What's Love Got to Do with It?

A Hospital Ethnography on Sexual Violence Response and Care in Bangladesh

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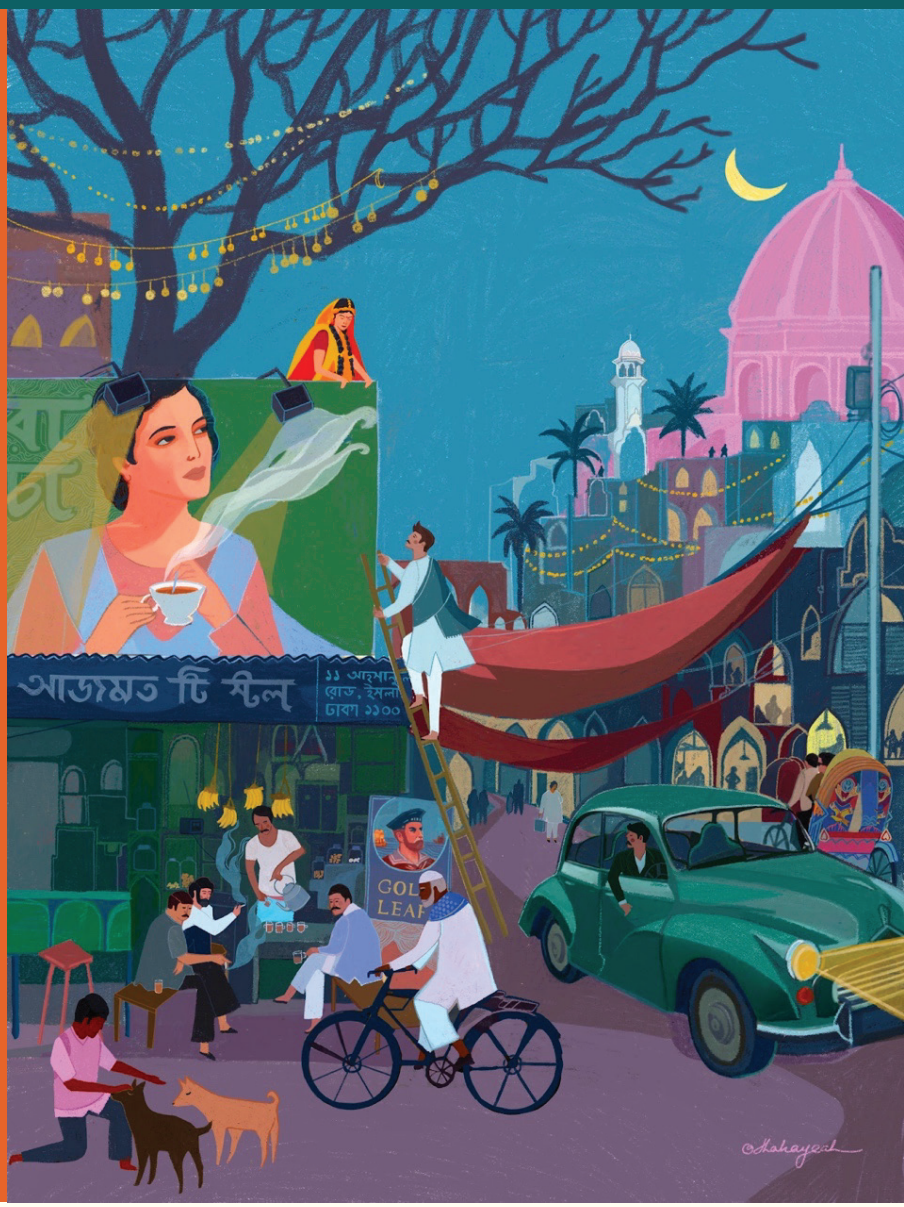

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This research was funded by NWO, AISSR, BRAC JPG School of Public Health, BRAC University

The seminar was organized by BRAC JPGSPH, BRAC University and BLAST

The author would like to personally thank members of BLAST, Naripokkho, DANIDA, Ministry of Women and Children's Affairs, Ministry of Law, and Parliamentary Affairs, Ministry of Health and Family Planning for their kind support. And a very special thank you to Dhaka Medical College Hospital, particularly the doctors and staff at Forensic Medicine and Toxicology Department, Dhaka Medical College.

https://hdl.handle.net/11245.1/cebef5bb-69d6-4a82-9d99-f28f8559a15b

Research Summary

Bangladesh is one of the fastest growing economies in South Asia, having achieved milestones in both human and economic developments. One of major factors that attributed to the country's economic success is women's participation in formal and informal work force such as ready-made garments sector (RMG) and micro-finance-based entrepreneurship, respectively. While women and young people are at the core of Bangladesh's development discourse, the country also has one of the highest rates of violence against women (VAW) in the region, making it a gender and development paradox (Kabeer, 2024). According to the WHO's Violence Against Women Prevalence Estimates (2018), 50% of women in Bangladesh face one form of intimate partner violence in her lifetime, while 2 out of 3 women are said to have experienced some form of violence, harassment, and/or assault in their lifetime. And while there has been longstanding advocacy and service delivery programs to prevent and protect women and children from incidences of violence, the health sector response to VAW in Bangladesh remains limited, marred by questionable medical practices and beliefs. This research therefore investigates how the public health sector responds to VAW in Bangladesh, and more importantly, why do certain discriminatory practices continue as health services for victim-patients/survivors of assault.

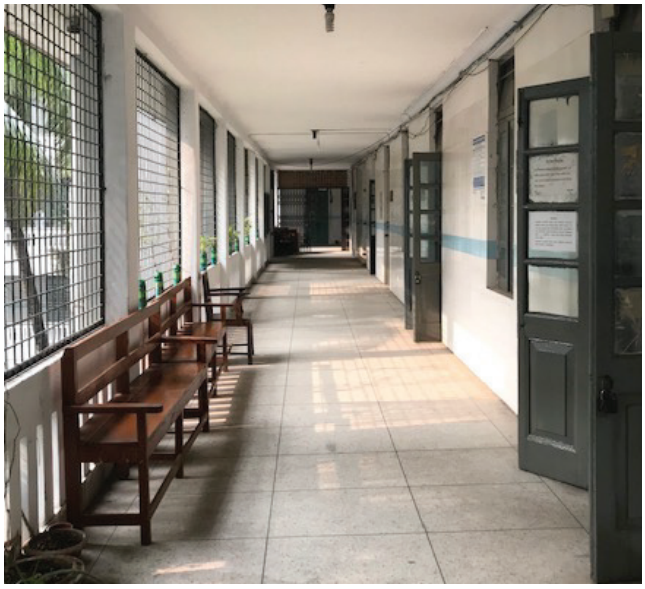


Photo 1: Forensic and Toxicology Department, Dhaka Medical College, 2017. P.c. author

Waiting area for victim-patients and police officers. The doors on the right lead to department offices, classrooms, and medico-legal examination center.

Through an in-depth hospital ethnography at the Forensic Medicine and Toxicology Department of Dhaka Medical College Hospital (DMCH), this research brings forward the complex story of "speculative medicine" (MITRA, 2020) or Victorian era social beliefs based non-scientific medico-legal procedures, that continue to be practiced as women's medicine in current day Bangladesh. Based on colonial Penal Code 1860 and Evidence Act 1872, over a century and a half old medical jurisprudence defines what constitutes as rape/sexual assault, "character" of women, and therefore medico-legal evidence gathering process. Despite High Court's judgment to repeal the highly discriminatory and scientifically challenged 'two-finger'/virginity test, the procedure remains a critical part in the examination requirements to determine whether a rape had occurred or not. Women's 'virtue' and 'character' take the center stage in a sexual assault investigation rather than the crime itself (Hossain, 2016; Huda, 2022).

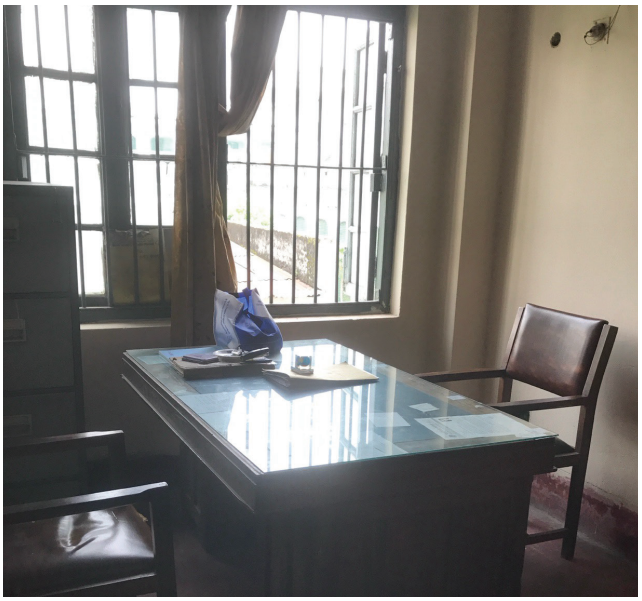


Photo 2: Doctor's chamber, part of the medico-legal examination center. Fieldwork 2017. P.c. author.

When the victim-patient came into the department, they would be directed to this room for an initial conversation with the duty doctor – verbal statement. This plays a critical role in determining whether the story was "patano" or "ashol".

While rape cases remain under reported, ethnographic research also brought forth an unexpected finding – the misuse of the special protective law, Nari O Shishu Nirjatan Daman Ain 2000, as a re-scripting tool for families of young people having consensual sexual relations outside of marriage. Sexual relation as an

outcome of promise to marriage, can be considered as rape in the Nari O Shishu. In a society where marriage and class mobility are intricately connected, pre-marital sexual relations become a familial crisis. Alleged rape charges are often made by the young girls' parents to reclaim the narrative that "something bad had happened" to their daughter, to retain some "marriage marketability", as opposed to accepting the reality that young people in Bangladesh are sexually active, making their own choices.

Government female doctors at the Forensic Medicine and Toxicology Department's (FMD) medico-legal center are at the heart of these complex case by case situations. As per administrative mandate, only government female doctors with forensics training can legally carry out the medico-legal examination. However, in a country with only five doctors meeting all the criteria, forensic medicine departments across the country, "borrow" government female doctors from mainly Obstetrics and Gynecology specialization track. While development sector reports insist that the doctors are "stigmatizing", the research shows the difficulties with which doctors navigate this landmine of family values, sexual propriety, romantic afflictions, the act of violence, and the medical and legal bureaucracies of Bangladesh. Doctors would get frustrated with the patano, or falsified cases, but demonstrated care and support for the ashol or "genuine" sexual assault cases. It is only at the medical examination that the victim-patient gets to speak with another female service provider in complete privacy. And in that quiet, secluded, all female medical zenana space, victim-patients reveal the entirety of their stories. And while care varies from case to case, doctors agree on the archaic nature of the two-finger test, and how the Ministry of Health prescribed form for evidence collection, does not meet global standards (WHO, 2013).

The research also demonstrated the critical disconnect between global North definition of the binary understanding of "consent" (i.e. yes is yes, no is no), and the realities of sexual navigations for young people in Bangladesh. As global citizens connected through social media, young people in Bangladesh are constantly negotiating between traditional values of retaining sexual propriety till marriage and wanting to make their own life decisions and choices. Marriage and sex, as university students explained, are two different things – one is for family, stability, social and financial advancement in life, while the other is about desire, love, self-expression and exploration. The two can converge, but not necessarily. Unlike global North interventions that insist upon having open conversations on sex, young people were more comfortable navigating through silences (Camellia et al., 2021), deconstructing "western" notions around bodily integrity and the meaning and application of consent. As one of the participants insightfully stated, "shommoti", the literal translation of "consent", only comes up in Islamic marriage proceedings, where sex is a precursor to marriage. Otherwise, the Bengali word hardly comes up in everyday interactions. Young women were aware of the term because of growing up in general sense of fear and insecurity in Bangladesh, but young men, could not entirely relate to the term and hence, why it was important in their daily lives.

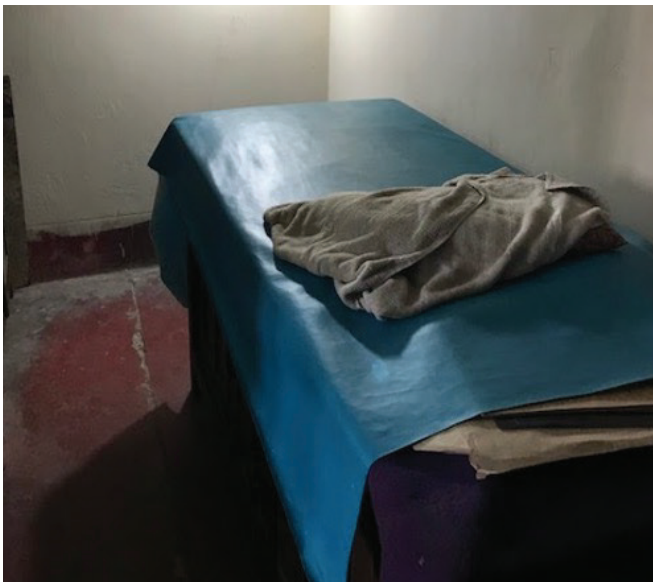


Photo 3a. Patient examination room, view from doctor's chamber.

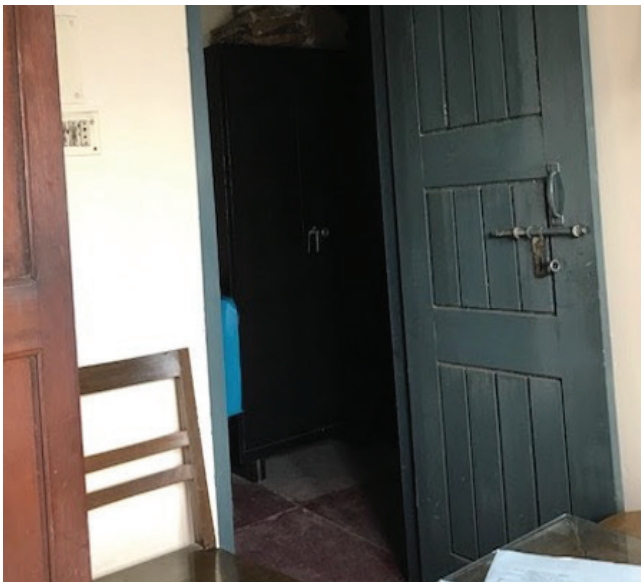
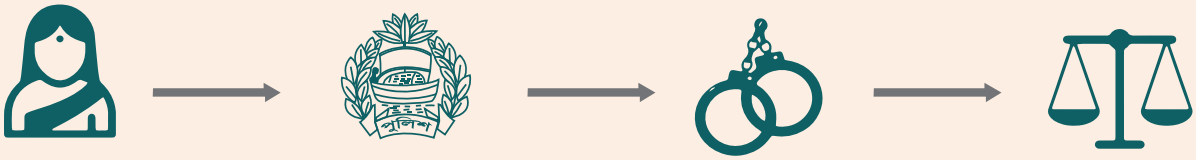


Photo 3b. Patient examination room

Consent, or “shommoti”, therefore, manifest as a hollow term, made popular through “traveling” sexual education interventions (Krebbekx, 2020). Young people, especially women and girls, find themselves stuck somewhere between a highly violent colonial penal system (Baxi, 2013), an overprotective post-colonial law, and social expectations around gendered roles and marriage. Sex and violence take place amid such patchwork of beliefs and practices, without any wider vision of how to address the needs of one of the largest youth populations globally.

In conclusion, the research also revealed the general disregard of sexual violence as a national priority for any political government. Sexual violence, women’s rights, and protection have become a “development” agenda rather than a crisis in citizenship and nation building. Especially in the health sector, there is a disinterest in viewing sexual violence as an endemic and, rather considered as a social phenomenon that will sort itself out in due time. There is very little incentive for the health sector to carry out a comprehensive curriculum and procedure change in medical teaching and practice of the two-finger test and other speculative medicine that continue to harm women and young girls in Bangladesh.

Legal Process in the Incidence of Violence Against Women and Young Girls



An incidence takes place. A First Incident Report (FIR) to be filed at the local police station. If the victim is under 18, legal guardian to file the FIR.

Depending on the incidence of violence, case is filed at local police station. Majority of rape cases filed under Suppression of Violence against Women and Children Act (Nari O Shishu Act) 2000

Immediate arrest is made of the suspect and the suspect is taken into custody. This is considered to be a cognizable offence which allows arrests without warrant.

All cases filed under Nari O Shishu Act 2000 go to the Nari O Shishu Nirjatan Daman Tribunals or speedy trial courts that have special provisions.

With a court order, the investigating officer accompanies the victim-patient to the government directed forensic medicine department for evidence collection. Examination must be carried out by a Bangladesh Civil Service Health Official who should also be female.

Forensic doctor carries out verbal and physical examination in accordance to Evidence Act 1872. Medico-legal form is issued by Ministry of Health and Family Welfare (MoHFW).

Doctor finalizes medico-legal report based on examination notes and investigation reports. Police picks up the report from FMD and takes it to court. At the court, the medico-legal report is needed to commence trial. Doctors may be required to appear at court. No further care or treatment provided by the medical system.

Verbal Statement

- Identity verification
- Official statement of incidence according to the victim-patient

Physical Examination

- Taking of weight, height, and number of teetch
- Overall physical check up to account fro abrasions/signs of violence
- Carrying out two-finger test to check for "habituation to sex" and any signs of violence in the genitalia region
- Swab test to be sent for DNA

Report Writing

- Forensic doctor writes the report
- Issues further investigations such as X-ray in the case of under-18; menstrual regulation (MR) in case of unwanted pregnancy due to sexual assault; DNA testing

Special thanks to Taqbir Huda, researcher and legal activist on rape law reform for comments and suggestion to the diagram

Research Methods and Findings

The research project applied qualitative approach including extensive ethnographic observation at Dhaka Medical College Hospital (DMCH) for 7 months, over 22 interviews including IDIs and KIIs with doctors and stakeholders, respectively. In addition, 4 FGDs were carried out with university students (male and female) from both public and private universities and 2 FGDs with doctors (with and without public health training). By using inductive methods, themes were identified using both data software (atlas.ti) and color- coding method.

Major findings from the research are the following:

1. While extensive and meaningful activism and changes have taken place in health services to survivors, the efforts have focused mainly on legal and governance aspects of the process. Initial BLAST report (BLAST, 2012) was the first to review the health system's response and responsibilities for sexual assault cases, followed by this doctoral study. More research-to-i mplementation efforts therefore are needed in the health sector to improve care services to survivors.

2. Perhaps the most critical finding from the study is that while the High Court has repealed the two-finger test, Ministry of Health has yet to issue a new set of guidelines on how to conduct the physical examination. Without Ministry of Health's guidelines, the duty doctors are bound by administrative procedures to conduct the examination as per status quo. There is no incentive or interest in changing colonial "speculative medicine" for women's healthcare in current Bangladesh.

3. There are not enough female, government Forensic Medicine doctors in the health force in Bangladesh. All three of these qualities (i.e. female, government doctor, forensics expertise) are required as per government rules to conduct the medico-legal examination. Female doctors, irrespective of public or private training and practice, seldom go into Forensic Medicine and hence the government doctors are "borrowed" from the Ob/Gyn department. That means, there is hardly any professional advancement in this field. They receive on-job trainings and the positions at the forensics department are viewed as temporary and standard procedural work rather than a scope to advance in medical jurisprudence.

4. Of the 55-57 cases observed, 90% were not rape cases but "patano" cases or falsified cases where the Nari O Shishu Nirjatan Daman Ain 2000 (Nari O Shishu from hereinafter) is used for revenge purpose or to "rescript" sexual relationships between unmarried young couples. This may be different in the rural areas but in Dhaka, majority of the "rape" cases that are filed at the police stations and brought directly to the medical centers, were found not to be coercive but rather consensual relationships between young people, disapproved by families.

5. Connected to this point is that of why cases do not go through the legal system. While the legal system is complex, costly, and highly stigmatizing against women, there is also the issue of cases not being substantial. Hence there are discrepancies in numbers between the cases filed at the police stations and that which go through the entire legal process.

6. The medical form that exists is highly pornographic and problematic. While the focus has been on the repealing of the two-fingers, the medico-legal form itself is based on century-old, gendered beliefs that have been medically and scientifically disqualified in Forensic Medicine globally. Yet, these socially constructed beliefs about women's bodies and sexualities continue to dictate rape case management in Bangladesh.

7. In trying to understand why so many cases are "patano", a series of FGDs were conducted with young university students from where it became apparent that young people in Bangladesh are sexually active before marriage. Yet, policymakers and service providers do not want to openly engage with this reality, continuing to create barriers to information and services on sexual reproductive health, which includes violence.

8. Young people do not understand Western definition of "consent". The Bengali term "shommoti" makes very little sense to either men or women. Women have an embodied understanding of consent because of gendered socialization and general lack of safety, but young men do not engage in meaningful talks about bodily integrity. Sex education materials require a different approach in explaining these terms to young people.

9. Bangladesh is a deeply class-based society and issues of sex, sexuality, sexual relations are intricately connected to that of class relations and issues of marriageability. Development sector does not look at class dynamics and the GBV sector does not take into consideration socio-cultural factors such as marriage and kinship.

10. Women in Bangladesh are not considered as citizens and hence, policymakers and stakeholders do not view the VAW endemic as a national crisis. There is a dire need to move beyond developmentalist approach to women's roles and participation in all walks of life in Bangladesh.

Way Forward

1. A way to bring about meaningful change to the myths about women's bodies is through collaborative research with medical systems and training. Bangladesh may be a social hub for public health research and interventions, but the focus is primarily on the health- seekers and community members. Critical health sociological/ anthropological research focusing on medical and non-medical staff are far and few.

2. A political upheaval is needed to push for comprehensive rape reform in Bangladesh. That includes not only a complete ban of the virginity/two-finger test but also administrative changes to the medico-legal examination report – the format is pornographic and therefore needs to be revised by feminist lawyers and doctors. Bimanual vaginal examination is at times needed in the evidence collection process, as demonstrated by WHO guidelines, but that is on a case by case basis and should not be a blanket intrusion and certainly not used to check one's virginity.

3. Active recruitment of female doctors in forensic medicine is needed in Bangladesh, along with new guidelines on how to carry out the medico-legal examination. Forensic medicine also needs greater professionalization to create incentives for Ob/Gyns to choose forensic medicine as a specialization. Ob/Gyn training can include training on sexual violence identification and examination in accordance with the WHO Guidelines. Women's medicine requires a greater assessment, keeping SRHR at its core.

4. The entire forensic medicine curriculum pertaining to female body and sexuality require revising. Doctors carrying out the medico-legal procedure can be trained in non- judgmental approach to sexual violence. There is also a need to strengthen referral systems within the public health services, i.e. how to send a victim-patient to OCC, or the Ob/Gyn department, or the Family Planning center.

5. More resources need to be provided for spaces like the forensic departments across the country. Forensic departments across all public hospitals are mandated to carry out the medico-legal examination and provide support to the One Stop Crisis centers. They should receive both financial and capacity building support to retain the all-women, quiet environment of the centers. There is also a need for modern medical equipment and DNA lab(s).

6. Design data collection from end to end of a rape case. A digital case filing system can be introduced for all cases filed under Nari O Shishu Ain that would track the process. Connected would be the OCCs, to work with external research institutes, on how to develop a data management system to account for the cases that go to them.

7. Recognition and realization by development sector and rights-based organizations that Nari O Shishu Ain is highly misused. The misappropriation of the law is not an exception, it has now become the rule. The human rights sector/activists need to be self-reflective of this reality.

8. The promise of marriage is NOT rape. This needs to be amended from Nari O Shishu Act. While an incident of romantic deception is socially and emotionally detrimental and social stigma does not

go away with law changes, but there must be a clearer understanding of what 'consent' is. A larger discussion is required to define and operationalize consent.

9. Recognition and realization by all stakeholders that young people are having premarital sex. Without this recognition, it is difficult to design effective sex education and sexual health programs or expect young people to trust service providers.

10. There needs to be a systematic review of what is taught as sexual reproductive health (SRH) in medical curriculum and to move away from 'disease'-framework of SRH. Alongside, centers like the police station, FMD, OCC should have emotional support personnel. Many of these cases turned out to be relationship issues. With the help of mediators, these cases can be resolved. In the same way, no one explains to the victim- patients on the medico-legal procedure. Information packages and dedicated website can be developed to better inform everyone on how the medico-legal process works.

References

Baxi, P. (2013). Public Secrets of Law. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198089568.001.0001

BLAST. (2012). *Medical Evidence in Rape Cases*, .

Camellia, S., Rommes, E., & Jansen, W. (2021). Beyond the talking imperative: The value of silence on sexuality in youth-parent relations in Bangladesh. *Global Public Health*, 16(5), 775–787. https://doi.org/10.1080/17441692.2020.1751862

Hossain, S. (2016). Public interest litigation on violence against women in Bangladesh:
Possibilities and limits. In A. Barrow & J. L. Chia (Eds.), ***Gender, Violence and the State in Asia***. Routledge.

Huda, T. (2022). "No signs of rape": corroboration, resistance and the science of disbelief in
the medico-legal jurisprudence of Bangladesh. Sexual and Reproductive Health Matters, 29(2). https://doi.org/10.1080/26410397.2022.2096186

Kabeer, N. (2024). Renegotiating Patriarchy: Gender, Agency and the Bangladesh Paradox.
LSE Press. https://library.oapen.org/handle/20.500.12657/93758

Krebbekx, W. (2020). Including Diversity? The Politics of Sex Education in the Netherlands. In
The SAGE Handbook of Global Sexualities (pp. 206–220). SAGE Publications Ltd. https://doi.org/10.4135/9781529714364.n10

MITRA, D. (2020). *Indian Sex Life: Sexuality and the Colonial Origins of Modern Social*
Thought. Princeton University Press. https://doi.org/10.2307/j.ctvkjb4fc

WHO. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.*

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