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Female Garment Workers' in Bangladesh: Violence, Gender and HIV/AIDS

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Abstract

This research contributes to the social science-oriented disciplinary and interdisciplinary epistemology and corresponding policy practices of human immunodeficiency virus (HIV) prevention in female garment workers' (FGWs), who work in the garment factories of Dhaka City, Bangladesh. According to National Violence against Women Survey report (2015) Bangladeshi women recognised the workplace as the second furthestmost place to experience violence then household. Empowering FGWs through formal health education on sexually transmitted infections (STIs) and HIV is essential and includes the prevention of workplace violence (WPV) and requires further training of their intimate partners' regarding violence (IPV). Structural reforms within legislation are essential for preventing violence in factories. Bangladesh Garment Factory Owners Association (BGMEA) should run explicit programmes on sexual harassment, including WPV and IPV training.

Keywords: Female garment workers', STIs/HIV, violence, gender, power, Bangladesh

The problem and its importance

Even though HIV prevalence in Bangladesh is lower than 0.1 percent, the anxiety is that extensive discrimination towards people, who test positive for human immunodeficiency virus (HIV), may leave infections unreported (Unicef, 2010). The negative impacts of gender inequality on HIV prevention efforts are felt even in developed countries despite the greater socioeconomic freedom among women and presence of gender sensitive health and social policies. The major hurdle for such accomplishments in developing countries, such as Bangladesh, is the lack of recognition of the problem and of infrastructural capacity to conduct quality research and thereby identifying the issues that underlie the problem (Yaya, Bishwajit, Danhondo, Shah, & Ekholuenetale, 2016), which is social barriers impacting women's lives and their insufficient knowledge about their HIV and sexually transmitted infections (STIs) status and the possibility that HIV infection is higher than officially recognized. Women are victims of various abuses including sexual ones, and their overall, gender-related status and corresponding acknowledgement is lower than those of men in Bangladesh.

According to United Nations (UN) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"(Mahmood, 2004).

Former UNAIDS Chief, Peter Piot pointed out that rape, violence, and other method of sexual abuse are uncouth violation of human rights. They are also closely connected to today's most problematic health issues, including the spread of HIV (Mahmood, 2004).

Throughout the world, researchers have begun to test and develop interventions that promote women's empowerment to decrease violence and related health risks (Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010; Dworkin, Dunbar, Krishnan, Hatcher, & Sawires, 2011; Helen Keleher & Lucinda Franklin, 2008; Solotaroff & Pande, 2014). Women's empowerment programmes have concentrated on improving women's access to and control over social, economic, and health resources, including credit, income and education, and health services (Krishnan, Gambhir, Luecke, & Jagannathan, 2016). However, there is slight evidence from low- and middle-income countries to monitor and guide policy and programme development, emphasizing the need for studies on interventions to stop and respond to intimate partners' violence (IPV) (Ellsberg et al., 2015). The Intervention for Microfinance and Gender Equity (IMAGE) study in South Africa, established that women who participated in the intervention had more decision-making autonomy, gender-equitable attitudes, and communication with family members and were 55% less likely to report experience of IPV in the previous 12 months (Paul M. Pronyk et al., 2006). Such a method has not been meticulously evaluated in the Bangladesh setting (R. Naved, Mamun, Mourin, & Parvin, 2018).

Current research in developing countries proposes that a substantial number of young women may experience sexual coercion (Jejeebhoy, Xavier, & Santhya, 2013). Bangladeshi muslim women have traditionally been excepted from taking part in economic, social, and political activities on the basis of the institution of *purdah*, which commands women's privacy from the society at large. Nevertheless, many positive social changes have occurred in the lives of Bangladeshi women with the introduction of the ready-made garments (RMG) industry, which started in the late 1970s in Bangladesh (Kabeer&Mahmud, 2004).

Thus the aim of this study is to examine how violence impacted on women and power can be extended and elaborated upon to identify the exposures and social/behavioral risk factors, and biological properties that increase women's vulnerability for acquiring HIV, especially FGWs in Bangladesh, the most disenfranchised and vulnerable female population. It also explores attitudes and the power dynamics between FGWs and their male supervisors.

Method

A systematic review was carried out of the literature, which were published in English and available in the databases of PubMed, Medline, Absco, Proquest, Scopus, Google Scholar, Embase, United Nations and World Health Organization (WHO). Furthermore, manual searching was carried out to review and categorize relevant papers in the academic database and library of University of Newcastle, Australia. Document enclosed an extensive range which included social science, public health, philosophical debates, descriptive reports and ethics, in adding to quantitative and qualitative studies. The key words used were: 'human immune deficiency virus', 'violence', 'gonorrhoea', 'syphilis', 'chlamydia', 'sexually transmitted disease', 'female', 'women and health', 'clothing' or 'garment' or 'fabric' 'textile', and 'Bangladesh'.

The literature search was carried out between October 2017 and October 2019; during this time the collected literature were synthesized and reviewed for analysis. Overall 263 articles were recovered from the databases of international and national peer reviewed journals and websites from 1986-2018. Online sources of public health and social and HIV/STIs connected journals were explored for relevant publications. This review involved two stages: first the author conducted an extensive examine of the existing literatures, secondly the author screened the collected literatures in terms of their significance to FGWs on HIV and STIs. In this paper, the author included 104 documents. During the evaluation process efforts were completed to synthesize the relevant resources to gain

a complete understanding. Significant conference presentations related to HIV/STIs in women of Bangladesh along with findings of historical explanations and a cross sectional prevalence study of HIV/STIs in Bangladesh were incorporated. This extensive critical review attempted to contribute to the existing literature in the form of new findings and critically evaluate existing findings aimed at reducing HIV/STIs risk, particularly FGWs in Bangladesh in connection with violence and other issues.

Literature Review

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) continues to spread in many parts of the world, women are now assumed to begin an increasingly large section of those infected worldwide. This has mainly been documented to the fact that till lately, women did not have an independent means of protection by which they could support safeguard themselves from both pregnancy and infection with HIV (Mahmood, 2004). The global HIV epidemic is rapidly "feminizing" (Thomas C. Quinn & Julie Overbaugh, 2005; Wingood, 2003) and worldwide, 50% of people living with HIV (PLHIV) are women, but then again this proportion is 59% in sub-Saharan Africa (GlobalReport, 2013). Women, especially from key populations are mainly affected by HIV. Amongst female sex workers, global HIV prevalence is projected at 12%, increasing to about 30% in settings with medium to high HIV prevalence. Women, especially from key populations, which includes: female drug users, female sex workers and transgender women, are mostly likely to experience violence (UNAIDS, 2013).

AIDS is gradually becoming a major social and public health concern in many developing countries (M. A. Khan, 2002). The World Health Organization (WHO) mentioned that in South Asia the most common mode of HIV transmission is unsafe sex (WHO, 2011). Bangladesh is a part of South Asian country with a Bay of Bengal to the south and it is surrounded by India on three sides and with Myanmar on the south east (Rahman, Shimu, Fukui, Shimbo, & Yamamoto, 1999).

STIs are a major public health problem in developing countries, including Bangladesh (Sabin et al., 2003). Nevertheless, the threat is momentous for Bangladesh, considering the aspects like geographic location (high prevalence countries, such as India, Myanmar), large number of population with STIs and above all, lack of proper knowledge about safe sex among the people. In India, women account for about 1 million out of the 2.5 million estimated number of people living with HIV. Increasing numbers of women are HIV infected globally and within the Indian setting, women account for an estimated 40% of cases among the 2.5 million people living with HIV/AIDS (Desai, Kosambiya, Mulla, Verma, & Patel, 2013). In Bangladesh female adolescents are more vulnerable and are biologically more susceptible to STIs, including HIV infection and sexual violence than any other (M. A. Khan, 2002; Tamanna, 2019). In comparing the knowledge and awareness about STIs, it showed that 17% of adolescents in Bangladesh had never heard of STDs; whereas Nepalese and Indians reported 25% and 37% respectively (Jahan, 2012).

Many demographic and socio-economic factors have played a serious role in influencing HIV in Bangladesh. By conducting a critical literature review the following aspects have been retrieved by numerous authors:

The themes of the literature review are provided in overview format, below:

- Violence and its impact to women in Bangladesh
- Bangladeshi women's vulnerability to STIs/HIV
- Statistics on violence against FGWs in Bangladesh
- HIV workplace intervention programmes for FGWs in Bangladesh
- Sexual harassment and HIV in FGWs in Bangladesh

Violence and its impact to women in Bangladesh

Bangladesh has experienced very high rates of IPV. 54% percent of ever married women informed lifetime sexual and/or physical IPV committed by their husbands and 27% informed such IPV occurred in the last 12 months. 11% of ever married women informed economic IPV in their lifespan (BBS, 2016). Bangladesh reports on IPV is

one of the uppermost rates in the world (BBS, 2016). Bangladesh reports on IPV one of the highest rates in the world. Even though wide recognition of IPV as a vital public health and human rights concern, evidence for IPV prevention is still scarce (R. Naved, Mamun, et al., 2018). In Global chart Bangladesh stands 2nd, when it comes to violence against women by men (Mahmood, 2004).

In Bangladesh, studies from rural areas (R. Naved & Persson, 2010) and formal urban areas of Bangladesh disclosed that work enhance women's experiences of IPV (BBS, 2013). Correspondingly, (Kagy, 2014) established that while work enhance women's decision making in the household, it also increased their experiences of IPV. Supporting this argument Heath (2014) established that women who were working in urban Dhaka had more risk of experiencing IPV, if they had married at younger age or had less education (Heath & Mushfiq Mobarak, 2015). Moreover, working women every so often handed over wages to husbands who may feel threatened by women's freedom, hence there is no changing on women's economic or gender position (Kabeer, 1997). The importance of the broader context is also recommended by (Blumberg, 1988), when she declares that the relationship between women's income control (wages) and family power is one that is reconciled by a variety of multifaceted factors, such as the extent of gender inequality at the macro societal point and the gender role ideology of family members (Fair Labour, 2005).

Bangladeshi women's vulnerability to STIs and HIV

Bangladeshi women, alike to the current global trend, share a greater risk of STIs/HIV infection and mortality compared to men (Glynn JR, Caral M, Auvert B, Kahindo M, & J, 2001). UNICEF estimates (2012) that the prevalence (per 10,000) of HIV among women Bangladeshi was 2.7 against total prevalence of 3.1 (Shannon et al., 2012). There is a growing agreement on the fact that gender inequality is a major contributor to women's increased susceptibility to HIV morbidity and its outcomes (Gari et al., 2013).

Women in Bangladesh are extremely vulnerable to STIs, including HIV/AIDS, and their knowledge about various diseases is exceptionally poor. STIs increase the likelihood of HIV transmission in addition to other reproductive health outcomes, such as chronic lower abdominal pain, life threatening pregnancies or infertility (UNFPA, 2003). The United Nations General Assembly Special Session on HIV/AIDS (UNGASS, 2001) announcement marked a renewed call for strengthening policy competences to address the gender issues related to HIV (Gari et al., 2013). Development and advancement of health and gender campaign policies are dependent primarily upon availability of workable perceptions in which Bangladesh lags considerably behind than expected (Yaya et al., 2016). One study incorporating information from 137 countries reckoned that the gender gap on HIV knowledge has been reducing; conversely, knowledge regarding preventive methods is still low. The same study stated that people (aged 15–24) the rate of inclusive knowledge about HIV prevention was lower among women compared to men 36% among women vs 40% among men (Hossain, Mani, Sidik, Shahar, & Islam, 2014). Although well-acknowledged gender aspects of the epidemic, and possibility of spread of HIV epidemic, more widespread and tactical efforts to endorse knowledge and awareness regarding HIV among Bangladeshi women are warranted. Previous studies stated low level of knowledge and awareness on the topic of STIs among Bangladeshi women (Azim et al., 2008). Since women share greater vulnerability to HIV, enhancing HIV knowledge among Bangladeshi women offers looming opportunities for long-term monitoring and controlling of the epidemic in Bangladesh (Yaya et al., 2016).

Speedy economic dynamics and development, social change and corresponding politics, are generating new shapes of vulnerability. In answer to these, there is high population movement within Bangladesh, and people going overseas for employment. For example, one million workers went overseas for employment in 2017 (Tribune, 2018), and approximately half a million migrants, who transfer into Dhaka City every year (CBS, 2010). In this setting established support structures are deteriorated and weakened, and the people, especially women are further exposed to exploitation, including sexual exploitation. Nonetheless, vulnerability is not essentially openly spoken but often hidden, thus difficult to address and measure (NASP, 2011)

Statistics on violence against FGWs in Bangladesh

A study led by Fair Labour Foundation on garment factories suggested that Bangladesh had the highest rates of violence compared to China, and other Asian countries (Fair Labour, 2005). The garment industry is the most prominent and leading employer of women working in various capacities in the private sector, (Campaign, 2012; Kabeer&Mahmud, 2004; Siddiqi, 2002). The industry hires primarily women workers (approximately 4 million), 80% of them are women; and 90% of them are the migrants from rural areas and greater part of them migrated from landless families (Afsar, 2000; N. J. Chowdhury & Ullah, 2010) although supervisors are mostly male, which creates a gender hierarchy and reflecting broader social associations in Bangladesh (Campaign, 2012; Kabeer&Mahmud, 2004; Dina M Siddiqi, 2003). Managers are almost entirely men, (Dina M Siddiqi, 2003). As per Bangladesh National Violence against Women Survey, 2015 report, 33% of income earning women reported physical and/or sexual violence during the past one year compared to their non-earning counterparts with 26%. The same report mentioned that in Bangladesh women recognized the workplace as the 2nd most possible place to experience violence after the household (BBS, 2016). Another study also suggest that with FGWs, there could be a higher level of IPV (53%) in the past one year compared to the overall income earning women with 33% in the past one year (Parvin, Al Mamun, Gibbs, Jewkes, & Naved, 2018). IPV is also documented to affect women's efficiency and work (Crowne et al., 2011; Gupta et al., 2018)

Workplace violence (WPV) against FGWs is also ignored and understudied. A few literature expressed that FGWs are prone to experience violence in the garment factories, even though the positive influence of formal occupation in the garment segment on women's economic and social empowerment. The FGWs of Bangladesh are subject to physical, verbal and sexual abuse (FWF, 2013; R. Naved, Rahman, Willan, Jewkes, & Gibbs, 2018b; Dina M. Siddiqi, 2003). Fair Wear Foundation found that 75% of FGWs had experienced verbal violence at work, 30% had experienced psychological violence and 20% experienced physical violence. 60% of FGWs had experienced sexual harassment in these garment factories (FWF, 2013; R. Naved, Rahman, et al., 2018b; Dina M. Siddiqi, 2003) and sexual harassment is the most common in the workplace (FWF, 2013; Dina M. Siddiqi, 2003). The middle and low level factory management workforce are the most regular offenders of workplace violence, and mainstream of them are male (Gazi Salah Uddin, 2008), comprising managers, supervisors and other male garment workers (R. Naved, Rahman, Willan, Jewkes, & Gibbs, 2018a). Other offenders of sexual violence includes: the owners', male relatives of owner's, and buyers, with alluring young FGWs most vulnerable (Dina M Siddiqi, 2003). In Nepal, instances of sexual exploitation by managers and factory owners were also documented (Puri & Cleland, 2006).

Another study revealed that among FGWs high rates of any IPV was 69%; WPV 73% and depressive symptomatology 40% (Parvin et al., 2018). There is indication of adverse consequences of WPV on workers' physical as well as mental health (De Puy et al., 2015; Hansen et al., 2006) and job performance (Lin et al., 2015).

Sexual violence in factories, which includes sexualized verbal abuse, patting, touching, slapping, pinching, rape and coerced sex by management or by hired criminals/ mastans (Alam, Blanch, & Smith, 2011; Mondal, Hossain, & Rahman, 2008; Muhammad, 2011; Dina M Siddiqi, 2003) and even death or secret killing by criminals/ mastans or in police firing (Muhammad, 2011).

HIV workplace intervention programmes for FGWs in Bangladesh

In contrast to Africa, there were very few reported HIV workplace intervention programmes in Bangladesh (NASP, 2012). As elsewhere around the globe (Laukamm-Josten et al., 2000; Witte, Lapinski, Cameron, & Nzyuko, 1998), workers, such as women in the workplace or domestic work, especially FGWs represent as an 'epidemiological bridge' were among the certain industrial groups to be considered as most at risk to the general population (2013b).

Little is recognised about WPV against working women in low income surroundings. According to National Violence against Women Survey report (2015) Bangladeshi women recognised the workplace as the second furthestmost place to experience violence then household-(BBS, 2016). Overall, evidence on addressing IPV and WPV against working women, predominantly garment workers is inadequate globally. Given the considerable increase in women's employment in factories worldwide, and precisely in Bangladesh, with the possible increase women's experiences of violence in workplace and home, the lack of active interventions to reduce this, still

remains the same. While there is evidence that a mixture of economic empowerment and gender interventions decreases IPV successfully in other surroundings (Gupta et al., 2013; R. Jewkes et al., 2014; P. M. Pronyk et al., 2006), however there has been no effort at assessing the effect of gender interventions among FGWs, who are comparatively economically empowered compared to their peers (Mahfuz Al et al., 2018).

Sexual harassment and HIV in FGWs in Bangladesh

Qualitative or empirical data on the magnitude of sexual harassment in Bangladesh is limited and in studies of garment workers the topic typically comes up indirectly. Harassment as a specific issue has received relatively little attention, despite the large body of research on women in the industrial sector. Both at the workplace and during commuting, sexual harassment of women workers is rampant. Women's visibility and employment in community may be observed as a threat to male supremacy in society, and numerous forms of harassment of working women may be an expression of revenge by males and the risks of sexual harassment higher for those, who are working in the night shift (Dina M. Siddiqi, 2003). As a consequence of sexual harassment, many women report embarrassment, shame, inability to concentrate on work, a decline in productivity, anxiety, fear, and depression (Ahmed, Koenig, & Stephenson, 2006; Dina M. Siddiqi, 2003). Women's vulnerability to sexual harassment becomes raised due to the lack of documented proof of employment, informal recruitment practices, fear of retaliatory violence in response to filing a complaint, fear of losing one's job, and the absence of woman-friendly legal provisions (Dina M. Siddiqi, 2003).

In Bangladesh the factory work has become gradually regulated, mainly driven by trade unions and workers. In answer to the height of reports of sexual harassment against women in educational institutions and workplaces, in 2008 the High Court released a directive for responding to and preventing this. Regrettably, most of the garment factories have not taken actions and measures for commendably addressing sexual harassment following the mandate (disciplinary rules and action, raising awareness and proper complaint mechanism) ("Special Original Jurisdiction", 2008). Another notion which was revealed that these FGWs were also not keen to join trade unions (Das, 2008).

Sexual harassment is likely to be the most leading source of psychological stress for garment workers established by a review of health and safety regulation in the garment industry. (Begum & Paul-Majumdar, 2000). The garment industry is the most prominent and leading employer of women with around 4 million women working in various capacities in the private sector, (Campaign, 2012; Kabir & Mahmud, 2004; Siddiqi, 2002). In Bangladesh garment workers are under massive pressure to engage in sexual activity, mainly as a result of the long hours that women and men spend together unsupervised by guardians or parents (R. T. Naved, Amin, Diamond, & Newby, 1998).

Workers' Narratives of Sexual Harassment

"They treat women in the garments like dogs.

Anyone can do whatever they like, whenever they want to, to them.

Working in a garment is like being in prison (Dina M. Siddiqi, 2003)".

Dominant discourse in Bangladeshi culture associated FGWs to sex workers, or being sexually promiscuous (R. Naved, Rahman, et al., 2018b). The literacy rate is low, these FGWs are not well-versed about safe sex, menstruation, contraceptive methods, STIs, and HIV infection. As there is large range of social insecurity, adolescent FGWs are often victims of severe sexual abuse. FGWs positioning as sexually promiscuous and/or sex workers increased their vulnerability to violence (R. Naved, Rahman, et al., 2018b), which can lead to HIV infection. Thus, the adolescent FGWs are considered as vulnerable group for HIV infection (Jahan, 2012)

Discussion

Connections among groups and activists, for example Bangladesh Parliament Members Support Social Group on Prevention of HIV/AIDS and Human Trafficking should be reinforced. Stakeholders, for example the Ministry of Transport, Department of Narcotics, Ministry of Education, Ministry of Religious Affairs, opinion makers', community leaders have a key role to play in HIV prevention. Private-sector involvement and business in the HIV

and AIDS epidemic needs to be encouraged and explored, particularly given the speedy urbanization contributing to different industries, especially ready-made garments, where four million young women work (Campaign, 2012; Nidhi, 2009).

In many countries around the world, statistics on furthestmost aspects of sexual violence are absent. Nevertheless, existing data demonstrates that in some countries closely 1 in 4 women may possibly experience sexual violence by their intimate partner, and equal to one-third of adolescent girls reported that their first sexual experience was being forced (WHO, 2013a). Furthermore, there is strong evidence regarding the association amongst IPV and HIV. Women, who are exposed to IPV in high prevalence area are 50% further likely to contract to HIV, compared to those, who are in low prevalence setting (Rachel Jewkes, Dunkle, Nduna, & Shai, 2010). Globally, young women and adolescent girls confront the highest levels of IPV. Globally, approximately, 120 million girls are sexually abused or raped by the age of 20, as it was reported by the United Nation Children's Fund (UNICEF) (Unicef, 2015). Forced sex or violent can increase the risk of HIV infection due to in forced vaginal penetration, scratches and cuts usually take place, which help the pass of the virus through the vaginal mucosa. Furthermore, without using condoms, men force their partner/spouse to engage in sexual intercourse (Rachel Jewkes et al., 2010; Unicef, 2015).

Knowledge of HIV status is vital for measuring reproductive health care and counselling HIV status, corresponding life related outcome and diagnosis of women in Bangladesh, and to assist women in making decisions on issues, for example the number, timing and spacing of pregnancies, infant feeding practices and personal usage of contraceptive methods. Furthermore, counselling and information are critical components of all reproductive health services and sexual, and continue to support women in making these decisions and carrying them out voluntarily and safely. Complex issues affect whether women's appearance and experience of sexuality leading to sexual health and put them at risk of ill health. High quality services and programmes that talks sexuality positively and promote the sexual health of women living with HIV/AIDS are crucial for women living with HIV/AIDS to have safe, responsible, and satisfying sexual lives, particularly in countries highly affected by HIV. Violence, comprising sexual violence against women, is deeply correlated with women's potential risk of becoming infected with HIV. Moreover, violence against a woman can hamper with her capacity to access care and treatment, maintain receptiveness to antiretroviral therapy. Health services, together with those focusing on HIV care, prevention and treatment provide a significant entry point for recognizing and answering to women, who experience violence (WHO, 2006).

Replicate below the paragraph of an essay on FGWs of Bangladesh:

There's a proverb among girls in the slums of Bangladesh: *"If you're lucky, you'll be a prostitute - if you're unlucky, you'll be a garment worker"*. Pinky was both lucky and unlucky. When she was 11, she was sold into a brothel. At the age of thirteen (13), she was living in the capital city of Dhaka at a shelter for victimized women and girls and working at a Garments. The bird-boned girl was undernourished, stood on her feet for up to fourteen (14) hours a day, six (6) to seven (7) days a week, for the equivalent of \$12.50 a month. The foreman (clients) came on to her all the time. 'No, not for a pretty one like that in a garment factory. Just threaten to fire them and they're yours. A girl in the labor force means she's unprotected. Either her family has abandoned her, or the family men are too poor and desperate to make trouble' (Dina M. Siddiqi, 2003).

There was a line chief of garment factory, who would say:

"You should be stripped naked and left standing by the roadside. ... You don't need to work here. You better go to the street and become a whore." (R. Naved, Rahman, et al., 2018b).

Around the globe, researchers have started to develop and test interventions that promote women's empowerment to decrease violence and related health risks (Barker et al., 2010; Dworkin et al., 2011; H. Keleher & L. Franklin, 2008; Solotaroff & Pande, 2014). Women's empowerment programmes have concentrated on increasing women's access to and control over social, economic and health resources, as well as education, income, credit, and health

services. Workplaces have been used as sites for HIV prevention interventions and for deal with sexual harassment (Solotaroff & Pande, 2014; Yassi, O'Hara, Lockhart, & Spiegel, 2013)

This intervention pilot demonstrates the acceptability, feasibility and effectiveness of workplace-based interventions to positively influence attitudes towards gender equity, IPV and alcohol use and increase awareness of IPV and alcohol-related support services. Workplace health promotion interventions are gradually being accepted as beneficial for both employees and employers (Baicker, Cutler, & Song, 2010). Programmes have also boosted awareness of HIV/AIDS and endorsed safer sexual practices (Mahajan, Colvin, Rudatsikira, & Ettl, 2007). The intervention has established that issues, such as attitudes towards gender equity, alcohol use and IPV can also be addressed in a workplace setting (Krishnan et al., 2016). According to Halli, 2009, proposes that a workplace-based intervention can proficiently indorse gender-equitable approaches, and decrease the acceptability of IPV and increase knowledge of IPV. This intervention also escalates employee productivity, satisfaction, and retention. Research reinforced that reappearance and scale-up of this intervention in workplaces throughout India offers an encouraging method to refining gender equity and health (Halli et al., 2009). Furthermore, male partners' should be part of HIV prevention programs. Interventions focussing on education about condom negotiation skills and HIV transmission not sufficient for many of these FGWs, since implementation requires male cooperation (Bjelland et al., 2010).

An African or Indian with a social or sexual violence, or Bangladeshi with intimate partner violence or workplace violence; the story is identical: a failure to comprehend social process leads to systematic catastrophes- a social paradox, with important implications for policy and praxis.

A social science literature has recognized the connections between social and monetary inequities, migration, structural violence, and HIV/AIDS (Bennet, 2006; Paul Farmer, 2004; Parker, Easton, & Klein, 2000) and has extended our understandings of the complexities of what is often termed "transactional sex" (Verheijen, 2011). A 2008 study (Makoe & Mokomane, 2008) of Lesotho garment workers' vulnerability to HIV transmission reports that low wages, migrant status, and gender inequities are major drivers of women's vulnerability to HIV infection. In India, this also portrays migrant women shifts from their community of origin to their destination. In other words, shifts in the power dynamics of sexual and non-sexual relationships, community factors (such as labour opportunities, access to health care resources and risk behaviour profiles), and the structural context of the destination (cultural norms, stigma and policies as they apply to migrants) may all theoretically impact on HIV prevention for these FGWs. Regardless of common and stereotypes assumptions, it is neither migration nor migrants as such that increases the risks of HIV transmission. It is the trying circumstances and hardships that several face all through the migration experience that makes them more vulnerable to STI/HIV infection (Webber et al., 2010).

In contrary, health education programs highlight the responsibilities of workers to manage their own health and protect themselves against HIV infection (Kenworthy, 2013). It is far easier for factories to keep aloof the FGWs from the social circumstances that add to the obviously high HIV prevalence among this population than it is for them to refute the workplace exposures that escalate stoppage among FGWs. In Lesotho, abortions are illegal and FGWs find that, despite their incomes, they either cannot give support another child or can't afford the loss of salaries due to enforcement of compulsory, but mainly unpaid, maternity leave (Kenworthy, 2014).

Sexual harassment deteriorate the susceptibility and vulnerability of the female workforce and that weakens their benefits, opportunities and rights in the Ready-made garment (RMG) sector of Bangladesh (D. S. Chowdhury, 2017). In the 2nd National Conference on Sexual and Reproductive Health and Rights at Workplace, the researchers mentioned that in Bangladesh sexual and reproductive health and rights (SRHR) is a neglected issue, and Bangladeshi people need to change their mindset to work on the SRHR issues. The researchers also discussed topics, such as pregnancy related services, family planning, and neglected issues of SRHR, which are gender based violence and HIV/AIDS at the workplace, also adolescent engagement in promoting SRHR service and education (Dhaka Tribune, 2019; Tamanna, 2019).

Women garment workers' poor command over commodities and limited purchasing power define and form their access to health, housing, sanitation and transportation facilities. Lack of job security is compounded by low salaries, which causes insecurity of life for women in urban areas. Nevertheless, women continue to work, and the explanations for this are obvious in the narratives (S. Khan, 2001). Bangladeshi factory owners put the lives of million FGWs in danger, even although these FGWs are dependent on this manual workforce for their business to flourish (Choudhury, Luthfa, & Gayen, 2016).

A key to reducing poverty and abortion and empowering women is comprehensive sex education. There are instances that comprehensive programs are effective. Though the global and United Nations (UN) agreements are not necessarily prioritised, it is a prominent characteristic that access to accurate and complete STIs and HIV and other health information is widely known as a human right by UN (Forbes, 2017).

Equity and rights in regard to gender play a significant role in influencing women's vulnerabilities to HIV infection and violence and providing the ability of care and support for them, access to treatment, and coping mechanism when both infected and affected. The recent scope of HIV policies and interventions need to be broadened to make gender equity an essential element in the fight against HIV. All women have the same and equal rights regarding their sexuality and reproduction, but women who living with HIV need further counselling and care during their reproductive life. HIV infection increases the usual history of reproductive disorders, escalates the severity of others and unfavourably affects the capability to become pregnant. Furthermore, HIV affects the sexual health and well-being of a woman (WHO, 2006).

In Bangladesh IPV is outlawed through the 2010 Domestic Violence Act. Nevertheless, there remain important encounters in implementation, as well as the continuing perception that domestic violence is a private concern. (R. Naved, Rahman, et al., 2018a).

All through the data the impact of this violence in the factory and home on women's real ability to work was apparent (R. Naved, Rahman, et al., 2018a). Structural reforms within legislation are vital for preventing violence in factories. There are evidence that non export processing zones (EPZ) factories have higher levels of violence than EPZ in Bangladesh, which are better monitored and regulated, and the mode of contracts they have with buyers (Ganguly, 2015; Dina M Siddiqi, 2003). Therefore, regulation, together with minimum wages are a significant building block of effective violence prevention. However, existing regulations are enforced very poorly, furthermore these methods may be somewhat ineffective, without also reinforcing trade unions as a way to enforce laws and regulations (R. Naved, Rahman, et al., 2018a).

Conclusion

An inclusive literature search has also documented that in Bangladesh there is no women STIs surveillance conducted. Furthermore this group are not included as vulnerable population in Bangladesh national surveillance and there is no explicit data available on their risk behaviours (Islam, Conigrave, Conigrave, & Islam).

Another source articulated that Bangladesh Garment Factory Owners Association (BGMEA) runs several programs with Asiatic MCL, Marie Stopes, Population, Council UNFPA, and WHO to transfer knowledge about reproductive health issues, including HIV and other STIs among the garment workers through workplace interventions and leave them better equipped to prevent the STIs and HIV (The Korea Times, 2013). However, the Bangladesh Independent Garments Union Federation (BIGUF), funded by USAID has no explicit programmes on sexual harassment, 'including WPV and IPV training' as such but raises the topic on AIDS prevention during their training (ILO, 2019). HIV workplace intervention programmes for FGWs need to be developed, implemented and evaluated that reinforce women to understand their rights to safety and decrease violence in their lives (R. Naved, Rahman, et al., 2018b).

In Bangladesh the politics and dynamics of STIs/HIV among women and the parallel policy replies to these disclose much about the difficult relationships between people in power, people, who are powerless and the theory of sexuality. Consequently, alternative design paradigms, which challenge power and create diversity and the

probability of empowerment into the argument are required for those comprehended to be powerless. Most of the sexually active women share biological risk to some extent, nevertheless it is apparent that the AIDS pandemic among women is extremely patterned along social, not biological lines and having outcomes of restricting women's autonomy, and enforcing male power. Though many people agree that forces, such as gender inequality and poverty inequality are the strongest enhancers of risk for exposure to HIV, however, this topic has been neglected in both the social science and biomedical literature on HIV infection (P. Farmer, Connors, & Simmons, 1996). It also revealed by UNAIDS, what needs to be established are policies and strategies that increase access to prevention choices, with 90% of individuals by 2020, particularly young women in high-prevalence nations, the removing of gender inequalities and the ongoing decline of all types of violence and discrimination against women and men who are living with HIV.

In Lesotho, the 'Labour Code Amendment Act (2000)', which introduced provisions on HIV/AIDS and transferred jurisdiction for specific types of employment disputes from the Labour Appeals Court to the Labour Court, which established the Directorate for Dispute Prevention and Resolution and Labour Code Amendment Act (2006) (Pike, 2014). Following Lesotho approach, Bangladesh should also establish the Labour Code Amendment, which can simplify employment disputes. Empowering FGWs by way of formal health education on HIV/STIs is vital, including prevention of sexual harassment, WPV and IPV related training. HIV prevention programme should comprise FGWs (100% participations), male partners', including owners of the factories. It is also essential to push for improved implementation of the Domestic Violence Act. NGOs, private sector involvement and community leaders aiming on STIs and HIV need to be encouraged to inform the FGWs about safe sex. Another key step would be reinforcing trade unions as a way to enforce laws and regulations. Female representative is to be ensured in the leadership of the trade union. All FGWs should have access to be a part of this union and can voice their rights and necessities. In this regard, BGMEA can play a key role. Moreover, counselling and supplementary education are significant components to assist women in taking sexual intercourse choices and supporting them out both safely and voluntarily at the same time.

AUTHORS' CONTRIBUTIONS

SM designed and conducted the literature review, methodology and contributed to the manuscript structure as well as drafting and overall editing of the manuscript. Author read and approved the final manuscript.

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CONFLICTS OF INTERESTS

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