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Story of *Rana Plaza* Survivours and BRAC's Support

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Acronyms

BGMEA	Bangladesh Garments Manufacturing Exporters Association
BEP	BRAC Education Programme
BIED	BRAC Institute of Educational Development
BLBC	BRAC Limbs and Brace Centre
BLC	BRAC Learning Centre
CBO	Community Based Organisation
DECC	Disaster, Environment and Climate Change
GDP	Gross Domestic Product
GSK	Gono Shasthyo Kendra
FGD	Focus Group Discussion
IDI	In-Depth Interview
NGO	Non-Governmental Organisation
NITOR	National Institute of Traumatology and Orthopedic Rehabilitation
OECD	The Organisation for Economic Co-operation and Development
RMG	Ready-Made Garments
TCC	Transitional Capitalist Class
WTO	World Trade Organization

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Abstract

The 2013 collapse of a multi-storied commercial building named *Rana Plaza* is a deadliest accidental structural failure and the worst garment factory accident in Bangladesh. During the collapse many workers died and trapped and in general it created great national and international outcry. Emotions and consciences were severely stirred. Civil society, students, community-based organisations, government, non-governmental organisations came forward with social and economic support for the victims. BRAC, also extended support through its many programmes. BRAC Limb and Brace Centre (BLBC) provided prosthetic limbs and braces to a number of survivours with critical condition immediately after the collapse. Survivours also received other assistance in various forms like follow-up treatment facility, psychosocial counselling and monthly monetary support. Few survivours have received livelihood skills training from Disaster, Environment and Climate Change (DECC) programme.

This study aimed to understand situation of the victims after one year of disaster and to see how they materialised BRAC's support they received so far. This study was done using multiple data collection tools and techniques of qualitative research methods. Collected data were analysed with thematic framework technique. Findings revealed that the survivours were severely traumatised experiencing the accident and their psychological stress was further catalysed by feeling of disempowerment followed by societal attitudes towards them because of physical impairments incurred to them. They were going through extreme financial hardship due to joblessness and other vulnerabilities and were struggling to meet the costs of basic needs and that of treatment, medicines and rehabilitation. Moreover, lives of their dependents were reported to worsen off. A strong link between disability, gender and poverty was noticed. Female survivours with physical impairment were more vulnerable than their male counterparts because of existing societal norms in the country.

Most survivours expressed their satisfaction over BRAC support they received. However, in cases it was found that recipients could not make fair use of the prosthetic limb due to practical complications associated with the use of the devices like feeling heaviness, headache, swelling, and pain and so on. Most of them also mentioned financial support provided by BRAC is inadequate to their actual needs. Some of the male survivours showed their frustrations for having training on issues they were not interested in and some other seemed tired of waiting long in the queue for livelihood training.

It is recommended that counseling facilities should be set up in a way that the survivours get continuing support from it to get out of the mental trauma and their anxiety is lessen to a level that they can rejoin livelihood activities according to their physical capacity. Also, selection for survivours for skills training must be made on the need of the prospective recipients so that they can get most benefit from it.

Chapter 1. Introduction

1.1 Background

The garments sector and Rana Plaza Collapse

After her independence in 1971, Bangladesh has come across many hurdles and has gradually transformed from a predominantly aid receiving nation to a trading nation (Yunus and Yamagata 2012).The export-oriented ready-made garments (RMG) sector has made crucial contribution to this transformation of the economy of Bangladesh. Ever since the 1980s, the RMG industry has grown enormously and is the biggest export earner in the country at present (Yunus and Yamagata 2012; Odhikar 2013). In 2010-11, the percentage of RMGs to total exports was 78% (Ahmed *et al.* 2013); the sector now employs around 4 million workers across its 5,150 factories; 80% of the total workers employed are women (Odhikar 2013; EPB 2006). These four million workers are about two-thirds the number of the total number employee engaged in the manufacturing sector, constituting the real backbone of the country's economy (Islam 2014).

As is evident, the RMG sector has played a major role in the country's social development. It recruited predominantly female workers. Since the 1970s it has catered to the employment needs of the working class, especially women and empowered them in multifaceted ways. RMG sector also has been playing an important role in enhancing Bangladesh economy. About 80 percent of the total export of the country and is the highest earning industry in the economy (Islam 2014; Ahmed *et al.* 2013). The apparel industry is undoubtedly the most potential of all the other sectors in the country. For three decades now the sector is contributing to employment generation, foreign exchange earnings and increasing contribution to the country's gross domestic product (GDP) (Hossain *et al.* 2016).

Despite the phenomenal success however, the RMG industry is commonly blamed for exploiting poor workers who migrate to the cities from rural areas in search of better jobs and a better life (Financial Express 2013). Some factories have very poor and dangerous work environments, long and tedious work hours with wages lower than the national minimum; there are frequent instances of sexual and verbal abuse, torture and so on. Low wages and lack of social compliance have been underlying reasons behind labour unrest and destruction of institutions and property since 2006 (Paul-Majumdar 2007). In another studies it has been shown that main causes of labour unrest include lack of minimum facility, and safety at work, sub-standard living conditions, deferred payment of wages and benefits, international conspiracy and coercive role of the law enforcing agency, too much dependency on buyers, pressures from the workers and local terrorists, use of workers by others and rumors, un-fulfillment of education demands of their children, distorted minded workers, political instability of the country, too much workload, lack of promotion opportunity, insufficient wages to survive etc.(Ahmed *et al.* 2013).

Industrial accidents are common in Bangladesh owing to poor enforcement of safety regulations. In Bangladesh most of the garment industries are situated in residential and commercial areas not in industrial areas. Moreover, buildings are closely spaced. Studies revealed that most of the garment industries do not have enough fire exit doors, ventilation for air circulation, fire and smoke alarm systems (Akhter *et al.* 2010). Since

2005, about 700 garment industry workers have died because of unsafe working environments (Walter 2012). The major deadly accidents in RMG sector includes the collapse of the Savar Spectrum sweater factory, The *Phoenix Fabric* mill limited, and then there was the *Tazreen* factory fire and most recently, the deadliest *Rana Plaza* tragedy. Such instances, especially the most recent and deadliest *Rana Plaza* tragedy directs focus to the systems that ultimately lead to such massive disasters.

Cracks in the giant structure of the eight-storied *Rana Plaza* were seen on the third floor in the morning of the 23 of April, 13. It was reported by the media that workers saw cracks in the huge structure but upon inspection, the authorities reassured the workers that the cracks were "nothing serious" and were "harmless" (Gomes 2013). Industrial police had however, asked the owner of the building, and the individual factory owners at the *Rana Plaza* to keep their factories closed and consult expert structural engineers before taking any decision of inviting in workers. Disregarding all these warnings, the workers were called back to resume work the very next day.

Many workers were naturally discouraged to come to work the next day due to fear of a possible mishap. As is evident from accounts of survivours and wide coverage by media, the workers were forced to come to work on the 24th of April,13 and threatened "…with a month's salary cut if they did not comply and come to work" (Gomes 2013). On the morning of the same day, the eight storied building collapsed with hundreds of workers inside the building causing deaths and serious injuries and devastated hundreds of lives. This large scale industrial disaster, the *Rana Plaza* collapse came only five months after the *Tazreen* factory caught fire which killed more than 117 people, and about a little more than the year after the garments worker organiser, Aminul Islam was tortured to death. These incidents provide a deadly yet vivid picture of the work-related hazards and the underlying structural causes of suffering that welcome the working poor in plutocratic Bangladeshi factories every day (Gomes 2013).

The collapse of the *Rana Plaza* is considered the deadliest accidental structural failures and the worst garment factory accident in Bangladesh. The death toll was 1,129 (Times Magazine 2013; The Daily Star 2013) with another 2,515 cases of severe casualties. Women were believed to be the worst affected by this accident; 80% of the survivors and injured were women (Fox vog *et al.* 2013). Important to note that according to statistical year book of Bangladesh this sector employs approximately 2.2 million workers, of whom almost 80% are women (Statistical Year Book of Bangladesh, 2008 *in* Mridula and Khan 2009). Moreover, in the post-accident period, the women survivours were also the most vulnerable group.

BRAC supports towards survivours of Rana Plaza collapsed

Since the incident, BRAC has been working in close collaboration with the National Institute of Traumatology, Orthopedics and Rehabilitation (NITOR), Ministry of Health and Family Welfare under the leadership of the Prime Minister's Office (PMO) to support survivours. BRAC's support for victims came in the form of monetary assistance, treatment and rehabilitation related support. BRAC, standing true to its longstanding commitment of helping those in most need of assistance generously extended support to selected victims in 2013 under its BRAC Limbs and Brace Centre (BLBC). As part of this initiative BLBC gave prosthetic support to 12 survivours (11 semi-functional upper limb prosthetics an done lower prosthetics) and provided braces to 35 survivours with severe spinal injuries in NITOR (BRAC 2013; Mehrin 2014). In addition BRAC providing a fixed deposits of BDT100, 000 (approx. $1000) for all its beneficiaries to support their

long term rehabilitation (BRAC 2013) and they were allowed to withdraw the interest on a monthly basis.

Psychosocial training was given to the victims and in many cases to their immediate families. More importantly, surgical and all other treatment related support was facilitated under the joint collaboration of Institute of Educational Development (IED), BRAC University, BRAC Health and Disaster, Environment and Climate Change (DECC) with assistance from government and public and private medical wings in the country.

BRAC also arranged skills training to get sustainable livelihoods. Survivours choose their desire training from various issues like managing a grocery store, tailoring, livestock rearing and agriculture.

1.2 Study rationale

It is important for BRAC to know the present condition of the beneficiaries and understand its intervention. It is also crucial for future policy implications to understand how much the victims could benefit from the support that was extended. Understanding the specificities of survivour's sufferings, related to the context in which they live is important. Bangladeshi society is a very stratified one with deep-rooted patriarchy in all spheres of social life. This raises the relevance of whether the experiences of poor rural women affected by the tragedy differ from that of their male counterparts. The objective of this study was to understand their situation after one year of disaster and BRAC's support for survivours of Rana plaza collapse through the lens of sustainability and value creation.

1.3 Research objectives

The objective of this study was to provide a detailed profile of the survivours who were specifically supported by BLBC and to understand their situation after one year of disaster by assessing sustainability and value creation. The specific objectives were:

- To know the socioeconomic and health situation of the survivours after one year of Rana plaza collapse.
- To know the dimension of challenges and sufferings in relation to rehabilitating back into family life and society.
- To know experience of the survivours regarding supports they received from BRAC.

1.4: Conceptualisation

In the case of transnational economies such as Bangladesh, economic globalisation produces a breeding ground for the reproduction of the capitalist system, specifically in terms of class segregation. Robinson (2006) argued that since the 1970s, the global economy has undergone a major restructuring- an "epochal shift". The formation of a transnational class impeded by increased economic integration and trade liberalisation now controls global production, marketing and finance. It is widely argued that this new ruling class uses an emergent transnational state, in the form of supranational economic and political forums to dominate global society (Robinson 2006).

There is wide consensus that power is in the hands of the transnational capitalist class (TCC) which includes four fractions: i) people who own and control the major corporations and their local partners (the corporate fraction), ii) globalising politicians

and bureaucrats (the state fraction), iii) globalising professionals (the technical fraction) and iv) consumerist elites (consumerist fraction). TCC engages itself at different levels-urban, rural, community, national and global politics and other relevant actors in the national and global system. The question that often arises is whether TCC hold respect for human rights and democracy (Sklair 2002).

Moreover, recent literature (reference needed) shows that the number of occurrences of man-made disasters in industrialised countries is increasing exponentially and most of these incidents are related to fires and explosions. Coleman (2006) quotes that, "…although there has been a marked reduction in the severity of accidents as measured by the average number of fatalities, the overall number of deaths due to death has not changed." This evidence has serious policy implications as it points to the need for increased regulatory framework and for corporate governance to effectively manage risks and achieve industrial safety. Coleman also points out from his study on OECD countries that the number of industrial disasters is increasing due to a "…growing failure of traditional hazard minimisation processes…" rather than the introduction of new technologies and he concludes by saying that contemporary regulation and corporate governance are simply inadequate to manage modern industrial risks" (Coleman 2006: page number).

Literature and evidence on man-made industrial disasters and its severity becomes more and more relevant to Bangladesh as it industrialises and suffers from incidents like the *Rana Plaza* disaster and *Tazreen* factory-fire incident. The capitalist discourse and how it has influenced the business trajectory in Bangladesh is one way of looking at the existing problems. This gives one a macro-level view of the situation. A micro-level view however, vividly outlines how a very socially stratified society of Bangladesh has differential impacts on men and women. The nature and causes of sufferings of male and female survivours affected by a tragedy has distinct variations. A new kind of discrimination is generated by the intersectionality of gender and disability. Stereotypes are deep-rooted within our individual cultures. Gender stereotypes overlap with disability stereotypes that constitute "a deep matrix of gendered disability in every culture." (Meekosha 2004).These stereotypes often promote our cultural understandings of existing social practices and social norms. For example, the stereotype that disabled women may not be good mothers and are mere receiver of care by others. Meekosha says that these stereotypes and resistance coupled with conventional norms of femininity hinder the development of women with disabilities.

Chapter 2. Methodology

2.1 Study designs

As the sensitive nature of the issues, this study focused on qualitative approach to gather all relevant information from the survivours of the *Rana Plaza* tragedy. It is said as sensitive as it was scary and stressful. Most of the discussion tended to generate an emotional response, for example death, physical and economic disability. Data for this study came from three independent but related sources that included:

- The survivours
- The community people
- BRAC programme personnel including members from BLBC, DECC, BRAC Education Programme (BEP) and BRAC Institute of Educational Development (BIED), BRAC University

2.2 Data collection strategy

We used different types of data collection methods in order to gather more comprehensive data, that increased validity, enhanced understanding of the studied phenomenon (Casy and Murphy 2009). In-depth Interviews (IDIs), Focused Group Discussions (FGDs), community consultations and informal observations were used to collect data for this study. Separate checklists were used for each of the techniques depending on purpose and the subjects. Two day field trial with three survivours was held to identify the accuracy of the checklist. However, the survivours were further interviewed after finalisation of the checklist.

IDIs were chosen as the main research instrument because it helped the researchers to capture survivour's experiences better than other alternative methods. The respondents talked about their life in the pre and post-accident period and portrayed their feelings, thoughts, opinions, aspirations, choices and provided a holistic picture of how their lives changed due to the tragedy. Community consultations and several informal discussions were conducted with community members that included people from the same village/area who lived in close proximity of the survivour's house and were aware of the accident. This helped the researchers to achieve two goals. Community consultations were conducted to know the perceptions of the common people about the *Rana Plaza* tragedy and know how they feel about working in the RMG sector after this accident. It was assumed that community members could tell the researchers about the survivour's overall condition in the pre and post tragedy phase. Besides generating data in a group, these community consultations also served as a way of data triangulation. The researchers could relate and compare the data gathered from individual cases with the data gathered from the community consultations.

Figure1. Community consultation with the villagers and neighbours of the survivours

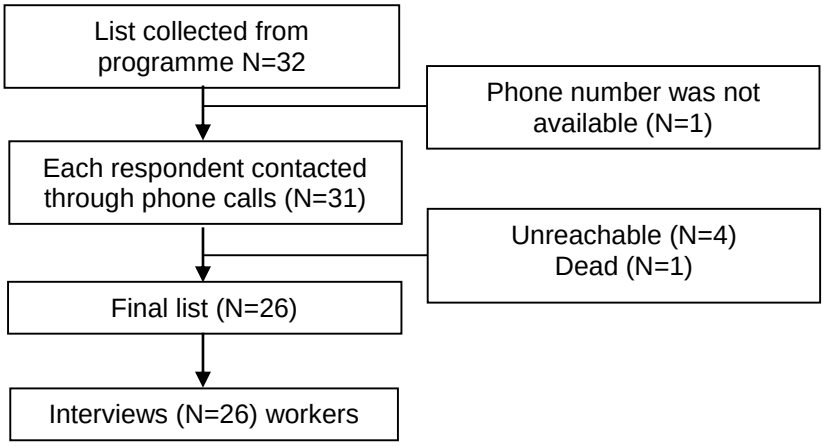
Figure 2. FGD with various programme personnel of BRAC

Lastly, FGD were arranged with programme personnel and this also served multiple purposes. A discussion with programme personnel helped the researchers to understand the day-to-day operations better and made it easier to identify the challenges of this intervention. It also helped validate the data collected from the interviews and community consultations. Within the paradigm of the research design, validation of data was done in this manner to ensure consistency. Researcher's triangulation was done to minimise bias and inconsistencies.

2.3 Sampling

Primarily BLBC supported 32 survivours. A list of these 32 survivours with their home address, telephone number and other relevant information was collected from the programme personnel. Each of these survivours were contacted via telephone by the researchers themselves and information was collected about their availability and current residence. From the group of 32 people, 26 survivours were available and agreed to participate in the study. Four survivours were unreachable. One of the male survivours in the list was reported dead by family members and in this particular case, the wife was interviewed. In total, 27 in-depth interviews, two community consultations and one FGD were conducted.

Figure 3. Data collection strategy



2.4 Data collection, analysis and reporting

The multidisciplinary team of four researchers conducted all the interviews themselves. Twenty-three of the survivours were interviewed in their own residences. Two of the most critical cases were interviewed in Dhanmondi, Dhaka hospital of Gono Shastho Kendro (GSK) and one was interviewed in BRAC Learning Centre (BLC), Uttara where she was undergoing a skills training given by BRAC.

Data were analysed using a framework analysis technique (Pope *et al.* 2000; Nicola *et al.* 2013). The framework analysis techniques has been developed specially for applied or policy relevant qualitative research in which the objectives of the investigation are typically set in advance and shaped by the information requirements of the funding body (Ritchie and Spencer 1993). The analysis has been performed in five logical and systematic steps by all four researchers who collected information, listened carefully discussed and worked with developments of the subthemes and themes. The analysis process followed five steps includes familiarisation of the data, identifying a thematic framework, indexing the data, charting data according to the appropriate part of the thematic framework and mapping and interpretation of the charts (Pope *et al.* 2000; Nicola *et al.* 2013). Data triangulation was done by the researchers during data collection and separate data analysis.

2.5 Ethical issues

Participants were informed about the study prior to the actual interview. They were ensured that their participation is voluntary and that they could withdraw at any point.

Verbal consent was taken from each participant before recording the interviews or taking photographs. Interviews were conducted at a location in agreement with the participants and their families. Confidentiality about their identity was guaranteed. Fictive names have been used in the report and dissemination sessions that were conducted.

2.6 Strengths and limitations

The fact that the researchers themselves conducted all the interviews in the respondent's natural household setting remains one of the major strengths of the study. The researchers spent a considerable amount of time interviewing the respondent's and observed the respondent's house, physical condition and interaction with other household members and neighbours. This brought a lot of personal observations and reflexivity in the analysis part of the report.

Given that this research was based on such an emotion laden and critical issue, multiple visits to the respondent's would make rapport building and data collection processes easier and ensure better quality data. Due to time constraint and resource limitation, the fieldwork had to be completed within two weeks. This posed serious challenge during the data collection phase and remains one of the major limitations of the study.

The respondent's for the study were socioeconomically deprived people who have been hugely devastated by the accident; all have been left jobless and some have been seriously physically disabled. The fact that the researchers were from a different socioeconomic background, able-bodied and representatives of an organisation who have benefitted them directly constituted an artificial sense of hierarchy and sometimes left the researchers in an ambiguous position of being and "insider" and an "outsider." To maintain a non-hierarchical attitude and establish a relationship with the respondents, the researchers maintained telephonic communication with them before and after the interview and tried their best to be empathetic and culturally sensitive throughout the field-work. Thus, this type of data collection with the affected people/regions would require a unique methodological approach to enable the collection of accurate and in-depth information (Parkes 2011).

Chapter 3. Results

3.1 Socioeconomic and health situation of the survivours

3.1.1 Demographic profile

A large number of the survivours under the study were in between the age group of 20-29 years. It was interesting to find out during face-to-face interviews that some of the female survivours were in fact younger than 15 although official documents validated they were 18 or older. Majority (16) of the survivours were females who were working in different factories in the *Rana Plaza* complex. They were predominantly Muslims. Most (12) of them completed primary education and only three completed higher secondary education. Two had Masters degree. Seventeen of those interviewed were married and fifteen had one child or more.

Table 1. Demographic profile of the 26 survivours

Characteristics	Survivours (N = 26)
Age	
<20 years	3
20-29 years	16
30-39 years	6
>39 years	1
Gender	
Male	10
Female	16
Religion	
Islam	25
Other	1
Education	
Primary incomplete (1-4 schooling)	7
Secondary incomplete (5-9 schooling)	12
Secondary complete (10-12 schooling)	4
Higher secondary complete (12+)	3
Marital status	
Married after the incident having no child	2
Married having child	15
Single	6
Separation/Divorce	2
Widow	1

Most (9) of the survivours under the study were from Dhaka division. Seven were from Rangpur, 4 from Khulna, 3 from Rajshahi, 1 from Barisal, Chittagong and Sylhet each (Figure 2). All those from outside Dhaka had migrated to the city in search of jobs. After the accident 14 survivours went back to their own communities, 10 remained in Savar, Dhaka near the former *Rana Plaza* in hope of receiving aid, assistance, treatment and job-related support (Figure 3). During the time of data collection, two survivours were still admitted to GSK for further treatment.

Figure 4. Permanent residence of 26 survivours

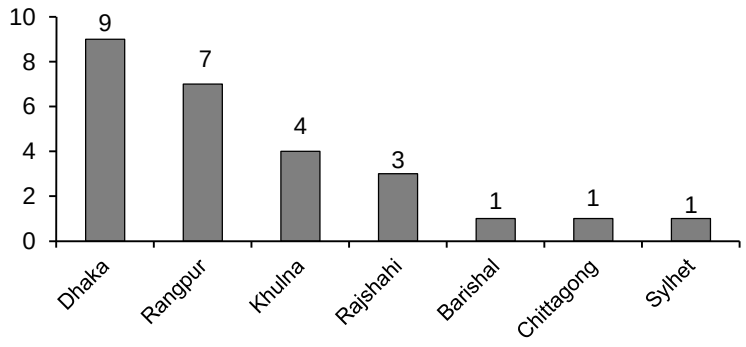
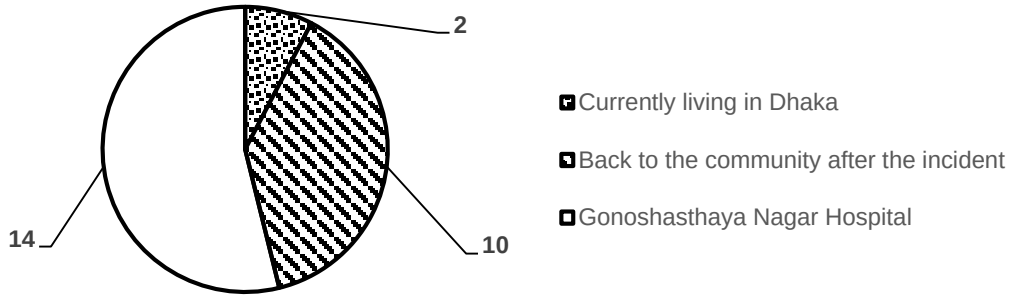


Figure 5. Residence after one year of *Rana Plaza* disaster



3.1.2 Economic and occupational profile

Most (12) of the survivours migrated to Dhaka from their village homes about five years before the accident occurred and were employed in the garments sector. Most respondents reported that their total monthly income (including salary and overtime) was less than BDT 8,000 ($ 90 approximately) when they were in service (Table 2).

Table 2. Occupational profile of the 26 survivours

Occupational history	Survivours (N = 26)
Involvement in the income activities of the survivour	
< 5 years	18
5-10 years	7
>10 years	1
Income (April-2013) of the survivours	
<8000 BDT	12
8000-10000 BDT	10
>10000 BDT	4

The spouses of 14 married survivours were garment workers, van drivers, car drivers, bus helpers or day labourers. Six of the survivours and their spouses used to work in the RMG sector. However, some of the spouses had to leave their jobs in the city and move to their village home after the accident to take care of their bedridden spouse. Many others involved in other kinds of jobs also migrated to their village homes, unable to bear the living expenditure of a city life.

The amputated survivours are particularly unable to work, at home or outside which is leading them to experience extreme financial crisis and a feeling of worthlessness. Most survivours could not return to work because they suffered from severe disabilities or trauma. The survivours reported that they were deeply traumatised and suffered from insomnia and trembling from loud sounds. Many reported that they were scared to walk into a building or an enclosed room.

Those interviewed showed reluctance to ever work in a garment factory or encourage friends or families to join the sector. Survivours who went back to their communities did so because of financial reasons; most of them were jobless and too poor to afford the expenses of a city life. Some also thought their lives would be much better in the village where they would have the option of working in their paternal/tenant farms or open a new shop. Apart from all these reasons, physical impairments, joblessness and restricted mobility were also crucial factors.

Many were also the sole income earners in their families. Alif for example, was a 18 year old boy who took care of all his family's expenses. His job at a factory in the *Rana*

Plaza enabled him to support his family. Having lost all that he had, he was now frightened to think of his future…

> *"I have six mouths to feed at home. My younger siblings already stopped their education and are currently working. My father is also paralysed and needs treatment. One of my sisters is old enough to get married but we cannot think of anything due to financial constraints."*

Akmol Hussain who had migrated to Dhaka in search of a job responded similarly. When requested to reflect upon his financial condition, he said,

> "*I was the only earning member in my family.* Now, h*ow can I manage medicine for myself and my old mother? How will I arrange for meals for them? How will my son continue his education?*"

3.1.3. Physical condition

The study sample included 12 cases of amputated survivours and 14 cases of survivours with spinal injuries. All respondents reported limitation in physical activity after the incident. Survivours with spinal injuries who used the brace given by BLBC for 3 to 4 months stated that they were experiencing restrictions in movement and difficulties in completing everyday chores. Most complained about constant pain in the backbone and reported that the pain increased if they walked, sat down for long time or climbed stairs.

Those with severe spinal injury with anterior posterior bed shell mentioned greater degree of sufferings and discomfort. Women who had spinal cord injury expressed anxiety caused due to their inability to do everyday household chores and personal work. Amena was suffering from backbone fracture and it is extremely painful for her to sit up for too long, she had difficulties moving around and travelling distances or doing household chores increases her backache. She also reported difficulties in her sexual life and was worried her husband would leave her if she could not "please" him. Almost all the survivours in this study experienced head injury of some kind during the collapse and now suffers from headaches of varying degrees. Some reported having extreme headache at some point of the day, particularly at night, hindering sound sleep.

All survivours amongst the respondents who underwent amputation were provided artificial devices by BRAC. They are still dependent on their spouse, parents, siblings or children for household chores like cooking, cleaning and personal work like bathing, eating, and toileting and so on. Rebita a 24 year old married survivour said that,

> *"What will I do with this life? It would be better if I just died on the day of the collapse. Now I can't move without the help of others. None but my husband takes care of me. But how long can he stay at home? I can't even move sides without anyone's help"* (ID21, 23 years old, amputee survivour).

Most of the amputees could not make fair use of the prosthetic limbs due to infection in the amputated spot and inadequate therapies, medicines and follow-up treatment. They suffered from pain and discomfort when they used the prosthetic limbs. Most of the amputees mentioned that they could not exercise regularly or since they forgot the exercises shown to them by therapists. A few could not attend the follow-ups since commuting was difficult for them in this physical condition. Some of the amputees were still in danger since they were suffering from infections in the amputated spot and needed follow-up surgeries.

3.1.4. Psychological condition

The accident affected all respondents psychologically in varying degrees. Findings show that most of the respondents had gone through prolonged periods of fear, anxiety and trauma. Most mentioned that in the post-accident phase, they developed a fear of sound and motion. They were traumatised by loud noise or motion; some were scared of brick-made tall structures and were scared to go near or inside any high-rise building. For example Islam was frightened to continue living in his brick building; he said,

> *"I am afraid of sound and I can't even use engine-run transport for movement. After the collapse, I shifted to a tin shed house. I cannot tolerate being inside a multi-stored building for a single moment."*(ID22, 27 years old, severely injured).

Case: Death of Abu Ahsan

Just two months prior to the building collapse, Abu Ahasan joined a cloth store in the second floor of the Rana Plaza. Abu Ahsan was admitted to National Institute of Traumatology and Orthopedic Rehabilitation (NITOR) hospital right after the accident where besides receiving treatment, he also received monetary assistance. However, even after all this expenditure behind his treatment; Abu did not get fully cured. In the post-accident period, he suffered from mental trauma and depression. He would worry for his children, wife and family. Abu once even tried to commit suicide but was brought back by neighbours. Family members then decided to keep him tied so that he could not roam around and be self-destructive. Gradually his conditions deteriorate so the family admitted Abu to the Pabna mental hospital. Abu stayed in the mental hospital for over three months. However, he showed no signs of progress. His health worsened and he got skinnier by the day. Around February 2014, he started to suffer from asthma too and lost the battle for life that very month. He left behind his family and the story of a life crushed in the forefront of greed, corruption and inhumane practices.

Most reported that they suffered from sleep deprivation. Nightmares and reflections of the horrendous memories of the collapse haunted them in their sleep. Some respondents mentioned that whenever they closed their eyes, they saw the helpless faces of their colleagues who lost their lives to the tragedy. Their deceased friends cried out for help; their last words and cries resounded in the survivour's ears night after night. Khaleda mentioned,

> *"I was stuck inside the collapsed Rana Plaza for two hours. It was a nightmare! After one year, I still sometimes wake up at night, haunted by those memories. I do not want to remember the incident but it keeps coming back to me."* (ID 20, 29 years old).

Many survivours also suffered from a feeling of worthlessness and have lost the motivation for work. A survivour mentioned, "*I do not feel good at all…I feel afraid to work. What if my spine is fractured again?"* Like this survivour, others responded similarly. Some (especially the amputee group) said that they had not recovered at all after the incident; while a few (who had spinal injury) considered that they had recovered.

The incident had different effects on different people and the severity of injuries varied greatly. The level of a person's recovery was seen to depend greatly on survivour's socioeconomic status, the degree and type of injury, treatment received, the kind of help/financial assistance received, mental strength and support from family or other support groups or individuals. Those who received counselling showed better progress. For example, a survivour admitted to *GSK hospital* during data collection was frequently visited by a donor who unofficially counselled her and provided mentorship. She recognised that such support made her feel stronger.

3.2 Experience of assistance given by BRAC and others

3.2.1 Experience on monetary supports

The respondents recognised various sources from where they received financial assistance in the post-accident period which included but is not limited to the government, BGMEA, individual support from independent hospitals and doctors, foreign donors, NGOs, student organisations, etc. Many acknowledged phone-based cash transfer facility through *bKash* though they were not able to mention the name of the actual sponsor.

It was known from the respondents that survivours with spinal injuries received cash support of BDT 1-5 lakhs ($1000-6000). Amputee survivours on the other hand received approximately BDT 10 lakhs ($12,000).This monetary support was mostly extended by the government, BGMEA and other sources for which the respondents could not provide authentic information.

When asked about treatment cost and financial assistance, Akmol said,

> "*My limb was not broken. My head and hand looked perfectly alright from the outside. There were no bandages anywhere in my body. But I was severely injured. My movement was restricted. Many people came and gave financial assistance to those who lost their limbs but nothing to people like me. Why would they help me? I looked fine from the outside*" (ID15, 31 years old).

This was a common response from survivours with spinal injuries who received significantly less assistance than amputee survivours. However, during the time of data collection, most respondents reported that they had not received any legal benefits from their former employees, including sick pay or compensation

With the monetary support, most of the survivours paid for daily expenses which included house rent, food, education of children and treatment costs. Most of the survivours utilised the money responsibly. They mostly used the money for meeting family expenses or for generating further income. Some were found to invest money in food stock business with relatives; rent land for cultivation, purchasing land and renting shop for doing small business. Maksuda, a divorced survivours described how she utilised the money:

> *"Apa I bought a shop for generating income. I can't sit for long time so I bought this shop. My father will run the shop and use the money to look after me and my daughter. I am divorced, so this is an asset for me."* (ID7, 25 years old).

Lipika also expressed her gratitude for all help that she got saying,

> "*Without that money we could not return back to our village. My daughters might have had to join in garments factory as well because their father is sick and cannot work for long. With this help, all my children are currently going to school and they are doing well. I am really grateful to those who helped me and pray for them at all times*." (ID6, 31 years old)

Most of the money that this survivour received as public donations were spent to pay house rent and cover food costs for her whole family who migrated to Dhaka together earlier and stayed in Dhaka until she was fully cured and discharged from the hospital. She mentioned,

"*I do not use my money inappropriately; always I think what will happen to my children if I fail to make proper use of money. So, I am cautious in making financial decisions. For example, from the remaining amount of the public donation I bought one decimal land and built this new house back home. I built a shop attached to my newly built house and am earning about BDT 2000-3000($40 approximate) from there each month. I am happy that my children have a permanent shelter now and I can bear their educational expenses from the earnings from the shop*".

On the 30th of each month she withdraws BDT 1000 ($12 approximate) from BRAC office as interest against the fixed deposit from BRAC. She has to withdraw it regularly to support her family's needs. Before going to Dhaka she took microcredit from three different organisations including BRAC and now is repaying the dues through instalments. It was also seen that many married female respondents perceived that their husbands were showing more responsibility towards them since they had cash support. The assistance from BRAC has helped empower many survivours.

3.2.2. Experience on artificial limb and brace support

All amputee participants got regular monetary support from yearly fixed deposit. This money was used by most survivours for medicines and follow-up treatment. Among the respondents, 15 with spinal injuries informed that they received brace and other treatment-related support from BRAC. Eleven reported that they received financial assistance and prosthetic limb(s) from BRAC and a few received AFO. Among the amputee survivours, most (11) were provided with follow-up treatment by BLBC. The follow-ups were conducted on a monthly basis and included training on the usage, adaptability and maintenance of the prosthetic limbs. BLBC also arranged for follow-up surgeries and treatments for survivours in critical condition. Additionally, in these sessions, users were also trained on how they could make the best use of their artificial limbs. Therapies and exercise related services were also given to survivours to help them adapt to their artificial limbs. One responded that he was now able to walk after receiving brace and other treatment related support. He said,

"When I was in Pongu hospital (Bengali name of NITOR) I got this brace from BRAC. I was instructed to use it for 6 months. I used it continuously and diligently. The doctors told me to use it during journey time. I do this even when I go to Dhaka. I can move myself now, I am able to walk to the nearby shops and talk with others".

Regarding prosthetic support, three among eleven amputee survivours were able to do a few things like hold a piece of cloth, glass, mug, hold a 2.5 ml bottle, move outside from room to yard etc.

Transport, food and accommodation costs were borne by BRAC for these follow-up visits. However, the study team found that one of the beneficiaries was not attending the follow-up sessions due to the inconvenience of travelling long distance from his village home to Dhaka and he also reported having miscommunication with BLBC members.

Most of the respondents expressed satisfaction with BRAC brace and prosthetic support. Most significantly, the support extended by BRAC is a source of mental strength for many. It makes them feel wanted and cared for. One of the respondents, emotionally said,

"*I never thought that BRAC could be such help for me. My family and I never knew that such limbs were available in Bangladesh. With this new hand I can hold small things that*

help me do basic things without anyone's help. I never thought this was possible when I lost my own hand. This hand saves me from stares and embarrassment in public places. I mostly wear it before going outside. If none from the government comes forward further to help me, I believe BRAC will do something that will help me to survive. They will find a way for me so that I can work and then do not have to depend on them anymore." (ID5, 24 years old)

Lipi's left hand had to be amputated and she was given an upper prosthesis limb by BLBC in 2013. Due to swelling and the formation of a tumor in the amputated place, Lipi was unable to make full use of the prosthetic limb. The prosthetic limb felt too heavy when she used it and she got a bad headache from using it. She also mentioned that it was painful whenever she used the prosthetic limb. BLBC personnel informed Lipithat she is still suffering from phantom pain in the amputated spot. Medical personnel informed that the affected area has not healed completely so using the artificial limb was uncomfortable. She informed that she was in regular follow-up with BLBC and went there for check-ups whenever necessary. Lipi kept her amputated spot hidden with a scarf for most of the time and she was uncomfortable discussing this issue but she responded,

"*Though I cannot always use the new hand due to discomfort, I feel this is useful to have rather than not having any hand at all. With this hand I can easily do little things better. Even if I do not use this hand for any activity, it gives me physical beauty and I gain more acceptances to people. I appreciate BRAC for giving me a second hand. Many of the community members become surprised seeing this and I try to show them how it works. I feel good with this interaction*" (ID6, 31 years old).

3.2.3 Perception on livelihood training organised by DECC

Apart from treatment related assistance, six survivours have already received livelihood skills training from DECC and some others were in the queue for livelihood training or other types of intervention-assistance from BRAC. It was also informed by programme personnel that after successful completion of the training, DECC would help them to build a small shop or arrange other earning sources.

Though it was difficult to get this training for amputee survivours but they tried. Amena came to Uttara BLC where she took a five-day long sewing training organised by DECC. She was informed that she could not do any kind of tailoring work anymore because it was physically too exhausting for her. However, she still travelled all the way from Magura to Dhaka for this training to give it one more try. She mentioned that the long journey by a local bus had increased her pain but that she was still happy to have made it to the training.

It was reflected from the survivours comments that few of them were not clear about the objective of the training that was given to them by DECC. It was found that some survivours attended the training only for getting financial assistance. One female survivour with spinal injury reported:

"*One of my ex-colleagues got training from BRAC on how to run a small grocery shop. She informed me after this training BRAC will provide BDT 100000 ($12,00 approximate) for building the shop*" (ID19; 45 years old).

3.3 Challenges and sufferings of survivours

3.3.1 Financial constraints

In the post-accident period, survivours suffered from lack of income and were unable to bear costs of basic necessities and rehabilitation. Majority of the survivours experienced severe financial hardship in the post-accident period. Most were directly affected by the incident and lost their income. Lipi earned BDT 10,000 ($120) a month and used to live with her elder sister and mother. All three worked there and earned almost same. Now, all of them are jobless and the whole family became poorer. Lipi shared that she was concerned about her family and felt guilty now that she was an added burden to them. In cases where the husband and wife both worked at the *Rana Plaza*, the condition was even worse since the families lost both income sources. Many families had no income to depend on, having lost their only source of income. These families faced greater financial constraints and vulnerabilities.

3.3.2 Treatment-related constraints

Although most survivours received free treatment and sympathy from the hospital management committee and doctors right after the accident, the situation is very different now. Some of the hospitals now charged survivours for services. Some hospitals or doctors treated the survivours rudely. One survivour mentioned,

> *"Even if I am in first serial, I have to wait longer because both the doctors and the hospital management prioritized the patients who could pay for their treatment.*"

Moreover, many were treated unfairly and with disrespect at hospitals. Without adequate support, most survivours now face extreme challenges in meeting the costs needed for their treatment and rehabilitation. Many cannot afford to go for follow-ups and pay for the costs of medicines and treatments.

3.3.3 Social constraints

More than individual physical impairments, the attitude and perceptions of society regarding the disabled were found to hinder the overall progress of survivours the most. Societal perceptions regarding disability were perhaps one of the greatest challenges negatively affecting the mental well-being of survivours. Among the women survivours, joblessness has put the fear of losing their family. Amena lived with the constant fear that her husband might soon not be interested in her anymore or will not pay for her expenses and kept mentioning, "*Kotodin ar amar jamai amare emon bosha boshaia khawabe?"* (How long will my husband take care of my expenses if I just sit at home unemployed?)

Neighbours and relatives regularly came to show their condolence to those affected and consciously or unconsciously, they kept reminding the survivours of their impairments. One respondent mentioned,

> "*When people see that I am one-handed, they give more attention that makes me uncomfortable. The way they look to me that always reminds me that I am not a complete human being*" (ID 6, 31 years old).

A neighbour insulted the mother of an amputee survivour by saying,

> *"Tora to papimanush tai toder uporei bipod asche (You are sinners; that's why something as bad as the accident happened to you)"* (ID-13, 19 years old).

Chapter 4. Discussion and conclusion

This qualitative study was done to provide a detailed profile of the survivours who were specifically supported by BRAC BLBC and to understand their situation after 1 year of disaster. Data were collected from the survivours, community people and BRAC Programme personnel through different tools and techniques such as IDIs, FGDs, community consultations and informal observations. This study enabled us to better understand the dimensions of challenges, experience of physical disability and psychological stress, everyday lives of the survivours of Rana Plaza disaster. BRAC had supported them during the initial phase of disaster. The study has revealed their experiences on this supports whether it creates any changes of their lives.

We have seen that almost all of the survivours at the *Rana Plaza* were the sole-income earners in their families, many had migrated to Dhaka in search of a better life, some left home their toddlers and families, many migrated to the city attracted by its many seemingly promising neon lights. A greater percentage of the victims of the *Rana Plaza* tragedy were from poor families and many were the sole income earners in their families. In a study on 786 families of the deceased workers, Action Aid found that these type of families have demanded long term compensation to meet their basic needs as they were struggling to meet those (Aaman *et al*. 2014).

The findings of the study clearly revealed that the survivours' physical condition is worrisome. They suffer from physical pain and extreme vulnerabilities and all of them are unfit for work. Since follow-up treatment and therapies are expensive, most had a tendency to avoid it. This hampered their overall physical progress. Our findings showed that the survivours are unable to go back to work due to physical injuries such as amputations, severe pain in the head, leg and body. A survey conducted by Action Aid supports the findings of this study. Of the total people surveyed, 92% reported that they have not been able to go back to work for the reasons stated earlier.

Their demise or physical and psychological injuries mean that their immediate families, especially people dependent on them now face extreme poverty and increased vulnerabilities. A study based on *Rana Plaza* survivours reported that almost 95% of them were facing difficulties in meeting their daily needs and were struggling with the same issues (paying for food, outstanding rent and personal loans) as they were in 2013(Aaman *et al.* 2014). It was evident from the findings of the study that the disaster brought significant impact on the livelihood of the survivours and their families- the families now face increased vulnerabilities due to loss of income and empowerment. A study conducted by Action Aid revealed that victims are facing extreme difficulties in paying for food, medical treatment and household essentials. Moreover, over 90% of those surveyed reported that they had no savings and had mounting debts (Action Aid 2014).

The feeling of worthlessness lead to a feeling of disempowerment in many survivours and caused mental anxiety and depression too. Loss of income worried survivours and uncertain about what the future had in store for them.

The *Rana Plaza* tragedy is seen by many analysts as a consequence of top-level corruption, greed, inefficiency, cost-cutting business approaches; of land snatching and using sub-standard materials for building constructions; of forcing workers to work despite life-threatening risks. This tragedy is also seen by many as the neglect of big

foreign retailers and little regard for human life and welfare. Study revealed that most of the survivours had not received any legal benefits from their former employees, including sick pay or compensation. A survey by Action Aid showed that of the total victims surveyed, 94% reported that they did not receive legal benefits or any form of assistance from their employees (Action Aid 2013). Corporations must therefore be held responsible, made to pay due compensations and survivours or families of those deceased adequately compensated. Moreover, dialogue and awareness must be held with active participation of multiple stakeholders to raise public consciousness and make efforts to resist and criticize exploitation of the working class.

In the post-disaster period, the focus of national and international media has most commonly been on domestic issues such as poverty, migration, climate change, and compliance. However, the implications of this tragedy go farther than that. It makes evident the processes by which the elite class manipulate their political connections to capitalise on the garments industry by exploiting the poor; “it reveals the evils of capitalism where the bid to minimise costs have led to complete disregard for human lives, perpetuating the “race to the bottom” (Murshid 2013). In both local and international media, emphasise was given on the lack of compliance issues as the root cause of these industrial tragedies. However, there was a lack of discussion on why big retailers associated with the Bangladeshi RMG sector create the conditions for “slave labour” in Bangladesh?

Disabled people are very often represented as “…without gender, as a sexual creatures, as freaks of nature, monstrous and the “other” to the social norm” (Meekosha 2004). It may thus be easily assumed that gender has little bearing for disabled people. Yet in reality the image of disability is intensified by gender; “for women a sense of intensified passivity and helplessness, for men a corrupted masculinity generated by enforced dependences (Meekosha 2004). These differential images have real consequences in terms of personal relationships, access to services, victimisation and abuse; “The gendered experience of disability reveals sustained patterns of difference between men and women” (Meekosha 2004).The capitalist discourse and how it has influenced the business trajectory, especially the ready-made garments industry in Bangladesh is one way of looking at the existing problems. It gives one a macro-level view of the situation. A micro-level view however, vividly outlines how a very socially stratified society of Bangladesh has differential impacts on men and women. The nature and causes of sufferings of males and female survivours affected by a tragedy has distinct variations. A new kind of discrimination is generated by the intersectionality of gender and disability.

Disabled women are at the intersection of these various forms of discrimination that manifests itself into many domains of public and private life, making women subject to double discrimination. Finding shows that the female disabled survivours are in fact worse off than their male counterparts BRAC should engage with the government and civil society members to draft a statement of principle recognising the existence of multiple and intersectional discrimination against women with disabilities and facilitate dissemination at a mass level. In addition, a prompt to readdress policies regarding treating the disabled as a uniform category must be made.

The realities of women victims are worse. Many have been abandoned by their husbands and in-laws because of their “deformities” and inability to work or be of any “use”; their own families are also too poor to support them (The Daily Star 2013). This shows that women, especially the unmarried girls in Bangladesh are dominated by a traditional social system and when it was coupled with disability their sufferings were

taken to a whole new level. It has been seen that In the case of Lipi, it was found that she perceived the loss of her limb as a major assault upon her dignity and self-worth. The loss of a full body and the aesthetic beauty of it traumatised her. She is yet to accept the prosthetic limb as a part of her own body. Besides, her disability has made her sensitive to circumstances; she mentioned that a nurse in the female ward showed negligence whenever she asked for any service or assistance. Her interpretation is that the nurse is uncooperative because there were no actions she could take because she is disabled---helpless!

Literature shows evidence that constant sympathy from collective groups of people, usually accompanied by extra attention leads to feeling of incompetence and discomfort. Moreover, survivour's parents and immediate families are always depressed and worried about their conditions and future. This is especially true for unmarried female survivours. Some of them said that they feel uncomfortable and guilty that their families have to go through so much because of them. Some unmarried girls reported that their families are treated rudely by the neighbours and acquaintances. The nature of such victimisation also has a gendered aspect; girls with disabilities were often quoted as unmarriageable and therefore, were seen as weak (!), vulnerable and not worthy of respect. It involves the loss of function, loss of sensation and the loss of bodily image. Experts identify many determinants of psychological response to amputation such as age, personality, economic and vocational variables, psychological support and other medical factors (Racy 1989). Related to the issue of adjusting to this new body image is the concern with social appearances and acceptance by others. Often even after the patient achieves considerable success in the functional restoration of the lost limbs, there is shyness about revealing the amputated body to others. Findings from this case and many other reconfirm that the survivours find it difficult to adjust to the reality that they had lost limbs to the accident.

Survivours and the families of those who died in the *Rana Plaza* collapse now face increased social and physical vulnerabilities in the form of economic hardship, discrimination, joblessness, lack of mental and physical wellbeing and so on. A good percentage of the respondents for this study were females. Their stories have made it evident that there is a very gendered aspect of disability; women with disabilities in a patriarchal society is subject to double discrimination in the private and public domain. This phenomenon also came out strongly from the findings from this study.

The assistance extended by BRAC to the survivours in the post disaster situation was an immediate response to a huge national crisis. This was an exceptionally challenging task given the extent of its severity and scale, the huge number of deaths and casualties. From our findings, we have found that the survivours assisted under different BRAC programmes are gradually progressing. The line of progression however, varied from case to case and in the severity of injuries. However, an overall picture showed that BRAC beneficiaries were benefitted by this intervention. Findings show that most of the beneficiaries expressed contentment from the services given. However, there was room for further improving the current recovery status of beneficiaries.

In a few cases, especially in the cases of patients given prosthetic limbs, it was found that some were unable to use the limbs due to a variety of problems including feelings of discomfort and heaviness, pain, feeling of restricted blood circulation etc. It should be noted that pain is common after amputation, as are phantom limb sensations (as first reported by Silas Weir Mitchell in 1871) (Badura *et al.* 2006) and "pain memories" (first observed in the somatosensory cortex in those with chronic back pain) (Katz and Melzack 1990). However, there is room for further improvement in ensuring that the

devices and limbs given are made proper use of; if not used currently, thorough investigation must be done to find out why and necessary steps taken. The use of well-fitting prosthetics reduces pain so this must be given due attention (Esquenazi and Meier 1996 as well as post-amputation depression (Cansever *et al.* 2003).Thus it require regular follow-up, further treatment and monitoring. In the post tragedy phase, amputations were done hurriedly and in most of the cases, burdened by resource constraints, amputations were not done properly. These patients therefore suffered from infections and pain and were not able to make fair use of the prosthetic limbs. Due to improper amputations many could not wear the prosthetic limbs since it caused severe discomfort. It must be mentioned here that BLBC was however, following up regularly with these patients and arranging for additional treatments, operations and providing counseling from time to time during the time of data collection.

Survivours with backbone fractures were comparatively worse off in terms of monetary and treatment related support. Most of them received inadequate compensations simply because they looked “better” than those with lost limbs. However, findings from the study revealed that most of these survivours were in fact physically unfit to do exhaustive work and suffered from bodily pain and restricted mobility. Perhaps increased follow-ups and assistance to this group in the form of supply of medicines and therapies of various types might be helpful.

BRAC has extended support in the form of skills training to some survivours. The nature and forms of training given to this group needs careful attention; travelling distances is a challenge for many. It was also found that some who are selected for skills training take the training even though they know they are in no position to do physical work like sewing or stitching for example. Selection of potential trainees must be done carefully. In cases where the survivour is incapable of working, training support can be given to an individual from the same family who bears the survivour’s expenses. Selection of beneficiaries for training and logistical support must be given more careful attention in the future. The training process must therefore add a component that will clearly explain the goals and objectives of the training to the recipients so that such confusions do not arise.

Conclusion

This study has tried to illustrate some of the many situations that arose as a result of the Rana Plaza building collapsed. The great degree of atrocities, pain and sufferings and such an overwhelming death toll, stimulated great national and international outcry about the disaster and called into question the compliance mechanisms in place in the RMG factories. Emotions and consciences were stirred. Civil society, students, community-based organisations (CBO), government, non-government organisations (NGO), commercial organisations and people from all walks of life came forward with social and economic support for the victims. All the stakeholders should come forward with the sense of togetherness to bring significant change in this industry so that such accidents do not occur. Like other organisations BRAC has attempted to take some interventions. Survivours although showed satisfaction and progress through brace and prosthetic support as they feel it. Further follow-up research is needed how skill development training is helpful to their greater sustainability. As financial and humanitarian aids are needs to handle differently efforts should be made to coordinate the aid. Systematic follow-up is required of these interventions and their effectiveness.

Chapter 5. Recommendations

Based upon the findings discussed above, following recommendations are made:

- Immediate and integrated assistance and support (in the form of education, health, livelihood support or training) is necessary for survivour's families and families of deceased
- Counseling programme for all survivours should be continued to help reduce the psychological trauma caused in the post-accident period. Having a setup for counseling centres that promise privacy, confidentiality and proper psychosocial counselling might be of added help
- Engagement in awareness-raising of general population for the mainstreaming of disabilities and gender issues is crucial. This can be done through mass media and under joint collaboration of Health, DECC and Gender, Justice and Diversity departments
- Government, non-government and private organisations need to be prompted to take responsibility of the children of the disabled workers and at least ensure their basic needs such as food security, education, and health.
- DECC can include few components in their training for survivours that looks at stability and development from a more holistic approach. For example, having people with disability come speak to the survivours, showing encouraging experiences, documentaries and films of successful people with disabilities might be a moral boost
- BRAC should initiate the drafting of a statement of principle recognising the existence of multiple and intersectional discrimination against women with disabilities and disseminate the information. In addition, the need to revisit policies addressing the disabled as a uniform category must be stimulated at a organisational and national level.

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