



# NEW CROSSROADS IN HUMAN RIGHTS ACTIVISM IN BANGLADESH

**Reflections by ASK**

July 2017-December 2018



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## ABBREVIATIONS AND GLOSSARY

BLAST\_\_\_\_\_Bangladesh Legal Aid and Services Trust. A human rights organization providing free legal service in Bangladesh

BSMMU\_\_\_\_\_Bangladesh Sheikh Mujib Medical University

CRAF\_\_\_\_\_Crime Research and Analysis Foundation

DMCH\_\_\_\_\_Dhaka Medical College Hospital

GD\_\_\_\_\_General Diary. A report, about an impending threat or existing complaint, registered at the police station.

ICT\_\_\_\_\_Information Communications Technology

ICU\_\_\_\_\_Intensive Care Unit

IPV\_\_\_\_\_Domestic violence by a current or former spouse or partner in an intimate relationship against the other spouse or partner.[1][2] IPV can take a number of forms, including physical, verbal, emotional, economic and psychological and sexual abuse

ISPAB\_\_\_\_\_Internet Service Providers Association of Bangladesh.

*Suo Motorule*\_Latin for “of one's own will” (cognizance). The term, as used in Bangladesh, refers to situations where the High Court initiates proceedings, without any party approaching it, against

infringements on the rights of an individual or group

TMCHTI\_\_\_\_\_The Maternal and Child Health Training Institute, located in Azimpur, Dhaka

UNICEF\_\_\_\_\_United Nations Children's Emergency Fund

Upazila\_\_\_\_\_An administrative unit below the district. It is the second lowest tier of regional administration and is immediately above the Union Parishad.

VAW\_\_\_\_\_Violence Against Women. Defined by the United Nations 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.”

HR\_\_\_\_\_Human Rights

PIL\_\_\_\_\_Public Interest Litigation

# Preface

A human rights organization is always under pressure for time. The nature of its work commits it to be always available to deal with unexpected events and unforeseen incidents, which compromise or threaten human rights. Whether it be an attack on a religious or an ethnic minority, or the collapse of a garment factory, or news of a woman forced to give birth on a city street, or a cry for help from migrant workers trapped in slave-like conditions overseas, ASK has to be ready to help with investigation, compiling evidence, registering complaints with the police, organizing legal representation for victims, arranging for medical help and, sometimes, shelter, food and counselling. Consequently, an organization like ASK finds it difficult to negotiate time to sit back and begin to stock of its activities aimed at uncovering hidden patterns and subtle coincidences that provide clues to unexpected ways in which it can improve its work.

At the start of 2018, ASK decided to do just that, i.e., set aside time for reflection. All Units were requested to closely examine their work in the 18-month period from July 2017 through December 2018. Units were to focus on unexpected occurrences or trends that had not caught their attention before. The emphasis was to be not so much on successes achieved but difficulties and challenges encountered in achieving present programme objectives. Another priority was to focus on how ASK can better fulfil its mission by moving its vision upwards towards more encompassing objectives or more challenging strategies.

To better demonstrate why and how suggested adjustments would be more effective in *engaging and benefitting victims* of abuse and violence, Units were asked to compile case studies of actions taken on all *active* cases during the selected time-frame. In addition, the emphasis of the case studies was to describe the experiences and reactions of individual victims, and what they tell us about how best to spark human rights activism in them.

The following publication selects three areas of human rights abuse are of interest to ASK and attempts to describe why and how efforts to counter them. The areas are: (a) domestic violence against women in advantaged middle- and upper-middle-class families, (b) internet threats and cyber harassment against children, and (c) medical negligence in Bangladesh.

**Sheepa Hafiza**

Executive Director

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## About ASK

ASK, a leading human rights (HR) organization in Bangladesh, uses a comprehensive strategy to protect and promote HR. Activities range from providing free legal aid, to advocating reform of existing laws, to investigating and monitoring HR violations by the State and large public institutions, to undertaking Public Interest Litigation (PIL). The organization was created with a strong focus on promoting the human rights of women, the poor and the disenfranchised—a combination that has, over time, naturally guided it into emerging areas of HR activism such as efforts to phase out child labour, counter trafficking, ensure the occupational safety rights of informal sector workers and workers in the garment industry, protect the human rights of migrant workers and the like.

The organization is acutely aware of the inherent contradictions and tensions that lie between democratic institutions, on the one hand; and social heterogeneity, on the other. Where large power gaps separate women from men, rich from poor, one religious or ethnic group from another, majority social group from minority group, it becomes difficult for democratic institutions to deliver on their promise of equality and justice to all. Narrow loyalties to self, family, or other reference group—whether defined by ethnicity, religion, race, language, and socio-economic class—hold sway, subverting legislation and law enforcement from their democratic obligation to advance the welfare of all to discriminately benefiting only a chosen few. Accordingly, in addition to its other functions, ASK is simultaneously engaged

in efforts to raise HR awareness and foster HR activism at multiple levels of the individual, the social group, and linked groups forming networks. The organization seeks to work closely with other HR organizations such as the National Human Right Commission.

ASK mission to create a society based on HR is carried out through national advocacy, and extensive educational initiatives and skills training programmes in HR advocacy and community organizing. The latter are made available through programmes organized at schools, colleges, and numerous forums in villages and towns in the districts.

As part of its efforts to bring Bangladesh into the mainstream of the international HR movement, ASK participates in a number of transnational forums, which are sponsored by the UN and regional HR organizations to discuss a country's progress with regard to promoting HR, and to develop strategies for countering emerging threats. It is through such participation that ASK can address the intractable problems of human trafficking and the abuse of migrant labour that have emerged as major challenges to HR over the last few decades.

The following report seeks to review ASK's experiences in the 18-month period starting from July 2017 through December 2018. The purpose here is not to be exhaustive but to touch upon striking impressions, surprising trends and unexpected ways that ASK has been able to counter them.

## A : IS VIOLENCE AGAINST WOMEN ONLY A POOR WOMAN'S ISSUE?



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Until now the struggle to stop violence against women (VAW) in Bangladesh has largely been framed in the context of advantaged, educated women, many employed in professional capacities exploring ways to “help” women living in poverty liberate themselves from male violence. Intrinsic to the context is the belief that any form of VAW is too crude – too alien --- for the refined sensibilities of educated, economically solvent households engaged in intellectually demanding and socially contributory professions. The category here includes besides university professors, cultural artistes, physicians, lawyers, engineers, architects, journalists, social reformers and senior civil servants --- in short, the occupations once associated with the “bhadrolok” in Bangladesh. The assumption seems to be that households of the latter are too cultured, too polished for such crudeness and cruelty.

So compelling has this myth been that little or no effort has been made to explore the possibilities, patterns and impacts of VAW in more advantaged households. Consequently, while admonishing their uneducated sisters striving in poverty to stand up for their rights, elite women themselves have done little to free themselves of VAW --- a large proportion of which coalesces with intimate partner violence (IPV). Nor have they done much to liberate their sisters in their own social circles.

Yet, as trends all over the world demonstrate, and at least two large surveys<sup>1</sup> conducted in Bangladesh show, while VAW tends to vary according to economic, cultural and social group, it is by no means absent among the affluent and educated. True VAW, including IPV tends to be more common among the poor and poorest households in Bangladesh. However, this does not mean that educated and more affluent households are free of such forms of aggression and cruelty. Rather, according to a joint survey undertaken by three universities from the United States, IPV occurs “*at high rates among even the most advantaged strata of Bangladesh society*”<sup>2</sup>, the respective rates being 81.99 per cent among the poorest, 77.56 per cent for the poor, 78.25 per cent for the middle, 72.64 per cent for the rich, and 63.99 per cent for the richest<sup>3</sup>.

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1. J.G. Silverman, J. Gupta, M.R. Decker, N. Kapur and A. Raj: “*Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women*”; June 2007. [www.blackwellpublishing.com/bjog](http://www.blackwellpublishing.com/bjog).

2. Silverman et.al. p.

3. What is particularly interesting is that the survey uses self-reports by men to establish IPV. The term itself covers physical violence and sexual violence. The former is defined as “pushing or shaking your wife or throwing something at her”, ‘slapping her or twisting her arm’, ‘punching her with your fist or something that could hurt her’, ‘kicking her or dragging her’, or ‘trying to strangle her or kill her by burning her’. Sexual IPV was defined as a positive response to ‘physically forcing her to have sexual intercourse even when she didn’t want to’ indicated sexual IPV perpetration



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Unfortunately, because the data do not separate women engaged in higher education teaching from those engaged in primary and secondary school teaching, it is not possible to give a full picture of trends. However, at its most conservative, i.e., excluding teachers, it can be confidently asserted that in the eight year period between 2010 and 2018, ASK's Legal Aid Unit registered *at least* 54 cases---an average of six such per year---professional women, i.e., women employed in jobs requiring a higher education and vested with authority to impart skills to others.

The case studies that follow in this section demonstrate that not only does VAW, particularly IPV, occur in middle and upper

On examining its record of new cases registered and old cases closed, between January 2017 and 30 June 2018, and comparing them with data from previous years, ASK suddenly became aware that there has been a small but steady trickle of middle-and upper-class women who have, all the while, turned for help to ASK's legal aid clinics. The stream comprises women from middle and upper middleclass families who, besides being highly educated (having post-graduate degrees) are also employed in professional jobs as physicians, university teachers, journalists, television news presenters, architects, singers and the like. While they are not poor and by no means fall within ASK's guidelines that limit it to helping those living in poverty, ASK has felt compelled to extend a hand to them because they are socially powerless to protect themselves. Hemmed in by unhelpful social myths that make it shameful to admit of VAW or IPV in their own home, middle- and upper-middle class women are even more constrained from seeking help than are their counterparts struggling in poverty.

middleclass families, but there are remarkable similarities in the patterns of such violence generally associated with poor, to very poor, families.

- As in the case of the very poor, the leading reasons for IPV in wealthy households are conflicts over a husband's infidelity, his desire to take on multiple wives, and his demands for more dowries.
- Again, regardless of socio-economic status, women react to IPV in very similar ways: Paralysis or slowness to act because of shock, disbelief, shame, psychological dependency, assumed or realistic fear of a man's social power.

## PROFESSIONAL WOMEN REGISTERED AT ASK'S LEGAL AID UNIT 2010-2018

Year	Occupation of Women Clients										Total	
	Doctor	Lawyer	Writer	Architect	Artist	Engineer	Journalist	Singer	Film Director	Teacher	With Teachers	Without Teachers
2010	4									18	22	4
2011	3							1		23	27	4
2012	2				2		2			30	36	6
2013	6						1	1		15	23	8
2014	3			2		1				19	25	6
2015	2		1						1	23	27	4
2016	5							1		19	25	6
2017	7						2	1		16	26	10
2018	3	1					1	1		27	33	6
<b>TOTAL</b>	<b>35</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>6</b>	<b>5</b>	<b>1</b>	<b>190</b>	<b>244</b>	<b>54</b>

- Rich or poor, the pressures a man can bring to bear against a woman are almost identical. Using a man's greater social authority to discredit a woman's version of events; casting doubt on a woman's testimony by casting her as over-emotional or hyper-sensitive; and withholding money for child support and household expenses.
- However, there is one form of pressure that is more feasible for rich, educated men: This is using frivolous lawsuits against a woman to harass, delay and increase the costs of the legal resolution she seeks.

## Case Study A.1.

On 18 July 2017, a woman arrived at ASK for legal aid. Typical of many other women who are targets of dowry violence, she had come for help after silently suffering years of verbal abuse and physical violence at the hands of their husband.

The woman bore the marks of a violent attack she had suffered two nights ago. She wore a bandage around her head, her left hand was in a plaster cast and she could barely walk and winced from aches that seemed to seize her body in waves. Two days earlier, she reported, her husband had returned home late at night, still furious at her because she had earlier refused his latest demand for dowry. Armed with a metal bar and swearing to cripple her for her refusal, he brought the heavy rod down on her head and the fingers of the hand she had raised to shield her skull, struck one of her shoulders and drew blood from her knees, trying to shatter her knee caps. As if this were not enough, he proceeded to choke her, covering her mouth with a hand to stifle her desperate screams for help. It was only the arrival of neighbours, jarred out of sleep by the noise that had saved her life.

Neither the brutality of the aggression the woman had endured, nor the 11 long years she had silently borne the torment of “dowry violence”, was out of place. What was untypical was that, contrary to popular stereotypes, the woman was neither poor, nor did she live in a slum, nor was she uneducated. Far from it, she lived in an upscale area of Dhaka, was highly educated and, worked as a physician at a leading teaching hospital in Dhaka. Adding to her social aura was that her husband was also a medical doctor. Only, he worked at a different hospital.



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ASK's mandates limit the organization to providing free legal service to the poor and the powerless. Dr. Firdausi Huq by no means met the first criterion but, she was powerless in the face of social attitudes that make it shameful for women from well-to-do families to expose violence in the family. With all its experiences and despite the skills of its legal staff since 1985, providing support to Dr. Firdausi would turn out not to be easy for ASK.... not despite, but because of her status and her social milieu. For one thing, Dr. Firdausi would turn out to be much more prone to doubt than a woman living in want. Also, once she had decided to stand up and fight for herself it was more difficult for her to stay the course. She worried more about the welfare and reputation of her family and struggled with greater fears about her husband's power to hurt her parents to wreak vengeance.

### Marriage and Marital Life

Dr. Firdausi Huq and her husband met each other while in medical college and were married in 2006. In token of how much they valued their daughter and her professional achievements, her parents were sure that she had all the advantages a new couple could desire. Besides 10 bhoores

(116.64 grams) of gold ornaments; they gave her a flat in Bashundhara, an up-and-coming residential area in Dhaka; and an enviable array of electric appliances and electronic devices. The list included air conditioners, a LED TV set, a refrigerator, a “deep” freezer, a washing machine and two computers --a laptop and a desktop.

However, early signs of warning soon set in. Electronic appliances were not enough. The flat lacked furniture. Pressured, Dr. Firdausi Huq's mother borrowed Taka 250,000 (2.5 lakhs) from a relative to buy a bed, a dressing table, a wardrobe, a sofa set, and a dining table set.

In time, the couple settled into their careers and gave birth to a son and a daughter, but neither changes in income nor the experience of parenthood had any effect in persuading the husband to assume greater financial responsibility for his own needs. Instead, he continued his demands for more.

Once, the demand was for a large sum of cash --Taka 1,000,000 (10 lakhs). Another time, it was for 15 bhorees (174.96 grams) of gold ornaments. It was never clear for who or what the ornaments were intended because his wife never got to wear them.

In 2017, when the husband asked for yet another lump sum of money (also 10 lakhs), his wife finally balked and refused to turn to her parents for the cash. As already seen, this refusal was to nearly cost her life.

#### Obstacles to Standing Up

One would think that after once finding the courage to break free, an educated woman like Dr. Firdausi would never go back to her former situation. But the realities of social power and gender relations in educated middle-class families are just

as inhibiting--if not more complicated than-- as is the case with poor families. As a result, despite help and assurances from ASK, Dr. Firdausi found it difficult to stay the course. As her fears mounted her resistance caved in, and she eventually gave up the fight for justice, i.e., the right to world that is free of violence in favour of something far less: mere escape for herself and her near ones from an immediate threat.

#### Gender and Social Power

Like many poor women, Dr. Firdausi found herself at a disadvantage from the very start. Whether because of the force of her husband's personality or his claims to being politically well-connected, she felt that she could never muster the same credibility or the same social sway her husband commanded with such ease.

- For example, on the night of the attack, when the neighbours converged on her apartment, instead of questioning what the husband had been doing all this time to protect his battered and bleeding wife, they fell into line as he deftly assumed leadership and smoothly took over decision-making regarding how and to what hospital to move the victim for treatment. Instead of helping him, neighbours fell into place as he helped them cope with what was a horrendous situation.
- Again, filing a criminal case entails obtaining a medical certificate from a government hospital, verifying that a victim's wounds are not self-inflicted. The natural choice for Dr. Firdausi was the government hospital where she worked. Strangely enough, when it came to Dr. Firdausi's turn, her colleagues, the majority men, closed ranks and refused to issue a certificate for her. ASK had to spend a whole day to break the impasse. The certificate was

finally obtained after lawyers from ASK had visited the Director of the hospital and apprised him of the serious legal consequences of withholding the certificate.

- Despite being well-known among medical circles in Dhaka, it took the police a full 10 days to locate and arrest the husband. Also, when the arrest finally took place on 29 July 2017, it seemed to do little to humble the man. Instead it seemed to goad him on to a new level of mockery and defiance, encouraging him to fight tooth and nail against every attempt at legal assertion against him by his wife.
  - ✓ The very day after his arrest, the husband filed for bail and when this was refused,
  - ✓ He reacted by using friends and relatives to launch a campaign of threat and intimidation against his wife and her family that was so unnerving that, with help from ASK, she was forced a GD (complaint) at the police station the very day following (1 August) his arrest.
  - ✓ Undaunted by the refusal of his first petition for bail, the husband submitted a second petition on 6 August 2017, but this too was refused.
  - ✓ He filed for bail a third time on August 21 and finally succeeded in leaving the prison seven days later bond.
- Following his release, the husband's threats against Dr. Firdausi Huq intensified, and were so effective in frightening her that, without consulting ASK, she dropped her suit for criminal assault against the husband altogether.
- Instead, she settled for a divorce through mediation and a cash settlement of only 13 lakhs (Taka 1,300,000).

## Case Study A.2.

On April 4th, 2017, a young woman named Veena visited ASK's legal clinic wanting help. She was married some five years ago and had spent most of those years suffering mental and physical abuse and violence at the hands of her husband. Both she and her husband were educated. Both worked as newscasters but were employed at competing TV channels. Her husband had more experience than her, she explained, because she had started working only after the birth of their 19-month-old son, Dayan.

When she got married, her dower was fixed at a full 10 lakhs (Taka 1,000,000) – a strong indication that her husband and in-laws considered themselves lucky to have acquired Veena as a new member for their family. Not long after, though, Veena's married life began to sour.

Much to her distress, she began to realize that her husband was a chronic womanizer – constantly falling in and out of love with one woman after another. When Veena protested he would grow very angry and take to sneering at and beating her by turns. He often dismissed her grief as feigned and would try to goad her into committing suicide. If she was that upset by his behavior, was his retort, why not take her own life?

Occasionally, when the abuse and violence became too much for Veena to bear, she would leave for her parents' house but these attempts at independence and claiming self-worth were usually short-lived. The husband would soon turn up at her parents' home, crying and wailing, and begging for forgiveness.



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Never again, he would promise, would he again be unfaithful to her. Never again, would he raise his voice or hand against his wife. Inevitably, Veena would melt and yield to his plea to return home with him.... Only to find herself back in the same cycle of abuse and violence followed by contrition and forgiveness; and only to discover that the mistreatment and aggression got crueler with each re-entry. Even pregnancy was no protection. The threats and beatings continued.

Try as she would, Veena could not break free. A few months after her son was born, she found her job as TV newscaster, but this only led her husband to tighten the financial screws. He stopped paying for the baby's food and other expenses.

For all her education and sophistication as a player in the world of modern media, Veena continued to be a classic case of the "battered woman's syndrome" --- a psychological state

of helplessness where a woman is unable to trust her own judgments and, instead of blaming her attacker, somehow blames herself for causing his anger.

.....Until one day, the husband went too far.

This was a day in February 2017, when Veena did not feel well and accepted some sort of medicine from her husband that he claimed would make her better. Instead, she developed such a severe reaction that she had to be rushed to the emergency room.

When she regained consciousness, Veena found that her husband had somehow used the incident to convince the hospital staff that she was over-dramatic and prone to hysteria. She suddenly began to realize that her husband had, all along, played at making her appear irrational, emotional, and prone to exaggeration. She saw this most recent incident involving the medication, as one of his strongest ploys to date to discredit her sanity.

Even so, it took her almost two whole months to come to herself and go to ASK for help. However, like Dr. Firdausi, Veena was adamant. She would NOT consider bringing charges of criminal assault against her husband through the courts. Rather than seek to bring her husband to justice for all the years he had abused and battered her, she chose to content herself with letting him simply walk away. All she wanted was a quiet divorce secured through mediation in the relative seclusion of ASK's offices. Respecting her wishes, and confirming her right to decide for herself, ASK arranged for just such a salish.

### Case Study A.3.

On 26 October 2017, Trisha Khondokar (age 30) was not sure whether to let out a sigh of relief. This was the day that her long legal battle for child had finally ended. The court had awarded her custody of her only child, a six-year-old daughter! The problem was that she had lived in fear and doubt for so long that she did not know how to relax or accept the news.

The fight had not been easy. Her marriage had not been all that happy. Her husband was self-centered and domineering. Somewhere along the way, he had surprised her by demanding dowry. She refused and paid for it by being verbally and physically abused. In time, the husband added yet another demand to his pressures on Trisha. He wanted his wife to consent to his acquiring a second wife. Her resistance intensified as did the beatings and torture.



[iconfinder.com](http://iconfinder.com) [iconfinder.com](http://iconfinder.com)

For all her resistance, though, Trisha never marshaled the courage to confront or expose her husband in public. Although she herself was accomplished and taught at a well-respected local college, she always felt outstripped by the husband.

After all, he was doctor. Besides, he was well-known in the community and belonged to several important social circles in town that she despaired of being able to join. Besides, where was the time? After returning home from work, she could barely keep pace with looking after her daughter, managing the household, and preparing for the next round of college teaching.

Eventually, Trisha's obstinacy resulted in the doctor announcing that he was filing for divorce. She did nothing to either oppose the divorce or challenge the grounds on which her husband based his request for the annulment. Instead, she quietly accepted the divorce decree, which was issued by the court on 20 May 2014, and moved back to live with her parents in their home.

As easy as she made it for her husband to divorce her, it was not enough to please him. He still seethed and fumed from her obstinacy, her unwillingness to bend to his will while she was married to him. He still craved dominance and prepared for one legal assault after another against Trisha.

- On 15 June 2015, a whole year and half a month after the divorce, the husband filed a criminal case against Trisha and her parents accusing them of stealing property from his home when she moved out of the marital home. Panicked, Trisha did nothing for two months before she picked up enough will to seek help from ASK. Lawyers tried to calm her fears by telling her

that the complaint was designed only to harass but it was only when the court dismissed it as frivolous that Trisha could allow herself to relax and begin to trust her lawyer.

- Stung by his defeat in court, the husband soon struck back by filing another case--this time demanding custody of the couple's daughter. This was even more frightening for Trisha but, at an interim hearing, the court again decided in favour of Trisha. It ordered that the child was to remain in the custody of the mother, limiting the father to two monthly visitations to see his daughter at her school.
- Enraged, the husband retaliated by appealing against the interim order. However, this appeal too was dismissed by the court, thereby further consolidating the slow changes that had begun to place in Trisha's understanding of the legitimacy of her needs and vision.
- On 26 October 2017, when the court finally held a hearing on the husband's original case demanding custody, it re-affirmed the existing arrangement: full custody of the daughter to the mother and visitation rights only to the father. The lawyers at ASK congratulated Trisha but knew and accepted it would take time before Trisha could relax enough to trust the world to listen to her pleas for justice.

## LESSONS LEARNED

Although ASK has an absolute obligation to defer to the preferences of those seeking help, it lives in the hope that educated and professional women, who enjoy so many advantages, will one day be willing to openly stand up for themselves when they fall victim to VAW or IPV.

**SOMETIMES, THE ADVICE  
YOU GIVE OTHER  
PEOPLE IS THE ADVICE YOU  
NEED TO FOLLOW.**

*highereye.com*

- A. Only as such women break the silence---- only as WE overcome the sense of false shame of admitting to being the target of violence from members of our own family, do WE acquire the chance to fulfil OUR social vision of ending VAW and IPV in Bangladesh.
- B. To conceal and accept violence against one's self is to lower the bar, dilute social standards of what is acceptable behaviour towards women, and eventually compromise the rights of all women to live in dignity and free of the fear of violence. In other words, when advantaged women choose to remain silent about VAW and IPV in their families, they create the conditions for the weakening of the human rights of all women, including the women who live in poverty.

## B : SUPPORTING CHILDREN TO OVERCOME INTERNET HARASSMENT AND INTERNET EXPLOITATION



Photo credit: krazytech.com

Violence against children is a major human rights challenge in Bangladesh where attention tends to fixate on the more spectacular forms of aggression, which we tend to associate with “others”. Statistics on violence against children are inclined to concentrate more on incidents of murder, public battering, abduction, trafficking and rape ---crimes that are so heinous that they we conveniently ascribe them to “others”, i.e., people who are not members of the family<sup>4</sup>. By contrast, there is little acknowledgement of the more mundane and everyday

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4. In reporting child marriage, the focus is more on the actions of the public and law enforcement in preventing their occurrence than on the personal motivations of the girl's family trying to free themselves of a burden.

forms of child abuse that take place in the privacy of the home and in intermediate social spaces in the local community, such as the school. As a result, left unanswered are questions such as:

What proportion of rape can we attribute to incest?

What proportion of trafficking can we attribute to the unspoken collusion between professional recruiters for the sex industry and an own uncle or aunt resentful of having to feed and support an orphaned niece<sup>5</sup>?

### Violence in the Home

Yet, child-rearing precepts traditional to Bangladesh should be cause for worry. Based on adages such as “children should be seen and not heard”, and aphorisms like “spare the rod and spoil the child”, the notions of effective child guidance practices common to the home and small community are problematic. Their effect is to project children as basically intractable, fundamentally lacking in civility and, therefore, untrustworthy. The consequence of these precepts is inimical to children. It creates a *silent culture of violence* that sanctifies the use of physical force against children and consecrates child labour in the name of “discipline”. Another negative aspect of this child management culture is that it concentrates all moral authority in the hands of adults, thereby making it difficult for children to protest, or protect themselves from, abuse by elders in the family and the community.

### Bullying and Violence in Schools and Intermediate Spaces

Also worrisome is the potentials of violence against children in the community where the school constitutes an important site. Despite new laws preventing corporeal punishment, teachers

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5. Even child marriage, which is more directly attributable to parental indifference to a girl's rights to education and autonomy, tends to be cast in a vague context where responsibility for preventing such events falls, not on the family, but on vague “others --- school teachers, law enforcement, local administration.



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and school administrators are reported to continue in their use of physical punishment and humiliation to control children. Also, lessons in aggression modelled by adults are not lost on children. Consequently, bullying and fighting is common to school children. In 2014, according to a report by UNICEF<sup>6</sup>:

- 35 percent of students in Bangladesh, between 13 and 15 years of age, reported being bullied one or more days in 30 days.
- An equal proportion of such students report that they had been involved in physical fights “at least once in 12 months”.

Bullying and fighting are not the only hazard confronting secondary school children. The report continues: “Every day, students face multiple dangers, including... pressure to join

gangs ...violent discipline, sexual harassment and armed violence”.

These dangers have heart-breaking consequences for the buoyancy of Bangladesh's future citizens: “In the short-term this impacts their learning, and in the long-term it can lead to depression, anxiety and even suicide. Violence is an unforgettable lesson that no child needs to learn.”

### **Internet Harassment and Internet Exploitation**

With the rapid growth of the internet in Bangladesh, there has been the inevitable growth of cyber abuse and harassment of children. With it has come a growing realization that violence against children today cannot be fully addressed without attention to the cultural sources of negation and aggression in the home and small community.

### **Patterns of Child Internet Abuse and Cyber Harassment & Exploitation**

Internet use (mainly via the mobile phone) rose from 0.1 million users in 2000 to 80 million in 2017<sup>7</sup> but, because of the shame, humiliation and fear associated with internet violence, victims and their families are reluctant to divulge their experiences in public. Consequently, figures on the prevalence of such internet abuse are unavailable. However, impressionistic evidence suggests that is already a serious issue for adolescents in Bangladesh.

- In 2018, according to a tally of 9 daily newspapers undertaken by ASK, the media reported a total of 41 individuals experiencing online bullying and harassment. Of these, over half (21) were children; eight between the ages of 11 to 14 years of age; and 13, 15 to 18 years old.

6 <https://bdnews24.com/education/2018/19/06/35-of-school-students-experience-bullying-in-bangladesh-unicef>.

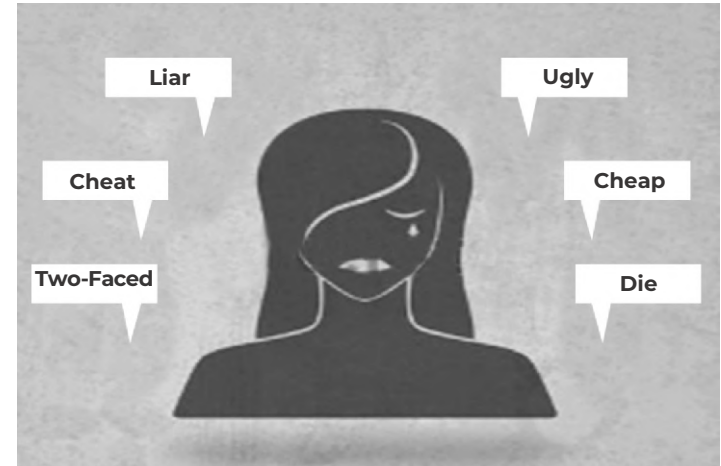
7 Daily Star, *Internet Use in Asia: Bangladesh in Top 5*, October 8, 2018.

- According to UNICEF, nearly one third (32 per cent) of children in Bangladesh, between the ages of 10 to 17, were “vulnerable to online violence, cyber bullying and digital harassment and exploitation” in 2018.<sup>8</sup>



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A second aspect of cyber persecution directed against children is that it is mainly targeted against girls. As with other forms of social maltreatment, internet harassment is fed by deep social divisions between groups--the scorn and contempt one social group feel and hurl against another. One of the most significant rifts, in this respect, is the gender gap that separates men from



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women, boys from girls. This gap reinforces a long-held prejudice that, while condoning dominance and aggression in men, prescribes submissiveness in women. Another feature of this gap is that while it tolerates considerable latitude in the behaviour of boys and men towards the opposite sex, it holds girls and women to much more stringent standards of “purity” and social “propriety” than men. The result of gendered social arrangements in Bangladesh is to leave girls and women both more exposed to being pursued and wooed (i.e., eventually susceptible to eve teasing and stalking); while, at the same time, more vulnerable to being blamed for not being “modest” enough, or sufficiently careful to avoid arousing unwanted male attention.

<sup>8</sup> <https://bdnews24.com/education/2018/19/06/35-of-school-students-experience-bullying-in-bangladesh-unicef>.

It is therefore not surprising that<sup>9</sup>:

- ✓ Out of the 1417 complaints, which the Criminal Investigation Department (CID) of the police received between 2012 and 2017, the “majority” were reported to be from women<sup>10</sup>.
- ✓ The government's ICT's Cyber Help Desk reports receiving at least 1487 complaints from 2013 to mid-2017. Of these, 70 per cent were from women<sup>11</sup>.
- ✓ A research study, conducted by BLAST, estimates that as much as 73 per cent of the victims of cyber violence in Bangladesh are women.

ASK's Child Rights Unit dedicated much of the first six months of 2018 to revising and updating a guideline on Safe Internet Use for Children, in Bangla, on how to protect children from misuses of internet.

Originally published in 2016, the manual recognizes the predicament that many an adult face today of not knowing enough about the new information technology to protect children from the dangers cyber space poses to them. As such, the publication adopts an accessible style to guide the reader through the many ways in which email, various social platforms and apps for on-line chatting and exchange can and are being used to entrap children into compromising situations that allow predators to subsequently embarrass, bully, threaten, blackmail or otherwise endanger them.

9 Zaman, S., Gansheimer, L., Rolim, S.B., and S.B. Mridha, cited by Farida Akhtar, *ibid*.

10 Dhaka Tribune, 21 September 2017, *Women: Biggest Victims of Cyber Crimes*. [www.dhakatribune.com](http://www.dhakatribune.com).

11 Farida Akhtar: *Cyber Violence Against Women: The Case of Bangladesh*.



[gettyimages.com/vectors/](http://gettyimages.com/vectors/)

The guide strongly urges:

- Positive parent-child relationships, and points to the importance of parental and adult involvement and engagement in children's extra-curricular interests and social life to be able to effectively guide them in their interactions with the internet.
- A strong gender focus to enable victims –mainly girls--to speak up and seek help from guardians when they encounter cyber threats.

### Objective of the Manual

The manual is aimed at one broad objective: To raise awareness about the real-life dangers to which the internet exposes children. As simple as it sounds, achieving this

objective is not easy. Raising awareness involves providing real-life examples of cyber harassment and child exploitation. However, because of existing taboos against discussing the sexual exploitation of children, there is a dearth of examples on which the manual can draw. Consequently, the guide is forced to rely heavily on examples that involve adult victims of the internet. In the end, though, the limitation proves to have its uses. For one, the forced reliance on examples of adult harassment makes it easier for parents and guardians to empathize with the gullibility and susceptibility of child victims. It also creates greater appreciation for the fears and hesitations that prevent children from seeking help from adults when they encounter internet harassment.

Case Study B: 1, which concentrates on a rare example of a child victim, is important for two reasons. It introduces a topic that is rarely discussed in Bangladesh: paedophilia. An added strength of this case study is that it also vividly demonstrates why greater parental involvement in the lives of their children is necessary in the age of cyber communication.

## Case Study B:1

Nahar, 12 years old, is a student of Class VI. She is the only child of parents who are quiet and withdrawn. The parents don't socialize much with other families nor do they take much interest in their daughter's activities. Nahar herself had few friends and is often lonely.

Desperate for companionship, Nahar begins to turn to the internet for fun. She eventually discovers an internet chat room where she can meet and talk to people. Posing as an 18-year-old, Nahar befriends a young man with whom she is able to share many interests. Among them is her love for band music.

One day, her new friend invites her to a music concert. A nationally popular band was coming to town to play at a local venue. Nahar is very excited. She had never seen a band of national repute; leave alone heard them performing live! A concert is something her parents would never think of attending, let alone waste money to attend.

Yet, Nahar reflects, here was her chat-room friend, a stranger, who had already bought two tickets, so she could join him at the concert!

On the evening of the concert, Nahar lies to her parents about where she was going and steals off on her own. After arriving at the concert, she grows more and more confused. Looking around her carefully, she cannot see anyone resembling the young man she had imagined she would meet. So, she calls him on her mobile phone.

Only to find an elderly man approaching her. He introduces himself as the friend she has been chatting with all this time.

Although guilty herself of lying about her age, 12-year-old Nahar is shaken. To think that a man so much older than her could find it interesting to spend time with someone her age. To think that a man of his stature had the time to spend in an internet chat room!

Luckily for her, rather than paralyze, the shock works to send her rushing back to the safety of her home.



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A second case study (Case Study B.2) demonstrates how a mistake made on the internet by a teenage girl (of 16) can follow her into adulthood and continue to plague and ruin her life as a young woman. This case study is also interesting because it reflects a dominant pattern in cyber harassment: boyfriends, ex-boyfriends and aspiring using the internet as a weapon to extract vengeance for being challenged, defied or spurned, respectively.

## Case Study B.2.

Rafaya, now 19 years of age, lives in Chittagong. Three years ago, when she was in Class 10, she met a young man on Facebook. He had a job in Dubai.

After exchanging written messages on Facebook, they began to video-chat, using an app called Emo.

Warm and trusting, Rafaya liked to please her friend. She would dress and pose for him on video-chat according to his whims. Also, when he asked her for the passwords to her Facebook account, she did not even question his motives. Not even for a single moment.

In 2015, when the man came to Bangladesh on a home visit, Rafaya was able to meet him in person for the first time. Initially very excited, her mood soon turned to disappointment. She found him brusque and his attitude towards her quite negative.

Worse, he shocked her by revealing that he had taped their video-chats and now planned to use the tapes for blackmail. He eventually returned to Dubai but continued to threaten her from there, warning her of dire consequences if she did not come up with the money.

When he visited from Dubai again at the end of 2016, the man was even more insistent about being paid. Scared, not knowing what to do, Rafaya secretly sold off a gold necklace that her parents had been saving for her wedding and handed over the money to her former boyfriend.

.... Only to find that this had made him even greedier.

The man now demanded that she hand over an even heftier sum of cash by mid-January of 2017 or face the prospect of

having photographs and videos of her released on three internet sites. Three days after the deadline had passed, Rafaya learned from friends that the young man carried through with the threat: the personal images that were meant only for her and her former boyfriend to see were now splashed over the internet for the world to view.

Distraught, overcome with humiliation, Rafaya lost all will to live, and made two attempts on her life. Somehow an older sister came to guess her situation and offered help.



Instead of berating her, the sister filed a complaint with the police and, with the help of the Crime Research and Analysis Foundation (CRAF), a specialized voluntary NGO for countering internet crime, succeeded in having the offensive tapes removed from one of the sites.

However, even CRAF was able to delete the videos from the 1 site but remaining two sites and coped with the situation by persuading the government to shut out their servers from viewers in Bangladesh.

### **Current Uses of the Manual**

Ask is currently using the manual to train educators, and raise awareness among students, parents, teachers, members of school management committees and community leaders in four districts. A total of 28 secondary schools in districts of Cox Bazar, Dhaka, Rajshahi and Satkhira have begun to use the manual as a basis for training teachers who, in turn, have begun to use it to start discussions and awareness-raising programmes with students, parents and community leaders. On April 2019, 62 secondary schools in Satkhira sadar upazila incorporated the safe internet handbook in their regular ICT and other classes through a directive from the District Education Officer where 26,235 students (12,025 boys and 14,210 girls) were sensitized on the specific issue.

Feedback from schools indicates that the publication is proving useful. Teachers are reported to have become alert to signs of internet addiction and internet abuse among students. When a teacher notices that a student seems inordinately distracted, withdrawn or has lost interest in her studies and academic performance, it serves as a cue for beginning discussions with the student, opening up the topic of internet harassment and the need for counselling. What is especially encouraging is that teachers have begun to rally help from parents and community leaders in efforts to deal with the problem.

### **Symptoms and Forms of Cyber Sexual Abuse & Exploitation**

Experience from the outreach to schools shows that the *main hazards* associated with internet use at secondary school level are:

- Obsessive use of mobile phones for calls and other applications, leaving little time for study.
- Addiction to sites offering pornography and
- Threats and harassment from boys when girls refuse to bend to their will. Predators include boyfriends frustrated when a relationship begins to sour, and ex-boyfriends angry at the termination of a relationship. Aspiring boyfriends, frustrated over not being able to gain a girl's attention, forms a third category.

The usual *form* that internet harassment and exploitation assumes among secondary school children is the threat to *ruin a girl's reputation*. Fodder for the blackmail is lies and gossip about the victim, compromising personal letters and posts, photos and videos linked to a girl that happen to be in the possession of the aggressor from past interactions with the victim. Alternatively, it is not necessary to be in possession of authentic images. Thanks to new technology, it is now possible to digitally manipulate photographs, and to merge an authentic image of the head a girl with an image of a highly sexualized body to suggest that the victim is not "pure".

### LESSONS LEARNED

- A. Although ASK's programme in schools has now become popular, initially progress was slow. A principal obstacle to tackling internet harassment is that it involves realistically dealing with the complex physical and socio-psychological changes --- the blossoming of poetry and interest in the opposite sex that occur at puberty. However, this is made awkward by the persistence of outdated social perspectives in Bangladesh that require "innocence" and "purity" in

today's teenagers, especially girls. If the fight to protect children against cyber harassment is to succeed, careful thought needs to be given to re-orienting existing viewpoints. One place to start may be focus attention on historical changes in the structure of the family and make people aware of basic contradiction between demanding "purity" of today's 14-to 17-year-olds when, in the days of their fore-mothers', not so very long ago, a girl of 14 or 16 years was expected to be already married and the mother of one or two children.

- B. Another urgent need is to reckon with is a generalized culture of violence against children, which tends be rationalized in the name of "discipline".
- One drawback of this discipline-centred child guidance philosophy is that it generates social distance between adults and children and creates a veil of formality that distances parent from child, guardian from ward. If we hope to protect children from the risks and dangers of the internet, however, it is necessary for parents and guardians to develop closer, friendlier and more collegial relations with children. Only then can adults expect to accompany and monitor their wards' exploration of cyberspace, but this entails changing attitudes towards children, i.e., learning to trust the young, having greater faith in their testimony, and becoming more interested and involved in their interests and hobbies.
  - Another pernicious aspect of existing child management patterns is that, by vesting all moral authority in the hands of adults, it makes it difficult for children to voice their concerns or ask for help when they face internet sexual harassment and exploitation from grownups.

- Yet, a paedophile using the internet to prey on unsuspecting children is a common phenomenon elsewhere and is a genuine threat in Bangladesh also. If anything, the recent surge of reports in the newspapers about incest and the sexual exploitation of children by adults is a sober reminder that, contrary to the moral lustre with which we vest adults, the potentials of paedophiles are high and pose a real danger to children in Bangladesh.



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## C : MEDICAL NEGLIGENCE IN BANGLADESH



<https://www.carbray.es/claiming-medical-negligence/>

Medical negligence is a problem that is universal to the world. Be it India reporting on an orthopedics doctor plastering the wrong hand:

### **Medical negligence in Bihar: Left hand fractured, plaster cast on right**

A case of medical negligence from Darbhanga Medical College Hospital has come into light after an orthopaedic doctor plastered the wrong hand of the boy who fell from a mango tree.

**Times of India:** 26 JUN 2019

Or Ireland, contemplating 1,000 deaths a year due to medical errors:



Medical errors causing 1,000 deaths a year conference told [irishtimes.com](http://irishtimes.com)

Or the United States mulling over the reality that almost half million people die in that country annually because of medical errors

**The third-leading cause of death in US most doctors don't want you to know about**

Ray Sipherd, special to CNBC.com<sup>12</sup>

- A recent Johns Hopkins study claims more than 250,000 people in the U.S. die every year from medical errors. Other reports claim the numbers to be as high as 440,000.
- Medical errors are the third-leading cause of death after heart disease and cancer.
- Advocates are fighting back, pushing for greater legislation for patient safety.

The concern is the same: how to respond effectively to the contradictions between the promises of modern medicine, and the increased risks associated with human error and outright negligence on the part of its practitioners. This contradiction, today, accounts for a growing body of laws and law firms, which attempt to provide better protection to consumers of healthcare in cities ranging from Australia:



Medical Negligence Lawyers Adelaide | Medical Negligence Claims and lawyers.com.au

12 <https://www.cnbc.com/2018/02/22/medical-errors-third-leading-cause-of-death-in-america.html>

Two towns and cities in the United Kingdom:

**Medical Malpractice Solicitors and Law Firms in England**

Accrington	Hale	Manchester	Shrewsbury
Basingstoke	Hull	Milton Keynes	Solent
Birmingham	Kent	Morpeth	Solihull
Blackburn	Leamington Spa	Northampton	Southampton
Brighton	Leeds	Norwich	Southport
Burnley	Leicester	Nottingham	St Helens
Cambridge	Leicestershire	Oxford	Stockport
Coventry	Liverpool	Portsmouth	Stoke on Trent
Gloucester	London	Preston	Taunton
Guildford	Ludlow	Reading	West Radcliffe

<https://www.hg.org/law-firms/medical-malpractice/england.html>

The issue in Bangladesh, however, is that it reaches the dimensions of a major threat to national health. Here the divide separating healthcare seekers from healthcare providers, frequently seems to reach epic proportions with patients complaining about unimaginable slip-ups and mishaps; and doctors protesting unfounded criticism (see Case Study 3.1.). The impasse often produces violence against health professionals and a phenomenon that is rarely seen elsewhere in the world: Doctors going on strike and shutting down whole hospitals. In 1999, in response to a Writ Petition (No. 1783 of 1999) protesting a strike by doctors, the country's High Court was led to declare such work stoppages a:

*failure (on the part of striking doctors) to perform their statutory and Constitutional duties to ensure health services and medical care to the general public*<sup>13</sup>.

The three case studies presented in this section are by no means offered as a comprehensive effort to understand the crisis. Rather, they are provided here as an attempt to shed some light on the depths of the confusion, grief and despair common to patients; and on some major lacks in the culture and organization of the healthcare system, which constrain doctors and associated personnel from delivering quality healthcare. As the case studies demonstrate:

- The nature and effects of medical negligence experienced in Bangladesh are indeed distressing. A woman, recovering from delivery, expects to welcome a new child into her family. Instead she is confronted with the spectre of a dead infant whose head has been decapitated. Another woman awakens from surgery to find that not one, but both of her kidneys are missing! Yet another woman, in advanced labour, is physically dragged out of the hospital and forced to deliver her child in broad daylight and on an open road at a busy intersection!
- Some of the animosity directed at doctors stems from a lack of communication between healthcare provider and receiver, which arises from an outdated authoritarian medical culture where doctors are all-knowing experts while patients are ignorant laity who are incapable of understanding complex medical information, leave alone

make decisions about treatment options open to them. This is a culture that stands in striking contrast to contemporary medical perspectives based on human rights principles that affirm a patient's rights to autonomy and to informed decision-making. According to this perspective, regardless of education and exposure, a patient has an absolute right to be treated with dignity as a rational human being, who is capable of acting in their best interest if and when provided relevant information in an accessible way about their diagnosis and the treatment options open to them. While placing a premium on the adequacy and accessibility of information, medical practice that is informed by a human rights perspective, stresses the amount of time a doctor dedicates to a patient. Yet the amount of time dedicated to doctor-patient consultations in Bangladesh is abysmally low: an average of only 48 seconds compared with 22.5 minutes for Sweden!<sup>14</sup>

A 2013-2014 survey conducted by Transparency International of the Dhaka Medical College, one of two leading government teaching hospitals in the country, confirms the picture. Outdoor patients complain about long waits for (of up to 78 minutes), but short visits (of 5 minutes) with the doctor, lack of privacy during such consultations (the presence of non-involved others), and perfunctory attention from the doctor. On the side of inpatient care, healthcare seekers complain that the mandatory daily visits by the doctor is more the exception than the rule.

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13 Shyikh Mahdi, Medical Negligence vs. Violence on Doctors: Alarming Trend on the Rise in Bangladesh, May 21, 2017. <http://futrlaw.org/category/articles>.

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14 Carolyn Crist, The doctor will see you now, Reuters.com. Source: [bit.ly/2Ad59yA](http://bit.ly/2Ad59yA) BMJ Open, online November 8, 2017. 16 Taslima Akhtar and Shahidul Islam, Dhaka Medical College: A Diagnostic Study, Transparency International Bangladesh, <http://www.ti.bangladesh.org>; The Daily Star, Healthcare curbed by corruption: TIB, April 15, 2018; Prothom Alo, Corruption in Health Sector: Opinion, November 9, 2014.

- The case studies, which follow, create an over-riding impression of lack of vertical control within hospitals. There seems to be little concern on the part of management to ensure quality of care in their institutions. Doctors appear to operate without being accountable for maintaining protocols or standards of behaviour designed to ensure patient safety, security (see especially Case Study 3.2.) or dignity. Support staffs, such as ayahs seem to be beyond the control of physicians and surgeons.
- One gets the impression that directors and superintendents come together express concern over quality of care issues and start to investigate only when a crisis descends, and the media are in hot pursuit (Case Studies 3.1. and 3.2.). The same holds for entities higher up in the chain of command. Apex bodies, such as the Bangladesh Medical and Dental Council, appear to be largely dormant. Apart from their functions in licensure and certification (registration), they seem to have little to do either in terms of monitoring, public censure or disciplinary action against even the most heinous lapses in medical care.
- Other problems that hamper quality of care in the medical system of Bangladesh are lack of resources, lack of coordination between and among specialized institutions, and corruption in recruiting and transfers.
  - ✓ In Case Study 3.2., a patient is pushed out to another hospital because the Bangladesh Sheikh Mujib Medical University, the country's leading government teaching hospital, does not have enough space in its ICU facility. In Case Study 3.1., a woman in labour is turned away by the first of three government hospitals because of overcrowding. Among them is the venerable Dhaka Medical College Hospital, which is unable to

accommodate the patient because of a backlog of 40 patients in its gynaecological emergency ward!

- ✓ Case Study 3.1 is important for highlighting yet another deficiency that affects quality of medical care: Lack of coordination and information-sharing among hospitals. Whereas the first hospital lacked space, the second turned out the same patient because it lacked the necessary expertise to deal with the patient's complicated health needs. As a result, the same patient found herself being referred to a third hospital where, it also turned out, help was not possible. Here, the issue was that the patient did not meet the intake requirements of this hospital.

Sadly enough, the lack of coordination among different hospitals, the paucity of information flows between and among them, ultimately derive from low awareness among providers about the social responsibility, the ethical obligations of the medical system in Bangladesh as a whole to the healthcare of its people. A more attuned awareness would certainly raise issues such as:

How does the burgeoning medical system in the country measure up against its formal commitments to provide quality healthcare services to the nation? What would it take to stop the outflow of health seekers from Bangladesh to countries abroad?

- ✓ These questions and the incident reported in Case Study 3.3 open a window on a much-discussed issue in the healthcare industry: Corruption. The Transparency International survey exposes the corrosive effect of corruption in procedures for hiring and transferring medical personnel. Doctors are found having to pay bribes of 3 lakhs to 5 lakhs (Taka 300,000 -Taka 500,000)

for recruitment and Taka 1 lakh to 2 lakhs (Taka 100,000- Taka 200,000) for a transfer to a hospital from upazila centres to Dhaka city and its environs. Even support staffs (Grade IV employees) have to pay 1 to 2.5 lakhs for recruitment and Taka 50,000 to 2 lakhs (Taka 200,000) for a transfer from the countryside to more lucrative areas in Dhaka and adjoining neighbourhoods!

Once employed, the doctors and staffs must raise hundreds from patients in order to recover from the debts they incur to buy their jobs and transfers. Hence, doctors who run between two or more hospitals and clinics with little time for patients. Hence their efforts to channel patients to private diagnostic centres in return for 30 per cent to up to 60 per cent in commissions.

The effects of corruption in recruitment and transfers do not stop there. It leads to the diversion of drugs meant for to be distributed to the patient free-of-charge to commercial outlets near hospitals. The same holds true for medical supplies (gauze, antiseptic, laboratory chemicals and X-ray film). In the end, corruption even results in the creation of artificial scarcities in hospital beds and food trolleys, the sole purpose of such contrived shortages being to create opportunities for ward boys and orderlies to force patients to pay for the use furniture and equipment that is theirs by right.

- Side by side with this scenario of want of resources, the healthcare system in the country struggles with another and contradictory development. The growing commercialization of medical practice and its development into a highly profitable industry, which further cuts into the time doctors can invest in patients.

- Another major drawback in countering medical negligence in Bangladesh is the lack of a system of adequate laws that are and, moreover, actionable. Although several articles under the Constitution provides safeguards against such neglect, existing laws for concretizing such protections are scattered, weak, in need of substantial strengthening, regarding adequately compensating patients for their loss.

### Relevant Laws Against Medical Negligence

- Medical and Dental Council Act, 2010.
- Medical Practice and Private Clinics and Labs (Regulation) Ordinance 1982.
- Consumer Rights Protection Act, 2009.
- Penal Code, 1860.
- Contract Act 1872.
- Specific Relief Act, 1877.
- New Medical Services Act (Draft), 2014.

(Shyikh Mahdi, *Medical Negligence vs. Violence on Doctors: Alarming Trend on the Rise in Bangladesh*, May 21, 2017. <http://futrlaw.org/category/articles>)

Consequently, such legal action against medical negligence as exists in Bangladesh has mostly been limited to writ jurisdiction where the country's higher courts (Case Studies 3.1. and 3.2) respond to legal initiatives launched by activist organizations, or where the courts themselves choose to *initiate* action against the grosser forms of medical negligence and abuse that spark off frenzy in the national media<sup>16</sup>

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16 Tasmiih Nahiya, *Legal Remedy to Medical Negligence*, [www.newage.bd](http://www.newage.bd), August 12, 2018; Faria Ahmad, *Medical negligence and duty of care*, The Daily Star. Law Letter, April 2 2019; and Shyikh Mahdi, *Medical Negligence vs. Violence on Doctors: Alarming Trend on the Rise in Bangladesh*, May 21, 2017. <http://futrlaw.org/category/articles>.

## CASE STUDY C.1.

25 Mar 2018 Jono Konthho and other newspapers published news about a bizarre incident in Cumilla that defied belief. A 27-year-old woman, Zuleikha Begum, who hailed from a village under Muradnagar upazila Cumilla District, had gone to the government-run Cumilla Medical College Hospital (CMCH) for the delivery of her second child. When all was done, she emerged from treatment at the hospital to find that her child

had died, its head having been decapitated. Moreover, her uterus had been removed.

ASK's Investigation Unit spent March 27 interviewing the victim, her husband and mother; and March 28 interviewing the staff of the hospital.

### A. TESTIMONY OF THE PATIENT, HER HUSBAND, AND HER MOTHER

Saturday, 17 March 2018. Zuleikha Begum was only eight months pregnant but on the morning of March 17, she began to feel slight pains. Concerned, she went to Cumilla Debidar Maternal and Child Hospital, a private facility, to consult a doctor. He arrived at 1 P.M. and ordered an ultrasoundogram. Based on the results of the latter, doctor assured her that the baby was doing well but, for future reference, referred her to the government Cumilla Medical College Hospital because it was more affordable.

Zuleikha Begum's pains grew worse as the day progressed. Around 8 P.M., her husband took her to the Comilla Medical College Hospital (CMCH). By the time she had finished registering as an in-patient it was about 8.45 PM. Sometime

after this, the patient's mother came to the hospital to help out.

On examining her, the doctor-in-charge, confidently announced that both mother and child were doing fine. She assured Zuleikha Begum that she was headed towards a normal delivery, which she estimated would take place sometime in the afternoon of the next day. Four to five other doctors who also examined her confirmed this initial diagnosis: There was nothing to worry about; it was going to be a normal delivery and would occur some 12-14 hours later.

Contrary to what the doctors' prognosis, however, the pains rapidly worsened and Zuleikha Begum raised the alarm, but the doctors ignored her warnings that something was very wrong. Instead they prescribed some medicines to help with the discomfort and dull the pain and sent the husband to a local pharmacy to buy the drugs.

Much to Zuleikha Begum's dismay, the medicines did not help. The pains intensified, leaving her screaming and imploring the doctors to perform a C section to end her agony. Despite her intense discomfort, the doctors remained unmoved and persisted in their assurances that the delivery was going to be normal and would occur, as originally estimated, in the afternoon of the next day. Instead, of listening to the patient, they implied that she was over-reacting.

My pains were excruciating, Zuleikha Begum says, and I kept asking for a C section, but they paid no heed.

"Instead", she continues:

...they scolded me and repeated that there was no need (for a C-section).

Nevertheless, they had her moved from the ward into the labour room where, she continues:

They kept giving me medicine and kept me the whole night.... pulling and pushing me around while I spent a long, long time in pain...

Sunday, March 18, 2018. It was not until 2 P.M. the next day that the hospital finally moved Zuleikha Begum from the labour room into "OT" (operation theatre).

- Soon after the move, a person suddenly rushed out to ask the husband for his immediate consent to an emergency surgery for his wife without which, he was warned; his wife's life was at stake.
- Stunned, with no idea as to why or how the situation had changed so drastically and so swiftly, nor any inkling about the nature of procedure he was being asked to approve, the panicked husband blindly signed the consent form that had been handed to him.

When the surgery was all over, the husband and patient woke to a strange new reality:

- What was supposed to be an uncomplicated, "normal" delivery had ended in his infant daughter being extracted from the womb.
- Extraction entailed having the baby's head removed from the body.
- Following the decapitation, the doctors had to perform a C-section to open the uterus and lift out the head from it.

- Finally, for reasons unclear to the family, the doctors opted to remove the patient's uterus.

Stunned...Unable to comprehend what he was being told all the husband could do to stay in control was to use his mobile phone to take a picture of the tiny decapitated body of his daughter.

As for Zuleikha Begum....Her attempt to cope with reality--to restore some sense to her world, and to reassure herself that she was a fully functional, rational human being capable of thinking for herself -- consisted in raising a simple question:

So....What does the future hold for my daughter?

And to add an equally poignant observation:

If they had done the C-section on 17 March, my daughter would have lived.

.... My uterus would have been saved.

## B. WHAT REPRESENTATIVES OF THE HOSPITAL HAVE TO SAY

As incredible as the incident appears, what is even more incomprehensible is that, according to the Director and the Vice Principal of the teaching hospital, the shock and confusion shock that the patient and her family had been put through could easily have been avoided.

### The Director of the Hospital

According to Dr. Shapan Kumar Adhikari, the Director of CMCH, Zuleikha Begum had a complicated medical history. She had had two previous stillbirths that, he implied, were linked to her being born with a septal defect. In other words:

- Contrary to what the patient said she was led to believe, when she was admitted to the hospital on the night of March 17, the doctors had ascertained that the foetus Zuleikha Begum was carrying was already dead. In fact, the Director stresses, at some point the uterus had already ejected the palms and feet of the foetus.
- The reason why no surgical procedures were performed on the night of March 17 is that when a foetus dies, the usual course of action is to rely on a normal delivery to eject the foetus. All that is required, under such circumstances, is to control pain and speed up the dilation of the cervix (opening of the uterus) with the help of medicines. This is exactly what was done in the case of Zuleikha Begum.
- The next day, when the patient was taken to the OT, it was discovered while that the baby's body had been ejected from the uterus, its head had not. Consequently, the doctors removed the head using standard procedures, i.e., decapitation, followed by a C-section.
- Finally, because of excessive bleeding and damage to the uterus during the birth, the doctors had to make the decision to remove the patient's uterus itself.

#### The Vice Principal of the College

Dr Jahangir Hossain Bhuyia concurs that given the patient's gynaecological history, the treatment plan was an example of textbook correctness. In fact, he is outraged and talks about how, because of the hubbub created by the media and public over-reaction to "this incident":

The work of the entire (OB-GYN) ward is in shambles.

He takes an entirely statistical view of the situation and dismisses what to the patient is the loss of the dream of a lifetime as uninformed---oblivious to the rules of probability. According to him:

When there are one hundred pieces of work to do, there can always be an error in one or two (in the pieces of work). Where was the mismanagement in this case?

Dr. Bhuiya is also meticulous in his interpretation of the hospital's obligation. "Our target", he says, "was to save the mother". Since it is not the mother but the baby who has died, the doctor is at a loss to understand:

....then why the hue and cry about mismanagement?  
Where's the mismanagement here?

As for the patient's grief over the loss of her uterus, the Vice Principal is equally pragmatic. "We threw out the uterus", he observes. "She is a young woman and it would have been better if we had kept the organ" but, he continues adding the caveat:

If she had the uterus, the outcome would be the same because she was born with a septal defect<sup>17</sup>. She has a history of still births.

Dr. Bhuiya is irritated: “Now the whole hospital is distressed over this incidence”. He proceeds to warn that doctors in Bangladesh do not feel insecure.

If we (doctors) don't have government protection, none of us will work. She (Zuleikha Begum) was a critical patient.... and we work under risk. If this goes on, (then) no doctors will work under such risky conditions. We take the risk and do the work and then have to run to the court to defend ourselves.

What are patient's right?

Popular examples of patient's rights includes:

A right to health care.

A right to be informed.

A right to participate in decision-making concerning treatment and care.

A right to give an informed consent.

A right to refuse consent.

A right to a second opinion.

... slideplayer.com

17 A ventricular septal defect is a hole in the heart, a common heart defect that is present at birth (congenital).

## Pregnancy in adults with repaired/unrepaired atrial septal defect

Journal of Thoracic Disease<sup>18</sup>

Abstract<sup>19</sup>

Atrial septal defect (ASD) is the most common form of congenital heart disease. Left-to-right shunting leads to right ventricular (RV) volume overload with excessive pulmonary blood flow. Complications include exercise intolerance, pulmonary vascular disease, RV dysfunction, paradoxical thromboemboli, and atrial arrhythmias. Women with coexisting severe pulmonary hypertension should be counselled against pregnancy due to high incidence of maternal and fetal morbidity and mortality. In the absence of pulmonary hypertension, pregnancy is generally well tolerated in the setting of an ASD. Nevertheless, hemodynamic changes throughout gestation may increase the risk for complications, particularly in those with unrepaired ASDs. Arrhythmias are the most common cardiac event and occur in 4–5%, followed by paradoxical emboli in 2–5%. Obstetrical and neonatal complications include preeclampsia, a higher incidence of infants born small for gestational age, and higher fetal/perinatal mortality. Although there is no definitive evidence demonstrating superiority of an aggressive approach to ASD closure prior to pregnancy, it is currently common practice to electively close asymptomatic but large and/or hemodynamically significant ASDs prior to childbearing. Cardiology follow up during pregnancy should be adapted to clinical circumstances and includes transthoracic echocardiography during the second trimester and arrhythmia monitoring in the event of symptoms.

18 Charlene Bredy, François-Pierre Mongeon, Line Leduc, Annie Dore, and Paul Khairy, Pregnancy in adults with repaired/unrepaired atrial septal defect, Journal of Thoracic Disease, 2018 Sep; 10 (Suppl 24). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6174140/>

### C: ASK'S RESPONSE

A. While the technical soundness of the diagnosis and treatment plan may be beyond question, what does not make sense is why the hospital did not tell the patient and her family the truth about Zuleikha Begum's health problems and their implications for the survival of the baby. Why, during the early stages of her hospital stay, was the patient duped into believing that the foetus was alive?

B. Even if Zuleikha Begum were inclined towards exaggeration (the evidence clearly shows that this was not the case and that was correct in her perception that her condition was critical), the doctors had an absolute obligation to apprise her of the facts. To argue that it was out of kindness, the desire to spare a woman in labour the hard truth, which had led the doctors to conceal information from Zuleikha Begum, does not hold water. In the end, the same news had to be coldly thrust on a much more vulnerable woman; –a woman physically spent from 18 hours in agonizing labour pain and with doubled hope from 18 hours of assurances from doctors.

C. More crucially, and contrary to fundamental medical ethics, CMCH took the surprising step of “disappearing” of all records relating to Zuleikha Begum's treatment. This included not only the notes and reports of not only CMCH's own staff but also the ultra-sonogram images and report provided by the Cumilla Debidar Maternal and Child Hospital, which the patient visited prior to entry into CMCH on 17 March 2018.

D. On 25 March 2018, seven days after Zuleikha Begum entered the hospital, the High Court Division of the Supreme Court of Bangladesh issued a *Suo Moto* rule and summoned ten doctors from the Comilla Medical College Hospital, including the head of its OB-GYN, to explain the botched delivery. ASK joined the rule as an intervener representing Zuleikha Begum.

### CASE STUDY C.2.

On the 23rd of September 2018, the media were abuzz with news about a woman who woke up from surgery to have her left kidney removed, to find both kidneys had been taken out. The surgery was performed at a leading government teaching hospital located in Dhaka city. ASK immediately rallied its resources to conduct a probe. The Investigation Unit undertook the query between 24 September and 1 October 2018 interviewing the patient, members of her family and the physicians of two hospitals involved.

Rawshan Ara (age approx. 55), a resident of Ahmedpur Village under Aminpur Thana (Pabna District), was brought to the Bangladesh Health Sciences Hospital (BHS) Hospital<sup>20</sup> on 27 June 2018. She complained about pains in her stomach and back and was told that her left kidney was bloated and had become blocked. Because BHS Hospital was not equipped to handle her condition, she was referred to the Bangladesh Sheikh Mujibur Medical Hospital (BSMMU), a premier teaching hospital in Dhaka.

#### NARRATIVE BY RAWSHAN ARA AND HER THREE SONS

1 July 2018. Rawshan Ara was admitted into BSMMU hospital for treatment of an infected left kidney under the care of Dr. Habibur Rahman Dulal, head of Urology. After two weeks of treatment during which her left kidney drained, her family was told the best course of action would be to have her left kidney removed altogether. The attending physicians assured them that Rawshan Ara could live a full life with only

20 Located in Mirpur, Dhaka.

one surviving kidney. Persuaded, the family agreed to the suggestion but because no beds were immediately available,

Fifteen days later, on 15 July 2018, Rawshan Ara checked out of BSMMU.

It was not until one and a half months later, on 27 August 2018, that Dr. Syed Sultan called from BSMMU to say that a bed had become vacant and

The very next day, on 28 August 2018, Rawshan Ara was readmitted to the BSMMU hospital –this time for surgery for the removal of her left kidney.

By 30 August 2018, the patient had completed the required tests. The tests were completed at BSMMU and at the Salimullah Medical College Hospital (Mitford).

5 Sept 2018 was the date of the surgery. As far as the patient's understood, the presiding surgeon was to be Dr. Habibur Rahman Dulal, and the operation itself was to be around noon. The whole process lasted some three hours or so.

- Between 2.30 P.M. to 3 P.M. The surgery completed; the patient was moved into the post-op recovery room. When the sons visited her in the room, they could see blood on the bandage covering the left side of her stomach. The doctors instructed them to buy two bags of blood. These would be needed, they were told, for their mother around 4 PM.
- 8.00 P.M. the same day, the sons were suddenly received startling news. Their mother had to be moved into the ICU. The eldest son, Rafiq Shikdar asked the doctor for an explanation for the abrupt change and was told that

Rawshan Ara was in acute renal failure. Her RIGHT kidney had stopped functioning. Moreover, because BSMMU had no space in its own ICU, the patient had to be moved to one in a private clinic.

Sept 2018, less than 12 hours after her surgery, very early in the morning, Rawshan Ara was admitted to the ICU of the Insaaf Barraka Kidney and General Hospital. The hospital is in the Maghbazar area of Dhaka city.

- Two days later, however, on 8 Sept 2018, Rawshan Ara's family received another shock when Dr. Fakrul Islam, the supervising physician at Insaaf Barraka, raised the alarm with news about a precipitous decline in the condition of their mother. The patient's right kidney had stopped functioning altogether and the doctor immediately ordered a CT scan. The sons had their mother transported to the Labaid Hospital, in Dhanmondi, Dhaka for the scan.
- On examining the CT scan, Dr. Fakrul Islam declared that Rawshan Ara's right kidney was missing altogether and followed up by putting in a phone call to the surgeon, Dr. Habibur Rahman Dulal, at BSMMU.

The same day, the sons visited BSMMU to talk with Dr. Habibur Rahman Dulal. The doctor was very reassuring. After examining the CT scan, he told them that there was no reason for panic, and to stop getting excited about everything they heard from people. With dialysis, their mother would be fine.

Nevertheless, because of the further deterioration in Rawshan Ara's condition, and on the advice of a well-meaning acquaintance, at 8 P.M. the same day, the sons

moved her to the BRB Hospital on Panthopath Road in Dhaka, under the care of Dr. M.A. Samad. The patient's family continues:

- Examining the CT scan from Labaid, Dr. Samad also confirmed the initial finding: Both kidneys of Rawshan Ara were missing. Just to make sure, though, the doctor ordered a new scan which, again corroborated the earlier finding: Rawshan Ara was missing both kidneys.
- Dr. Samad also carefully looked over the various pathology reports chronologically. Going back in time, he was struck by evidence of a noticeable deterioration in the patient's creatinine level after her left kidney had been removed. Before surgery, the creatinine level of her left kidney was 0.61 (within normal range) but it had climbed to a high of 6.0 following surgery three days later.

At some point, the brothers could no longer bear what they perceived to be having been “toyed with”. Looking back, Shahid Shikdar, the second son, could only get angry when he recalled a conversation where a Dr. Mustafa of BSMMU had tried to make him believe that “a person without kidneys could survive 20-25 years with dialysis!” In his turn, Shafiq Shikdar, the youngest son, seethed at what he perceived as the hospital trying to “distract attention”. Declaring himself unimpressed with the games, all he sought was for his “mother to get well”.

The demands of Rafiq Shikdar, the eldest son, went well beyond that. He wanted justice. He wanted the hospital to give his mother a new kidney and pay compensation for all the costs the family had to bear. Not only that, he sought to “punish those responsible”.

- So, began an effort by the brothers to publicize the incident through the media, and to initiate legal action against the perpetrators. In response
  - ✓ On 23 Sept 2018 the BSMMU responded to the heat from the media by announcing that it had set up a 7-person inquiry committee to investigate the incident.
  - ✓ In addition, it had established a 6-person expert medical team to ensure further treatment for Rawshan Ara. The medical team, in turn, announced that Rawshan Ara would need two weekly dialysis treatments per week and that BSMMU would assume full responsibility all for costs and services.
- Six days later, on 29 September 2018, the eldest son approached ASK for help and, jointly with ASK sent a Demand for Justice Notice to the Director and responsible doctors of BSMMU.
- The notice produced a direct impact. Upon receiving the notice, the Director of the BSMMU invited the brothers to sit down with him and negotiate a settlement. At the meeting, he suggested that the family find a suitable kidney donor. For its part, the hospital would pay 3 lakhs (Taka 300,000) to cover the cost of purchasing an organ as well all costs and services associated with a transplant.

#### NARRATIVE OF DOCTORS

Dr. Habibur Rahman Dulal (BSMMU), professor of Urology and head of the hospital's renal transplant division. ASK met to interview the doctor in his office at BSMMU, on 24 September 2018.

The interview shows that while Rawshan Ara's family was under the impression that Dr. Dulal was directly involved in Rawshan Ara's treatment and surgery, the doctor himself implies a more distant role—a role twice removed.

- Describing the patient's admission to BSMMU he says: "From what I have heard, her left kidney was found to be damaged, and it was assessed that it should be removed. At that time, pus was removed from her left kidney".
- Again, he distances his role in the surgery by implying that the work was done by junior doctors with him stepping in to assist when things got complicated: "doctors called me for help, and I went and gave a hand".
- He presents himself as more of a spectator than the primary responsible surgeon when he comments: "There was a lot of bleeding during the surgery. It appears her blood vessels, the tubes and vessels associated with her kidneys and digestive system were all jumbled up and the patient went into shock on the table. She was brought back after a lot of effort and the surgery was completed".

Around 1 A.M., Dr. Dulal continues, the duty doctor "informed me" that she (the patient) was having problems with breathing and Dr. Dulal "advised" them that she be removed to an ICU.

Dr. Dulal also has a very different recall of what was exchanged between him and Dr. Fakrul Islam of the Insaaf Barakka Hospital. For one thing, he says the call from Dr. Islam happened on the September 6 before the new CT scan and not, as the sons imply, on September 8. Also, whereas the sons' narrative would appear to imply that Dr. Islam's call

was to let Dr. Dulal know about the surprising results of the scan, Dr. Dulal says that the call was to let him know that Rawshan Ara no longer needed "ventilation" (or the services of an ICU) and could, therefore, be moved back into BSMMU.

Dr. Dulal goes on to relate: "But, instead (of bringing the patient back to BSMMU on the 6th.), the relatives took her to Labaid and discovered that she did not have any kidneys". Continuing, he adds: "They brought her back here and demanded to know how come her right kidney was missing?" Dr. Dulal answered cryptically:

Either the right kidney is absent, or it is non-functional.

Without explaining how the right kidney could have vanished or hinting at his culpability, Dr. Dulal moves on to talk about his future commitments to restoring Rawshan Ara's health. He assures ASK that he is now involved in arranging a replacement of Rawshan Ara's right kidney and that, in the future, he will take full responsibility for all costs for dialysis as well as kidney replacement.

Dr. M.A. Samad (BRB Hospital). Dr. Samad was interviewed around 12.20 PM on 1 Oct 2018. His office is located at the BRB Hospital on Panthopath Road, Dhaka. The doctor is a man of few words.

The patient's son came to say his mother had been on dialysis but had stopped urinating. I wanted to know why dialysis? What was the problem?

The son answered; his mother had a kidney infection before. So, they admitted her to a hospital where they operated on her. But now the urine has stopped.

Then, Dr. Samad asked: “Why an operation?” and began to look at the patients records. Going back chronologically in time, Dr. Samad found that:

- The very earliest CT scan showed that “the left kidney had become so enlarged that it was covering the right kidney”.
- Moving on to check creatinine levels before and after the surgery, Dr. Samad found that “the creatinine level of the left kidney was 0.65 (normal) pre-surgery, and that of the right kidney was zero”. After the surgery, however, the creatinine level had deteriorated significantly. It now stood at 6.0. He wondered: “Why did creatinine level worsen?” and moved on to look at recent CT scans.

Upon examining a recent scan (post-surgery), he found no kidneys at all. “One of the sons asked why they (the kidneys) were not visible (in the scan)”. Doctor Samad skirted the issue by simply responding:

It was not possible for something structural to exist but not to show up in a CT scan.

#### FINDINGS BY ASK

ASK concluded that doctors at BSMMU were responsible for removing both kidneys of Rawshan Ara. In consequence, a month after joining the victim’s eldest son in issuing a Demand for Justice Notice against staff of BSMMU, ASK took further legal action by joining the eldest son as petitioner in submitting a writ petition demanding justice to the High Court.

The writ petition, entered on 29 October 2018, demanded a number of authorities to show cause why Dr. Habibur

Rahman Dulal should not be removed from his post in BSMMU; and why, under the provisions of the Bangladesh Medical and Dental Council Act 2010, Dr. Habibur Rahman Dulal’s professional license should not be revoked on grounds of medical negligence and misconduct. Finally, the Writ Petition questioned why the victim’s family should not receive a compensation of 20 crores (Taka 200,000,000). The authorities addressed include the Secretary of the Ministry of Law, the Secretary of the Ministry of Health and Family Welfare, the President of the Bangladesh Medical and Dental Council, and the Director and staff of BSMMU. BSMMU staff includes Professor Dr. Habibur Rahman Dulal (Urology) and Assistant Professor Dr. Farouk Hossain, (Urology).

On 20 November 2018, less than a month later, the High Court held a hearing and ruled asking:

1. Why the respondents should not pay taka one crore in compensation to the victim’s family.
2. Why the concerned doctors’ professional registration under the Bangladesh Medical and Dental Council should not be cancelled.
3. Why the concerned doctors should not discharge from their duties at BSMMU.
4. Why the surgery conducted by BSMMU should not be declared illegal.

### CASE STUDY C.3.

On October 18 Oct 2017, ASK responded to a story in the Daily Shomokal and other newspapers, which reported that, after experiencing pain, a young pregnant woman had visited three different government hospitals in succession for help. However, for some unfathomable reason, all three hospitals, all located in Dhaka, had refused to so. The result was that the woman gave birth to a child in broad daylight on the road fronting the third hospital that had turned her out. Sadly, enough, the child died soon after on the same road.

The news made no sense. By law, state-owned hospitals are mandated to provide emergency healthcare services regardless of a patient's ability to pay –the special focus of the law being on benefiting the poor and the indigent.

The news made no sense. By law, state-owned hospitals are mandated to provide emergency healthcare services regardless of a patient's ability to pay –the special focus of the law being on benefiting the poor and the indigent.

ASK Investigation Unit spent two days interviewing Parvin Akhtar and visiting the three hospitals involved and ascertained the following:

Parvin Akhtar (age 26), pregnant but separated from her husband, was member of the floating population of Dhaka city, which ingeniously ekes out a living from living and begging around the numerous mosques and mazaars (religious shrines) in the metropolis. Originally from a village in Jessore city; in 2017, she used to live near a mazaar in the Gulistan area.

In the evening of 16 October 2017, Parvin Akhtar began to feel pains and went to the Dhaka Medical College Hospital (DMCH), a premier teaching hospital for help. The doctors at DMCH advised her that the child had defecated in her uterus and her pregnancy was at risk. Unfortunately, however, because of a backup of 40 patients in the emergency section of its maternity ward, the hospital was unable to help and referred her to another government facility, the Sir Salimullah Medical College Hospital (also known as Mitford Hospital).

Later, the same evening, Parvin Akhtar went to Mitford Hospital but was told that they did not have the expertise to handle complicated cases of pregnancy. Accordingly, she was referred to a third facility; a leading training institute specialized in women's reproductive health. It was too late in the day, so the patient decided to wait till the next day.

Monday 17 October 2017, Parvin Akhtar went to visit The Maternal and Child Health Training Institute (TMCHTI), a 173-bed facility, located in Dhaka on Azimpur Road, near Lalbagh Fort in Dhaka city. Unfortunately, for her, she was told that she did not qualify for assistance from the Institute. It served only those registered in its rostra of patients.

- Even so, seeing her stressful condition, a doctor very solicitously took Parvin Akhtar into an examining room on the second floor of the hospital. However, before the doctor could complete the examination
- An ayah, named Shaheda, rushed in and forcibly dragged Parvin out of the room.

- Outside in the hallway, Parvin Akhtar found that she urgently needed to use a toilet. The ayah proceeded to hand her a bucket but when Parvin sat on the pail, she began to demand Taka 1,500 for its use. When she told the ayah she had no money, the latter straight away dragged her down the stairs, across the first floor and pushed her out of the main gate of the hospital.
- Soon after, the unfortunate woman gave birth to a child, but it died soon after. Parvin attributes the loss of her child to her poverty. According her: “Because I am poor, my child did not get to see the light”. She concludes by saying that she wants justice “against the people who are responsible for this”.

#### NARRATIVE BY THE HOSPITAL

On interviewing the representatives of the hospital, it turns out that the institution lives up to its promise of a progressive “women friendly” institution dedicated to the reproductive health rights of women. The superintendent, Dr. Ishrat Jahan, fully acknowledges that what had happened was wrong. “We are responsible for that”, she spontaneously offers, and goes on to add that TMCHTI had already set up an investigation committee and, using data from the CCTV footage, had already fired the Ayah at issue. Because the case was under investigation, she did not have the authority to say anything more about the incident.

#### ASK’S RESPONSE

ASK’s Investigation report concludes that The Maternal and Child Health Training Institute was clearly responsible for

the incident and was unique in acknowledging this without hesitation.

After completing the investigation, ASK followed up with a letter of appeal to the Ministry of Health and Family Welfare and the National Human Rights Commission.

On date the High Court, on behalf of the Supreme Court, issued a *Suo Moto* rule asking a range of government authorities to explain their failure to ensure treatment for Parvin Akhtar and to explain why the victim should not receive compensation. ASK joined the High Court’s ruling as intervener on behalf of the victim.

The organizations named in the *Suo Moto* ruling were the Inspector General of Police, the Secretary of Social Welfare, The Secretary of Women and Children Ministry, the Director of Health Administration, the Director of the Dhaka Medical College Hospital, Superintendent and doctor of The Maternity and Child Health Training Institute (Azimpur), and the Officer-in-Charge of the Lalbagh Police Station.

#### LESSONS LEARNED

The topic of medical negligence and medical malpractice in Bangladesh is complex. Besides issues of the quality of technical skills, and the adequacy of medical education and training; health services in the public sector are affected by low resources, high unemployment, which ultimately corrodes professional morale and rational management in government hospitals and clinics. An additional drawback is poor monitoring and indifferent regulation by apex bodies, such as the Bangladesh Dental and Medical Council,

entrusted with overseeing the performance of individual and institutional practitioners<sup>21</sup>.

Available evidence suggests that human rights organizations can do much to improve the situation by:

- A. Intensifying efforts to monitor medical negligence while stepping up efforts to provide legal defence to victims and
- B. Confronting a key obstacle to quality healthcare: a questionable work culture and a general erosion of the altruistic values traditionally associated with medical ethic, which has historically been the key mechanism for regulating a service that eludes the control of state watchdogs because of the highly technical and complex nature of its concepts and tools.
- C. To be effective, advocacy efforts need to
  - ✓ Be equally directed at healthcare users (people) and providers (members of the healthcare establishment). The primary focus of advocacy ought to be to raise awareness about a patient's inherent right to informed consent, on the one hand; and the absolute obligation of healthcare professionals, on the other, to provide information about a patient's diagnosis and options for treatment

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21 Impressionistic evidence suggests that although facilities in private sector clinics and hospitals are better, similar concerns about the duration of consultations and quality of care have begun to be raised about private clinics and hospitals. A primary issue such criticism is the growing commercialization of healthcare and the transformation of this service from an altruistic commitment into a profit-making industry.

in an accessible, easy-to-understand language and idiom.

- ✓ Establish close working relationships with individual practitioners and institutions within the health industry.
- ✓ Encourage/support efforts to digitalize and make reliable medical information available in Bangla by relying on existing sources of authoritative information.



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