

Work, gender roles, and health: neglected mental health issues among female workers in the ready-made garment industry in Bangladesh

Sadika Akhter^{1,2}
Shannon Rutherford¹
Feroza Akhter Kumkum²
David Bromwich¹
Iqbal Anwar²
Aminur Rahman²
Cordia Chu¹

¹Centre for Environment and Population Health, Griffith University, Brisbane, QLD, Australia;
²International Centre for Diarrhoeal Disease Research Bangladesh, Dhaka, Bangladesh

Background: Traditionally, women in Bangladesh stayed at home in their role as daughter, wife, or mother. In the 1980s, economic reforms created a job market for poor, uneducated rural women in the ready-made garment industry, mostly located in urban areas. This increased participation in paid work has changed the gender roles of these women. Women's earnings support their family, but they are also separated from their children, with impacts on their mental health and well-being. This study explores the lived experience of women in Bangladesh working in the ready-made garment industry as they strive to be mothers and family providers, often in high-stress conditions.

Methods: The study was conducted in two industrial areas of Dhaka over 8 months. Data collection included a literature review, 20 in-depth interviews with married female garment workers, and 14 key-informant interviews with officials from the Ministry of Labour and Employment, health-service providers within the garment factories, factory managers, and representatives of the Bangladesh Garment Manufacturers and Exporters Association. The data collected were analyzed thematically.

Results: Poverty was a key motivating factor for female migrant workers to move from rural areas. Their children stay in their village with their grandparents, because of their mothers' work conditions and the lack of childcare. The women reported stress, anxiety, restlessness, and thoughts of suicide, due to the double burden of work and separation from their children and family support. Further, they cannot easily access government hospital services due to their long work hours, and the limited medical services provided in the workplace do not meet their needs.

Conclusion: In order to improve the health and well-being of female garment workers, steps should be taken to develop health interventions to meet the needs of this important group of workers who are contributing significantly to the economic development of the country.

Keywords: female workers, Bangladesh, ready-made garment industry, gender, health, work

Introduction

Since its independence in 1971, Bangladesh has gradually transformed its economy from an import to an export orientation.¹ In the early 1980s, Bangladesh initiated a series of economic reforms under the guidance of the International Monetary Fund and World Bank to begin a new export-led industrial policy.² The establishment of the export-oriented ready-made garment (RMG) industry has made a significant contribution to the economic growth of the country during the last two decades, and export earnings from the industry in the 2014–2015 financial year were over US\$25.49 billion.³ In Bangladesh, 56.7 million people are employed, with an unemployment rate

Correspondence: Sadika Akhter
School of Environment, Centre for
Environment and Population Health,
Griffith University, 170 Kessels Road,
Nathan, Brisbane, QLD 4111, Australia
Email sadika.akhter@griffithuni.edu.au

of 4.7%, and 49% of employees work in the industrial sector.⁴ Within this sector, 4 million work in the RMG industry, and 50%–60% of these workers are women.⁵ Given the significant contribution that women are making to improve the economic development of the country, the question needs to be asked: at what cost to the women themselves?

This increasing participation of women in the industrial workforce marks a significant change in Bangladeshi society. Traditionally, Bangladeshi women have had the primary responsibility for household work.⁶ Household work includes taking care of the children, husbands, and elderly members of households.⁷ Further, the concept of *purdah* restricted the mobility of women outside the home.^{8–10} In traditional society, men are responsible for providing all financial support to women, and any economic role of women is considered secondary.¹¹

Despite these traditions, the female-participation rate in paid work in Bangladesh rose quickly from 1983 to 2000, and with the rapid development of the RMG industry during this period, many poor, uneducated women migrated to the city from poverty-stricken districts of Bangladesh to work in the RMG industry.^{6,12} Some research has suggested that women were recruited to the RMG sector because they were “docile”, could be paid less, and were more willing to do overtime.^{6,11,12} Within the sector, the higher-paying positions with power and labor-policy influence are dominated by males. Given that traditional gender roles are still strong and these types of attitudes prevail, significant gender inequality exists. However, the consequences of this on female workers have not been well investigated.

Despite the economic empowerment brought by increased work opportunities at the global level, surprisingly little is known about women’s occupational health.¹³ Most health research in developing countries still focuses on women’s reproductive health issues. For instance, the UN Cairo Declaration of 1994 emphasized the concept of gender as an important determinant of women’s reproductive health.^{14,15} However, the research ignores women’s health problems due to participation in paid work, especially industrial work.¹⁶ There remains a serious lack of analysis of women’s health problems that incorporates issues that affect health and well-being due to their changing roles.¹⁷

Further, when women move away from their family to pursue paid work, there is evidence of mental health consequences.¹⁸ Mental health problems, including depression, are a global health priority, and socially disadvantaged people are more vulnerable to suffer from mental health problems.^{19,20} There is evidence that scarcity of human resources, limited

access to, and cost of mental health services are critical issues in most low- and middle-income countries.^{21,22} Further, studies have revealed that context and culture are important factors influencing people’s attitudes to medical treatment for mental health problems in poor countries.^{23,24} A systematic review found that women in developing countries did not share their problems with family members, and were also reluctant to take medical treatment.²⁵ However, several studies have also suggested that an integrated approach in primary-care settings involving different types of services, including community health care, legal services, and individual caregivers through community-based interventions, can deliver mental health services in low-resource countries.^{26,27}

The national economy of Bangladesh depends on the work these women do, yet very little is known about the lived experience of these women as their roles and responsibilities change.²⁸ Therefore, the aim of this research was to bring new insights to understanding the impact on women who are working in the RMG industry in Bangladesh, specifically issues about work, new roles, and life experience of workers as mothers.

The results include a description of female workers’ lived experience of work and consequences for their mental health, along with views of the employers, health care providers, and government officials. We conclude this paper with remarks on how this situation could be improved in Bangladesh.

Methods

Study setting

The study was conducted in the Mirpur and Savar subdistricts of Dhaka. These were chosen because manufacturing is one of the major economic sectors in these areas. The population of Savar is 1,387,426.²⁹ The population of Mirpur is 266,046.³⁰ Four factories (two from each subdistrict) were chosen as the setting for this research. We had no prior knowledge about workplace conditions at the chosen factories; they were chosen on the basis of their export orientation (and hence have compliance conditions imposed by the Bangladesh government) and the willingness of factory management to participate.

Study population and recruitment

We conducted a total of 20 in-depth interviews (IDIs) with women working in the selected RMG factories. We also conducted 14 key-informant interviews (KIIs) with supervisors of the workers (n=4: two production managers [from different factories], one line supervisor, and one in charge of a floor), doctors of the garment factories (n=4), government

officials from the Ministry of Labour and Employment (n=3), and nongovernment officials, particularly staff of the Bangladesh Garment Manufacturers and Exporters Association (BGMEA; n=3). KIIs provided detailed understanding of the employers' and health care providers' views about working women's experiences. By utilizing two groups of informants, we were able to compare and contrast our data from different stakeholder perspectives.

The study participants were selected purposively, based on their potential ability to provide detailed insight and first-hand experience about their work in the garment industry in Bangladesh while also being a mother. Other study participants were recruited based on their relevance to the study topic using a snowball-sampling method. Data collection continued until thematic saturation was reached.

Data collection

Data collection occurred from December 2015 to July 2016. Open-ended topic guides were developed in English and translated into Bengali. Before starting data collection, the interview guides were pretested and adapted according to the findings of field testing. The principal researcher, a native Bangladeshi, first identified non-governmental organizations (NGOs) relevant to the study sites. These NGOs then helped to identify slums around the two study sites where the garment workers live, and introduced the researcher to the workers. The researcher was considered an outsider. Therefore, it was important to explain carefully the purpose of the research and the research sponsor (an Australian university) first to build trust. Assurances were provided that the women's identity would not be disclosed to anyone. Finding time to have interviews turned out to be as difficult, due to the women's long working hours. Appointments were made for a convenient interview time for them, which was usually weekends or weekday nights. They frequently welcomed the researcher into their homes to share their experiences and feelings.

Conducting the KIIs with factory managers and doctors was challenging. Initially, they were not interested in participating in this study, as they considered the researcher to be a journalist. Once the researcher provided them documents of affiliations with the university, including a student identity card, more rapport was established. They then agreed to participate. The government officials were interested in participating in this study, despite initial suspicions that the researcher was a journalist. However, following an explanation of the ethical processes and assurances of confidentiality and anonymity, they also agreed to be interviewed.

All the interviews were conducted in Bengali. The principal researcher is a native speaker, and hence did not face language difficulties in data collection or preparing transcripts. To minimize the challenge of translation, the study team interpreted data as much as possible in the original language.³¹ Most interviews lasted approximately 1–1.5 hours. All interviews were digitally recorded, and detailed field notes were taken simultaneously during each interview. Data collection was stopped after reaching data saturation (no major new themes emerged from the interviews).

Data analysis

A qualitative thematic method was used to analyze the data. After each interview had been completed, a transcript was written in Bengali. First, familiarization with the data was achieved by reading and rereading the transcripts several times. After familiarization with the data, two researchers independently coded the transcripts to ensure intercoder reliability.³² Initially, from the narratives of the texts, a code list was developed for data analysis.³³ Based on the codes, themes were identified for framework analysis and the framework adapted and finalized based on the findings and emergent themes as part of the iterative process of qualitative data analysis.^{33,34} Data were managed by using Atlas.ti software version 5.2.

Ethical clearance, consent, and protection of data

Ethical approval for this study was granted by the Griffith University Human Research Ethics Committee (2015/668). Informed consent was asked prior to data collection from all study participants, and they provided their written consent to participate in this study. To maintain the privacy, anonymity, and confidentiality of data, it was explained to each of the respondent that his/her identity and the information he/she would provide would be confidential. Prior consent was requested to record the conversation. If the respondents agreed to recording, then the interview was recorded. If they did not (n=1), the interview was continued without recording the session. For this interview, detailed handwritten notes were taken. The participants were assured that no one except the people directly involved with this research would be able to see the information. After completion of transcripts, all identifying information was removed from the transcripts and other documents. Audio recordings, transcripts, and codes were in an unidentifiable form, and we use the generic terms "study participants" and "female workers" when making reference to responses made by all study participants.

It was further explained that study participants were free to decide whether or not to be in the study. After starting the interview, they could stop at any time if they decided not to be involved in the study. No money was provided for participating in the discussion, although a small gift (value US\$2–3) was given to the IDI participants in appreciation of their efforts.

Results

Sociodemographic characteristics of the study participants

The sociodemographic characteristics of the female workers are presented in Table 1. Most study participants were less than 31 years old. All were married, except two who had divorced. Around half had only completed up to grade 5, a few had no formal education, and only one woman had completed grade 10. Most of the female workers had migrated to the study sites from rural areas due to poverty. All of them had living children – generally one or two – though two mothers had three children. Some of their husbands were working at the garment factory. Others were working in other sectors, such as construction or carpentry as day laborers.

Table 1 Demographic information of in-depth interview (IDI) participants

Demographic information	n
Sex	
Female	20
Age	
18 to 23	8
24 to 31	10
32 to 40	2
40+	
Marital status	
Married	18
Separated/divorced	2
Parity	
1	10
2 to 3	10
Religion	
Islam	20
Education	
None/illiterate	4
1 to 5 years	10
6 to 10 years	5
More than 10 years	1
Spouse's occupation	
Garment worker	5
Farmer	1
Construction worker/carpenter/day laborer/driver	12
Unemployed	2

Stress: the nature of the work

At the factories visited, there were three levels of female workers: quality inspectors, machine operators, and helpers. We interviewed three quality inspectors, five sewing-machine operators, and 12 helpers. The quality inspectors, sometimes called “quality girls”, stand in front of a table 10–12 hours per day to check the quality of the products and affix a tiny round sticker marked “QC” to indicate that the product has passed the quality check. The sewing-machine operators sit on a small stool continuously running a sewing machine on average 10–12 hours each day. Each machine operator does one task for the entire day and week. There is no task rotation. The “helpers”, who have the lowest position on the production floor, work in a standing position and do different types of work, such as cutting thread, folding the shirts, placing collar inserts, and ironing the product. These women do the most repetitious jobs on the production floor. Once again, they are allocated one task (eg, cutting thread), and they do this every hour, every day, every week. The work is piecework: each worker is expected to meet a daily quota. They must stay working until this quota is met.

One female worker said:

We need to make 100 shirts per hour. I can make 89 shirts per hour. I am 10–20 shirts behind per hour. I need to work extra 2 hours every day to meet production quota every day. When I return home at night, I need to do all household works, such as cooking and cleaning.

The women enter the factory by 8 am and return home around 8–9 pm. In this regard, one female worker said:

I work from dawn to dusk. I see the sun is rising, but it is rare that I see the sun is setting, as I return home always after dark.

They have one break for 1 hour at lunchtime. That is, they work around 12 hours a day, depending on how quick they are at meeting their daily quota. They walk to and from work for a total of around 30 minutes per day. The normal workweek is 6 days, but for 9 months of the year they are required to work 7 days a week. They are able to take a maximum of 7–10 days' annual leave twice per year during national festival periods.

Stress: separation from children

As all of the study participants were mothers, separation from their children is an important issue for them. Most had left their children in their home village, citing lack of time to care for them, due to their long work hours and difficulties in paying

for the costs of their children to live with them in the city. They work from morning to night and during weekends, with nobody at home to look after their children. They get leave only a few times a year, and the distance to their villages can be up to 10 hours' travel time. As such, they have no option but to leave their children in their village to live with their grandparents. However, avoiding long working hours is impossible, as they need money to provide for their impoverished families.

Each of our study participants shared their tribulations as a mother living away from their children. Most of the women said that they lived with constant feelings of guilt, anxiety, and feelings of poor appetite, and that these feelings of guilt contributed adversely to their mental well-being. One female worker described her sad experiences:

Last month, I cooked fish and meat. I also cooked some rice [ie, she was eating better than her son in the village]. That night, my son called me from my village and he was crying over phone to see me. I tried to make him calm and committed to bring him to me as soon as I can. After that, it's been a month I couldn't go to my village to bring him to me. I spent my nights without sleep and I cannot eat, as I always feel guilty for my son.

Our study participants also indicated that they felt restless, fatigued, and wanted to die, due to longing for their children. They struggle to find meaning in their life, as their children are away from them. They explained that when they talk with their children by phone, they always promise to bring them back, but they cannot. The guilt of telling a lie to their children makes them feel empty, and thoughts of suicide are common:

I suffer from constant pain in my heart. I always miss my child, as my child is part of my body. I feel constant pain in my mind and my heart burns. I do not have anybody to share my pain. I feel very empty inside me. Life has no meaning to me. Rather, I feel that I should die when I see children with their parents.

Another woman explained her feelings:

I came to Dhaka from the northern part of Bangladesh for a job at the garment factory with a woman who lives at the same village of mine. The woman helped me to get a job at the garment factory. I have been working at the factory for the last 5 years as a sewing-machine operator. My son was very sick with high fever and vomiting. On that day, I carried my cell phone with me in secret inside the factory to talk with my parents to know the condition of

my son during work. I stayed a few minutes longer than the usual time in the toilet to make a phone call secretly to talk to my parents. The supervisor observed me and seized my phone. I was sewing a shirt in tears, as I couldn't return home till night and won't be able to talk to my parents to know the condition of my sick son. I felt so suffocated. I couldn't breathe, felt so restless for my son, and also felt as if I would die when my phone was taken from me. My supervisor saw me in crying. He got angry with me, as he thought because of my crying I would get slow to meet my production quota. This work does not give me anything except some money.

Inadequate health support

The factories in our study sites have factory clinics to provide health services to the workers, and the clinics run 6 days a week from 8 am to 9 pm. They are also open during the weekend if the factory is open. The factory clinics mostly provide basic painkillers and oral saline as medicines when workers get sick. They have a very limited number of beds and other equipment. They do not have established referral pathways with the government hospital for further treatment of the workers if deemed necessary. Their services are limited to basic physical health problems, though factory doctors reported that female workers suffer from depression relating to managing the stress of work and their family life. They indicated that they do not have any facility to counsel the female workers when they communicate their stress:

We only provide primary health care service, such as if any worker gets sick from cold or fever, we give them treatment with Panadol. If the workers have injury, such as cut or needle puncture, we provide them some treatment. If they have small burn, we take care of them. We cannot counsel them when they are under stress to manage their family and work together.

The doctors also acknowledged that they were providing very limited services to the workers, with insufficient staff to serve the number of workers. The factory clinic is staffed by two nurses and two doctors to serve thousands of workers. The nurses work by rotation. The nurses are available from morning to evening, but doctors are available for only a few hours on weekday afternoons. In this regard one doctor said:

We have total 3,000 of workers in our factory, but we do not have enough medical staff to provide good service to the workers. The factories do not have enough budget to bear the cost of the treatment for the female workers.

A majority of female IDI participants reported a lack of acknowledgement and compassion of the health care providers when consulted about female workers' concerns. They also indicated that this indifference of the doctors to their problems made them more upset. They further reported that due to the nature of their job, it was difficult for them to manage time to go to the government hospital. One female study participant described the attitude and behavior of the doctors and nurses when they go to them for treatment:

We only get treatment for some common diseases like fever, cold-cough, and headache or if we get injured during our work, but they do not care about our mental health. The doctor and nurses of the factory do not want to listen to our sufferings of everyday life. They do not give us enough time. If we want to share our pain of life, they will hurry us to go to work. They do not have any sympathy for us. If the doctor would listen to us, our pain of suffering would be lessened. We cannot go to government hospitals, as we work from morning to night. We cannot go to a private doctor, as it costs a lot of money.

Different stakeholders' views on the situation

Voice of the female workers

The narratives and experiences of female workers revealed another aspect of the behavior of their supervisors and how they are treated at the workplace when they get sick. One IDI participant revealed her perspective:

Our bosses want us to work and work to finish the target quota. If we cry, feel bad for our children, and seek leave to go to our village, they scream at us saying that we always look for excuses for leave and treatment. They do not care how much we suffer for our children as a mother living away from them. They do not care about our stress of hard work. They would say instead to leave the job to stay at home to look after our children. They would also say that you do not need to come to the factory again for work.

Another female worker expressed how the lack of sympathy from their supervisors added to their depression:

We don't know where to go for health care when we cannot sleep night after night due to feeling of guilt for our children. Our supervisors do not have any empathy for our health, sufferings, and pain. Our doctor and nurses do not care about us. Sometimes we feel like I have no place to go to share our pain. If we share our pain with our husband, they will say to leave the job. If we leave the job, who will give us food and shelter?

All of our study participants stated that although their access to treatment for their physical illness was limited, they do have some access. They can even share the physical illness, as it is visible. But the continuous battle with depression, guilt, and stress and the nonempathic behavior of their employer exacerbate their mental health issues:

When I get physically sick from any diseases I have medicine to get well from it but no medicines to get well from mental health problems. I feel I want to die when our supervisors behave badly with us. I work hard all day and night but I could forget all these pains if I could see the smile of my child after returning home from work at night.

Voice of the supervisors, government officials, and BGMEA representatives

Supervisors acknowledged the poor attitudes and behavior of work supervisors, and blamed heavy workloads and the stress of fulfilling production quotas:

Most of the days, our workers work from morning 8 am to 9 pm to meet our production quota. The nature of work in the ready-made garment factory is like this. I am to be blamed by the factory owner if I cannot meet the deadline and the factory owner needs to deliver the production to the foreign buyer in time. There is no option to work except pressure. We do not have time to listen to the complaints of the workers.

Another supervisor of a factory said:

They earn very little amount of money. If they bring their children, they need to rent a big house and they also need to bring their mother or mother-in-law to look after the children. They can't afford the house rent. Now they are living in one room and they pay 3,000 taka per month. It will be double if they hire two-room houses. The food cost will be double. Food and everything is cheaper in village in compare to city. So it is better if they keep their children in their village with their grandparents.

Discussion with government officials revealed that the government is concerned about the health problems of the female garment workers. One government official said:

We are a poor country. We have a lot of problems. The poor female garment workers suffer from many problems, and we know this. We are trying our best to create a safe working environment for female workers. We are thinking to increase the facility of day care for these working women. We do not know magic to solve the problem overnight. We have already increased their wage so that they can live a decent life.

Representatives of the BGMEA stated that they do not receive many complaints from factory workers about the problem of their mental health; rather, they receive many complaints about their wages. They also indicated that BGMEA is a voluntary organization, and they do not have enough power to deal with the factory owner about the health problems of the workers. In this regard one respondent from the BGMEA said:

These female workers are working hard, and they are contributing to the economy of the country. So the factory owner, buyer, and government all need to sit together to create good health care system for this worker. The BGMEA cannot solve the problem individually.

Discussion

This study identified several interlinked factors that influence the health and well-being of female garment workers, including factors from the individual level to the global level, including work environment and health system factors (Figure 1).³⁵ While global level factors were not explored in this research, they have been included in Figure 1 to provide a more complete perspective of the determining factors and their relationships.

The experiences of female workers explored in this study reveal the importance of nonphysical illness, with women frequently mentioning stress, anxiety, and helplessness relating to their separation from their children and lack of

support to cope with this separation. This serves as a timely reminder of the World Health Organization definition of health, modified in 1948 to include “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”.³⁶ This definition of health not only puts emphasis on the absence of disease but also includes other factors, such as social, economic, and environment of living and coping strategies.

Some health system level factors were found to play an important part in the views expressed by the different study participants. The factory clinics did not have sufficient staff or equipment. Doctors confirmed that they did not have enough funds to provide a quality service, particularly in terms of listening to the breadth of problems expressed. The doctors can only treat the female workers’ minor health problems, such as persistent colds and coughs, with very limited resources. Another limitation identified was the lack of access to referral pathways to government hospitals, where costs are more affordable. Both the employers and the government officials acknowledged these problems of resourcing, but neither was able to provide a clear solution. Further, the experience of the study participants raises questions about the capacity of mental-health services within Bangladesh’s broader health system.

Studies have found that more women suffer from depression than men in Bangladesh and the country has

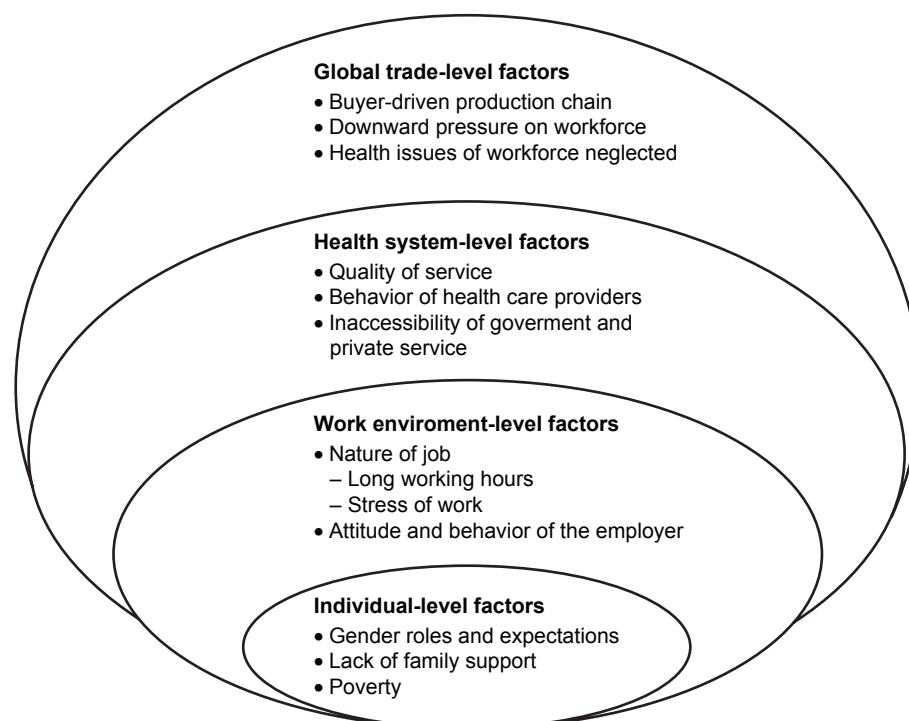


Figure 1 Different factors influencing health and well-being of female garment workers in Dhaka, Bangladesh.

many challenges, which include limited public mental health facilities, lack of a skilled workforce, limited financial resources, and reluctance to share their mental health concerns.^{37,38} Given the conditions of the current health system in Bangladesh, improving the counseling system alone will not be enough to tackle the problem of mental health, and more research needs to be done to develop culturally appropriate interventions to reduce the mental health burden in Bangladesh.

Discussion with the different stakeholders revealed the need for more collaborative work and relationship development among government, buyers, and factory owners to address the health problems of the female workers. The findings indicate willingness by the industry association and government to pursue improved referral pathways with government hospitals to increase access to treatment, albeit limited by mental health services. However, other solutions also need to be considered to prevent the mental health problems, such as creating low-cost housing and childcare facilities, so that the women can bring their children when they migrate to work in the RMG industry. Further pointing to the need for collaboration, this study revealed that the attitude and behavior of factory health care providers and employers exacerbate the mental health and well-being issues expressed by the female workers. It is evident from the narratives of the female workers that the nonempathic behavior of the employers and health care providers contribute to the women feeling helpless. Therefore, such strategies as conducting sessions among workers, employers, and health care providers to raise awareness of mental health and well-being issues and to develop the skills and systems necessary to identify and respond to them are crucial.

At a broader level, the imbalanced influence of multinational corporations (MNCs) in manufacturing with the support of the World Trade Organization compared with human rights-based organizations (International Labour Organization, UN agencies) contribute to the production pressures.^{39,40} These MNCs prefer lower-cost women workers, because they are submissive and unlikely to resist working under adverse working conditions.⁴¹ The government appears to be trying to fulfill the demands of the MNCs, but is neglecting the rights of workers to a safe and supportive workplace. The powerful MNCs have a strong interest in the continuation of these types of work conditions. The challenge will be for the government to adopt and enforce policies that address the issue of women's health in the workplace, including women's health in this important sector, where gendered division of labor is so prominent.

Conclusion

These data imply the need for a more holistic understanding about the health problems of female workers in this industry. By 2020, Bangladesh aspires to achieve middle-income status, and much of this growth is expected to come from the RMG industry. While the goals of female garment workers are to provide financial support for their poor families, their working conditions have led to anxiety, depression, and despair. Further, their stories indicate that they have very limited options to improve their health status, implying that more targeted research and design of interventions are required to support this important backbone of Bangladesh's economy.

Limitations

The research design used does not allow for generalizability of the results to the entire RMG industry, but instead it creates preliminary evidence to identify the types of challenges and consequent impacts that female workers in these industries face.

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Author contributions

SA designed the study, with significant contributions from CC, SR, and DB. Data collection and management of fieldwork was done by SA, with help from FAK. SA led the analysis, with input from all authors. All authors contributed toward data analysis, drafting and critically revising the paper and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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