did not have access or remained reluctant to have medical care and put themselves in a vulnerable situation. Moreover, working in the risky job fields impedes their natural physical and mental growth. The policy issues of the child labor have depicted no direct participation in policy making for them.

Some studies concluded that child labor cannot be eliminated from Bangladesh unless policies address the realities of poverty, unemployment and unawareness of adult workforce (Kalam, 2007) and reduction of child labor would be possible through a well combination of different policies that includes employment generation for households, compulsory children's schooling, adult-literacy (Khanam, 2006) etc.

### **Data and Materials**

The study is based on a critical review of both primary and secondary data. The secondary sources of information included books, journals, research articles and publications; reports by NGOs, United Nations and donor agencies; and government documents to look at the types, age, payment, working hours, schooling, health issues, and the measures adopted by working children regarding those problems. The primary data have been obtained by employing survey method based on personal face to face interview with a semi-structured questionnaire involving both open and close ended questions. The representative samples were collected by applying purposive/judgment sampling technique from eight large areas of Sylhet city well-known as child labor market namely Akhaliaghat, Ambarkhana point, Kadamtoli railway station area, Kajolshah medical area, Kin-bridge area, Mirjajanggal, Shibgang, and Taltola with a total of 80 (ten from each of above eight different places) respondents. This study covered those working children with full-time engagement in hazardous environment where no girls were taken as children below the age of ten are claimed to be unfit into the selected works.

## **Results and findings**

While processed field data, the study summarized percentage of respondents based on different characteristics like age distribution, wages paid, and literacy level attended. Maximum (around 39%) fitted to 12-14 age level while only about 13% respondents belonged to 10-12, the smallest age group. The 14-16 years age group represented around 21%, while 16-18 age group represented nearly 27%. In addition, the study reflects that the majority (about 59%) of the surveyed respondents were paid daily Bangladesh Taka (BDT) 40 to 60 (US \$ 0.60 to 0.95 when the survey was conducted); whereas simply around 8% respondents got a daily remuneration of BDT 80 to 100; 10% received wages between BDT 60 to 80, while around 24% got between BDT 20 to 40. Moreover, information related to the educational qualification of children during the period of engagement in employment is that most of them (70%) claimed to have accomplished primary education; only 5% claimed to have finished secondary level; while more than 16% children of the rest 25% were totally illiterate and other 9% could only sign their names.

The study showed the association of respondents' age level with the type of work they were performing that majority of the children belonging to the two smallest age levels (10- 12 and 12-14) were engaged in welding sector; the corresponding percentage were 33 and 35. The majority of other two groups were also in the same sector (corresponding percentage is 25 each) which indicates that welding sector requires more energetic laborers. However, around 17% of the 10-12 years were engaged in construction sector that was by no means suited for maintaining their sound physical health. Moreover, around 17 % respondents of the same age group and around 27% of the 12-14 years old were engaged in rickshaw-pulling, 22% of the 10-12 years were working in rickshaw-pushing that is also unsuitable for them at those ages. One quarter of the 14-16 years age-level children were working in welding factories while another quarter were in rickshaw-pushing; and other half of them were engaged in rickshaw-pulling (around 19%), in the construction sector (another 19%) and as van-pulling (around 13%). The majority (35%) of the oldest age group (16-18) belonged to construction firm, while 25% were in the welding factories. One-fifths of that age level child laborers were in rickshaw-pulling and remaining one-fifths were working as rickshaw-pushing and van-pulling. Therefore, it is evident that there are some relationships between the type of work and physical strength (because of age levels); they were youngest enough to take over such types of physical labors.



Table 1 represents the association between age levels and working hours of the respondents which is significant for the analyses of impact on their physical and mental health. This study found that majority (around 28%) of the age of 10-12 child workers were bound to engage themselves in the work for 10-12 hours; 11% worked 12-14 hours, and 22% worked 14-16 hours whereas only around 17% children of same age are working for 6-8 hours; that means more than 83% have to work more than 8 hours (normal working hour) daily. Nearly half (around 43%) of the 12-14 years aged children worked from 10-12 hours while around one quarter (about 23%) were bound to work from 12-14 hours. The longest working hours for the age group 14-16 were 37.5% who had to work for 12-14 hours and another 25% from 14 to 16 hours. Similarly, it is evident that only around 8% of 12-14 years age, more than 6% of 14-16 years of age, 10% of 16-18 years are working up to 8 hours respectively; but rest of them (more than 92%, around 94% and 90% of respective ages) were bound to work more than 8 hours. Another mentionable fact is that in an average, more or less, children of all ages have to work for 10-12 hours. The last column of the Table 1 also shows that only 10% of all surveyed child workers worked for 6-8 hours i.e. exactly 90% worked for 9-16 hours daily having adverse consequences for these children's physical and psychological health.

Table 2 shows the association between the types of labor they were engaged in and health-related problems they were facing. Among all 80 respondents surveyed, 90% were suffering from physical pain, more than 72% from breathing problems, nearly half (49%) from skin diseases, more than 71% from eye problems while 40% have been considered to have psychological immaturity. The highest rate of health problems was physical pain while all of the van pullers and welding laborers were suffering from it followed by rickshaw pushers (92%). In addition to that, the highest of breathing problem was in rickshaw pushers (92%); skin diseases welding laborers (87.5%); eye-sight problem in construction workers (80%). Among the child workers who were suffering from psychological problems, the highest (60%) in construction workers followed by welding workers (54%). A look at the last column and row of Table 2 shows that, every individual child suffered from more than one health problems (3.1 on an average) and construction workers experienced the highest number of health problems per child laborer (3.6 on an average) followed by welding workers (3.5) while rickshaw pullers were the least likely to suffer from health discomforts though more than one complications each (2.2) all of them indicate that the particular type of work environment are risky for specific health-related risk.

Table 3 depicts the association between the working areas chosen and medical care preferred. Better segment (around 54%) of all surveyed children; 53% of rickshaw pullers; 64% of van pullers; , 46% of rickshaw pushers; 47% of construction laborers ; 58% of welding laborers sought medicare facilities from locally self-educated physicians having no relevant formal knowledge. Furthermore, around 14% were getting treatment from kobiraj (traditional healers usually with herbal) and nearly 9% undergone some kind of homeopathic treatment. The remaining 24% visited rural medical centers.

## **Discussion**

This study has provided an overview of the position of child labor in Sylhet City and thereby an idea of the state of the whole country as well. The empirical results found through this study facilitated by some previous studies in this field of interest facilitated the discussion focusing the incidence, extent and consequences of hazardous child labor. As Basu (1999: 1-8) argues that the children are not deemed to productive jobs, mostly they are engaged in rickshaw or van pulling, construction works, domestic work, fuel collection etc. or some other socially unaccepted works. Poor families are largely depended on the children to share responsibility of earning and are recognized as important source of income due to the old age and disability of the adult members. The socio-economic scenario and structure in Sylhet city is thus, a big portion of the population face abject poverty and it encourages people to engage children in risky sector. The families expect their children in shouldering or at least sharing the economic burden with other members of the family.

The findings in terms of effects of the child labor in this study are discussed from physical, psychological and economic point of view.

## **Physical health**

The childhood labor indeed has debilitating effects on the physical health of the children and thereby causes negative affect on their physical growth. Since the major portion of them come from insolvent families and they are nutritionally unfit to tackle the discomforts of hard work. Similar results were presented by Khair (2005: 12) as the physical damage largely depended on the job types; and the long working hours they were working. This study showed that more than 70% children have to work on an average more than 12 hours daily among whom around 40% have more than 14 hours work to perform daily. On the other hand, more than 60% of 12-14 years old children have to work for more than 12 hours daily. Among the 10-12 years old children have to work for more than 8 hours (normal working hour per day) up to 16 hours daily.

Therefore, it indicates that they are bound to do these risky jobs which are not permitted by their physical ability and tenderly low age and obviously cause different types of physical discomforts with effects for short or long terms. They are usually at risk of physical tenderness and to health and safety at workplace which may be traced from rickshaw or van pulling and rickshaw pushing create extreme burden on their body. Besides, unhealthy working condition of the welding and construction sector made their physical temperament in vulnerable position. Maximum children (90%) were suffering from physical pain during and/or working hours. Moreover, skin diseases, breathing problems and eye-related problems are caused by unhealthy and unsafe workplaces like construction and welding sectors. So the study indicates that in the informal industrial sector, children are at great risk of injuries, mutilation, burns and infections, eye infections etc and of future vulnerable consequences. The working condition or working hour in the construction (requires more physical strength) or welding industries (the most alarming sector) are frequently devoid of standard health and safety measures. Carrying and lifting heavy loads or adopting uncomfortable and unwieldy postures at work sometimes permanently damage their physical growth of different parts of the body. Deformities in body structure, spinal cord and pelvis may be damaged as a result of maintaining their work in the unsecured condition. Apart from this, working for long hours under the blistering sun or incessant rain, and handling chemicals affect on their health that are being always ignored. What makes the situation worse is that they are not getting physical treatment from recognized health service providers. Most of them (about 75%) are getting treatment for injuries or diseases from local self-educated doctors, kobiraj, and homeopathies who do not have institutional credibility.

### **Psychological soundness**

Children working at hazardous jobs cannot maintain their normal psycho-social sound health due to the compulsion of taking up work at an early age and physical unfitness hindered the development of their mental faculties. Working longer than the usual work hours also raises their frustration, stress and tension. Besides this, their engagement in hazardous works hinders their emotional development and mental abilities and talents; and thereby compels to become introvert, withdrawn, and reticent. A significant portion of construction and welding sector working children were suffering from psychological naivety while overall 40% of them were suffering from unusual mental progression; and at the same time they remained deprived of getting special care required for their psychological firmness. Psychological effects may be regarded as the consequence of the final stage of their injuries and

infections. So it is clear that the serious vulnerability of children caused by their involvement in risky jobs is alarming and they have to be immediately rescued from losing mental equilibrium and engaging in delinquent behavior. Their longer working hour, in such a tender age causes serious intellectual harm as a consequence for the long-run effect. Additionally, treatment they seek from kobiraj, and local self educated physicians do their permanent and irreparable psychological damage.

### **Economic effects**

Working children are usually ill-paid which is less than that of adults in all arrears of jobs although they perform equally and have to work for longer hours than that of usual (Khair (2005: 14) commented that children in the wage market face pathetic situations since they receive a very tiny amount of money as wage/salary that hardly commensurate to the labor they put in. However, the employers in construction or welding sectors feel comfort to get work done by children that replaces adult male and female from that kind of jobs. This is simply exploitation over the child laborers having alarming economic consequences. This study shows that the standard earnings of child laborers vary from BDT 40 to 60 (i.e. 50 on an average) where nearly 73% child workers are paid this much amount for working more than 10 hours daily and only 17.5% are given above BDT 60 per daily. A little share of this income is spent for themselves because of feeding other dependent family members and gradually losing their work-potentials due to malnutrition and eventually become dependent on their own children in future which creates a cycle of dependency. Moreover, due to lack of formal contacts with child workers, employers make arbitrary decisions in determining working hours, payment of wages, termination from works and of other facilities. This study shows that 25% of children under survey are either totally illiterate or at best were able to sign their names. Known that 95% of child workers could not complete their primary education and children who start working from an early age attain a low level of education, which has an immense impact on their future welfare and their future inability to generate a decent income.

### **Concluding remarks and policy recommendations**

The study pointed out that, children usually work at menial and non-productive jobs. They are frequently falling ill while they are usually inclined to prefer no essential medical care no matter any workplace misfortunes. No treatment as well as ill-treatment along with compulsion of taking up long hour work at a very early age impedes their proper long-term growth. In conclusion it may be said that it is hard to tackle the

issues of hazardous child-labor and their impact on physical and mental health as there is lack of pragmatic policy initiatives and their implementation. Nevertheless, it is worthy to comment that in most cases child workers remain illiterate and unskilled due to earlier engagement in works. Therefore, it is imperative to improvise a congregation of various options with a view to attain the desired goal of disregarding child labor and improve their health conditions by adopting necessary actions. Another alarming fact is that the government machinery and its policy instruments could neither take enough measures to create a sense of responsibility in the tenderly minds or provide alternative opportunities for these underprivileged portion of the society. Evidence is also prevalent that many of child workers actually like their work and take a lot of pride in what they do (Ehsan, 2001: 45) but many of them do not know the negative long-term effects. So child labor problem should be comprehended from a broader socioeconomic perspective. Without a comprehensive view, intervention from policy level could be self-defeating. In this context, the government machinery may consider combined approach of a variety of integrative policy measures as:

- Taking necessary measures for improving elementary education;
- Building particular contexts for the poor families like non-formal education;
- Awareness building for parents regarding distresses of hazardous child labor;
- Creating alternative employment opportunity for parents;
- Giving allowance for poor families;
- Existing food-for-education program (FFEP) should be augmented;
- Ensuring and improving door to door health facilities for children;
- Making special unit or mobile medical team for the child workers at their workplaces;
- Improving the access and facilities of rural and community health centers;
- Creating integrative body for making combined effort of the public, private, and NGOs and civil society;
- The government should comply with the comprehensive document “UN Convention on the Rights of the Child’1989” covering major aspects of child rights and promote the integrative legislative, administrative, social and educational measures;
- The government should follow the ILO (International Labor Organization) standards and principles to protect child rights;
- The government should take immediate review measures of state plans, policies and legislation (The fifth five year plan: 1997-2002); Poverty Reduction Strategy Paper; Bangladesh Decade Action Plan for the girl child; 1991-2000; National Children

Policy'1994; National plan Action for Children: 1997-2002; National Education Policy'2000) relating to children.

- Infrastructure and organizational capabilities are required for responding to special healthcare treatment facilities for child laborers.

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**Tables**

Table 1. *Distribution of respondents’ age and working hours.*

Working hour (daily)	Age groups				Total
	10-12	12-14	14-16	16-18	
6-8	3 (16.67)	2 (7.69)	1 (6.25)	2 (10)	8 (10)
8-10	4 (22.22)	4 (15.38)	2 (12.5)	4 (20)	14 (17.5)
10-12	5 (27.78)	11 (42.31)	3 (18.75)	6 (30)	25 (31.25)
12-14	2 (11.11)	6 (23.08)	6 (37.5)	3 (15)	17 (21.25)
14-16	4 (22.22)	3 (11.54)	4 (25)	5 (25)	16 (20)
<b>Total</b>	18 (100)	26 (100)	16 (100)	20 (100)	80 (100)

Field data. Figures in parenthesis denote percentage of column total.

**Table 2. Distribution of Work areas based health-related problems.**

Health problems	Type of works					Total (Infection-wise)
	Rickshaw-pulling	Van-pulling	Rickshaw-pushing	Construction labor	Welding labor	
Physical pain	12 (70.58)	11 (100)	12 (92.31)	13 (86.67)	24 (100)	72 (90)
Breathing problems.	6 (35.29)	10 (90.91)	12 (92.31)	12 (80)	18 (75)	58 (72.5)
Skin diseases	3 (17.65)	2 (18.18)	5 (38.46)	8 (53.33)	21 (87.5)	39 (48.75)
Eye sight problems	11 (64.71)	8 (72.73)	9 (69.23)	12 (80)	8 (33.33)	57 (71.25)
Psychological immaturity	5 (20.41)	3 (27.27)	2 (15.38)	9 (60)	13 (54.17)	32 (40)
Total (problems)	37 (217.65)	34 (309.09)	40 (307.69)	54 (360)	84 (350)	249 (311.25)
Total (respondents)	17 (100)	11 (100)	13 (100)	15 (100)	24 (100)	80 (100)
Average health problems per child	2.2	3.1	3.1	3.6	3.5	3.1

Field data. Figures in parenthesis denote percentage of column total. The sample size is 80, but it is noticeable that one individual respondent was suffering from one or more diseases at the same time.



**Table 3. Association between respondents' working areas chosen and medical care preferred.**

<b>Medical care</b>	<b>Working areas</b>					<b>Total</b>
	Rickshaw-pulling	Van-pulling	Rickshaw-pushing	Construction firm	Welding factory	
Rural medical center	3 (17.65)	2 (18.18)	3 (23.08)	6 (40)	5 (20.83)	19 (23.75)
Local doctors	9 (52.94)	7 (63.64)	6 (46.15)	7 (46.67)	14 (58.33)	43 (53.75)
Kobiraj	3 (17.65)	1 (9.09)	4 (30.76)	1 (6.67)	2 (8.33)	11 (13.75)
Homeopathic	2 (11.77)	1 (9.09)	0 (00)	1 (6.67)	3 (12.5)	7 (8.75)
<b>Total</b>	17 (100)	11 (100)	13 (100)	15 (100)	24 (100)	80 (100)

Field data. Figures in the parentheses indicate column percentage.