Legal Interventions and Access to Maternal Health Services by Women with Disabilities (WWD) in Bangladesh: Lessons from Canada

by
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ABSTRACT

This thesis investigates how and why women with disabilities are facing various kinds of barriers and challenges while accessing maternal health services. It tries to focus on the barriers in the built environment and attitudinal barriers that hinder the way of getting maternal health services by women with disabilities which they are entitled to.

A literature review discusses the major barriers which women with disabilities encounter across different jurisdictions along with Bangladesh. The literature review on the accessibility of Bangladesh and real-life stories confirms the existence of some common barriers women with disabilities face while accessing maternal health services.

Further, provisions of the international disability convention, the UN Convention on the Rights of Persons with Disabilities, were discussed to establish the state obligation of Bangladesh to ensure the health care rights of women with disabilities. Moreover, the importance of the compliance of the human-rights approach in a national legal framework was discussed.

In addition, legal lacunas of Bangladeshi laws were examined and possible legal interventions are discussed. Concerning that, Canadian accessibility provisions were taken into consideration for discussion.

To conclude, recommendations are provided including necessary legal reforms of existing laws, incorporating new concepts and provisions to ensure accessibility of maternal health service in Bangladesh.

DEDICATION

This thesis is dedicated to all the women with disabilities in Bangladesh who are struggling in their lives but still progressing with courage and patience. It is my little effort to accompany them on their journey.

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LIST OF ABBREVIATIONS

AODA IAS	Accessibility for Ontarians with Disabilities Act
BMA	Bangladesh Medical Association
BMDC	Bangladesh Medical and Dental Council
BRTA	Bangladesh Road Transport Authority
BRTC	Bangladesh Road Transport Corporation
CRP	Center for the Rehabilitation of the Paralyzed
CRPD	Convention on the Rights of Persons with Disabilities (UN)
DWA	Disability Welfare Act
EmOC	Emergency Obstetric Care
HRTO	Human Rights Tribunal of Ontario
ICF	International Classification of Functioning, Disability and Health conceptual framework
IOM	Institute of Medicine
NCT	National Childbirth Trust
OHCHR	Office of the High Commissioner on Human Rights
OI	Osteogenesis Imperfecta
PWD	Person with disabilities
SCI	Spinal Cord Injury
WWD	Woman with disabilities
WHO	World Health Organization

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INTRODUCTION

Statement of the Problem

Bangladesh has two pieces of legislation governing disability rights: the *Protection of the Rights of Persons with Disabilities Act 2013* and the *Protection of the Rights of Persons with Disabilities Rules 2015*. Along with several other policies, this law and its related rules lay out the legal framework that governs access to maternal health services for women with disabilities (WWD) in Bangladesh. However, women with disabilities in Bangladesh continue to face barriers, including architectural and attitudinal barriers related to health care during pregnancy and childbearing. In this academic study, the author tries to locate the critical reasons why these legal instruments have been rendered ineffective in realizing maternal health care rights in Bangladesh.

Research Questions

In Bangladesh people including women with disabilities do not have universal health coverage. There are no health care coverage plans for the public provided by the government. Individuals may choose to obtain both public and private medical services. People generally go to the private clinics to get better health care services compared to public hospitals and clinics.

While accessing medical health care, persons with disabilities face barriers and encounter their own specific hardships as a marginalized group. To narrow down the ambit, women with physical disabilities have been chosen as the subject matter of the study.

This thesis, therefore, seeks to explore the following questions:

1. On the ground, how are women with disabilities facing environmental and psychological barriers, including knowledge gaps, discrimination, and medical experiences while accessing maternal health services in Bangladesh?

2. What appropriate legal reforms can be proposed in Bangladesh to realize maternal health care rights for women with disabilities and remove barriers, considering best practices followed in Canada?

Outline

The study is organized into three chapters. Following this introductory part, Chapter one provides a literature review of the barriers experienced by women with disabilities while accessing maternal health care services. It also describes some real-life stories of women who underwent different experiences during their pregnancy. This chapter includes relevant studies based on surveys, focus group discussions, in-depth interviews and real life experiences of WWD from different jurisdictions including Bangladesh. While examining the literature relating to barriers experienced by women with disabilities while accessing maternal health care services, it became apparent that every person with a physical disability in Bangladesh suffers from two major barriers which are architectural and attitudinal. This therefore became a central element of the thesis, with a literature review of the architectural and attitudinal barriers faced by people with physical disabilities in Bangladesh forming part of this chapter.

Chapter two reviews the provisions of international law on disability that are relevant to removing barriers for accessing maternal health care services. This chapter examines the significance of the UN Convention on the Rights of Persons with Disabilities[1], models of disability and the obligations of the signatory states to comply with the Convention's provisions.

[1] United Nations Convention on the Rights of Persons with Disabilities, 30 March 2007, 44910 UNTS 2515 (entered into force 3 May 2008) [CRPD].

Chapter three discusses the Bangladeshi laws relating to the accessibility provisions of the maternal health services of WWD. Further, the chapter explores whether the Bangladeshi legal system could effectively incorporate the provisions of the international convention on disability and the human rights model into its laws and its disability discourse. Lastly, recommendations relating to legal reforms in Bangladesh for the removal of barriers to accessing maternal health services by WWD are made, after investigating the best practices followed by Canada.

Chapter-1

BARRIERS TO HEALTH CARE SERVICES

1.1 Background of the Study

This study aims to understand the barriers of various kinds that women with physical disabilities in Bangladesh face during pregnancy. It will examine how they are treated by their families and by medical service providers, using women's narratives regarding treatment in their maternal-related experiences. This study will focus on Bangladesh's existing legal framework addressing these issues and on additional areas that require further attention. To achieve the research goals, Bangladeshi, Canadian and international laws relating to disability and maternal health care will be discussed.

Around 24 million persons with disabilities are estimated to live in Bangladesh, constituting 15% of the total population, and 50% of them are female.[2] The percentage of people with various types of disabilities, according to the Bangladesh Bureau of Statistics (2009), is as follows: vision-related disabilities - 31.3 percent, physical disabilities - 35.8 percent, hearing and speech-related disabilities - 28 percent, and psychological disabilities 4.9 percent.[3]

People with disabilities, including women, are arguably deprived of their rights and privileges because of existing social stigma towards them. People with disabilities are the most disadvantaged group in Bangladesh. The majority are isolated from the rest of society, stigmatized, and deprived of basic necessities like health care, shelter, education, jobs, and

[2] Aleya Akter & Md Mizanur Rahman, "Women with Disabilities in Bangladesh: Accessibility in the Built Environment" (2019) 26:2 *PROSHIKHYAN A Journal of Training and Development* at 2, online: https://www.researchgate.net/publication/331973820_Women_with_Disabilities_in_Bangladesh_Accessibility_in_the_Built_Environment.

[3] Muhammed Muzzam Hussain, "Models of Disability and People with Disabilities in Bangladesh: A review" (2020) 5:1 *Journal of Social Work Education and Practice* at 12.

transportation.[4] Being disabled and at the same time being women makes the situation for WWD one of 'double trouble.' Moreover, it has been wrongly portrayed in Bangladesh that WWD cannot form a family and are incapable of parenting, which constructs a robust negative stereotype. Here, I would mention that being a Bangladeshi human rights activist; I sought to foreground the experiences of WWD in this study similar to what other scholars have done.[5] Though I am not a person with disability, I address these issues as an ally.

Several articles of the international convention are directly relevant to the health care rights of women. The *Convention on the Rights of People with Disabilities (CRPD), 2006,* and specifically Articles 2, 5, 6, 9, 10, 14, 15, 16, 23, and 25, relate to the health care rights of women with disabilities. In the Bangladeshi national legal framework, section 16 of the *Protection of the Rights of Persons with Disabilities Act 2013* and relevant rules on accessibility deal with the health care rights of women with disabilities.

On the other hand, in Canada, the supreme law is the Constitution, including the *Charter of Rights and Freedoms 1982*,[6] which addresses the right of equality and non-discrimination where every individual must receive equal treatment before and under the law. Moreover, people with disabilities must get equal protection of the law without any discrimination. Therefore, the equality rights instruments, i.e., the Charter and statutory human rights legislation, supplement the *Canada Health Act 1984.*[7] Furthermore, in Canada, accessibility legislation aims to remove barriers in various social areas such as goods and services. For instance, the *Accessibility for*

[4] Zelina Sultana, "Agony of Persons with Disability- A Comparative Study of Bangladesh" (2010) 3:2 *J Pol & L* at 212.

[5] Cynthia Brown, *Disability Rights in an Ableist Health Care Environment: How do Women with Disabilities Understand and Address Systemic Barriers to Preventative Community Health Services?* (LLM Dissertation, University of Windsor, 2019), https://scholar.uwindsor.ca/etd/7778.

[6] Canadian *Charter of Rights and Freedoms*, Part 1 of the *Constitution Act,* 1982, being Schedule B of the Canada Act 1982 (UK), 1982, c 11 [Charter].

[7] *Canada Health Act,* R.S.C., 1985, c. C-6, <https://laws-lois.justice.gc.ca/eng/acts/c-6/fulltext.html>.

Ontarians with Disabilities Act, 2005 and its related *Integrated Accessibility Standards Regulation*[8] , referred to as the AODA IASR, set out a process for developing and enforcing accessibility standards for people with disabilities. Accessibility legislation in Canada is thought to be proactive. The primary mode of operation does not rely on complaints via an adjudicative process. Rather it seeks to define the content of enforceable legislation in order to eliminate barriers before they impact people with disabilities.[9] Moreover, the *Accessibility for Manitobans Act* has several underlying philosophical and social goals that refer to the foundational aspirations of equality for people with disabilities.[10] The social areas where it applies mirror the areas of protection found in the Manitoba *Human Rights Code*; namely, persons with disabilities should have barriers eradicated concerning goods, services, facilities, accommodation, employment, buildings, structures, and premises.[11]

However, the impact of these barriers on the lives of women with physical disabilities in terms of their own lived maternity experiences has yet to attract significant academic attention in the law and disability discourse in Bangladesh. As a result, we do not know much about how pregnant women with physical disabilities are treated in their own homes and surroundings, nor do we know much about the medical experiences they have encountered for maternity purposes.

In light of this background, this study will examine the international disability rights instruments, Bangladeshi law, and the Canadian legal framework that ensure maternal health care services for WWD. After exploring the real-life experiences of women with disabilities for this study, policy suggestions will be made on required changes in the Bangladeshi framework

[8] *Accessibility for Ontarians with Disabilities Act*, 2005, S.O. 2005, c. 11 [AODA], https://www.ontario.ca/laws/statute/05a11 and the *Integrated Accessibility Standards Regulation* O.Reg. 191/11 [AODA IASR],
[9] Laverne Jacobs., et al. *Law and Disability in Canada: Cases and Materials* LexisNexis, 2021 at 33.
[10] Laverne Jacobs, Victoria Cino & Britney DeCosta, "The Accessibility for Manitobans Act: Ambitions and Achievements in Antidiscrimination and Citizen Participation" (2016) 5:4 *Canadian Journal of Disability Studies* at 1-24, DOI: http://dx.doi.org/10.2139/ssrn.2753855.
[11] *Ibid* at 3.

and existing laws and policies to remove barriers and encourage effective implementation of the right to maternal health services for WWD.

1.2 Literature Review on Barriers Faced by Women with Disabilities

This literature review identifies qualitative and quantitative studies of resources, surveys, focus group discussions, and in-depth interviews of participants. These studies were conducted in various jurisdictions, including Canada, the United States, South Africa, Zambia, and Nepal, among others. The focus of the studies is to discover various kinds of barriers that women with disabilities face in different countries in order to find some common viewpoints and perspectives.

Baart and Taaka identified significant barriers women with disabilities living in low-income countries face while accessing health care. This study involved an online search of disability-related terms and a review of 16 selective research publications (published between 2012- 2017) based on pre-determined inclusion and exclusion criteria.[12] The study aimed to find out thematic barriers across different countries of low income. The research revealed seven key barriers, with four among them on the demand side (from the side of individuals seeking health care) and three on the supply side (from the side of healthcare providers). The researchers examined 16 articles in the literature from different countries, such as Ghana, Nepal, India, South Africa, and Uganda, supporting the idea that these barriers exist in almost all countries irrespective of income or economic status, or locality.[13] These seven barriers were "lack of

[12] Judith Baart & Florence Taaka, "Barriers to Healthcare Services for People with Disabilities in Developing Countries: A Literature Review" (2017) 29: 4 *Disability, CRB & inclusive development* at 26, https://dcidj.org/articles/10.5463/dcid.v28i4.656/galley/275/download/.
[13] *Ibid* at 36.

information," "additional expense of healthcare," "inadequate access of mobility," "stigmatization," "staff attitude," "communication barriers," and "inaccessible facilities."[14] Baart and Taaka found that there are specific reasons behind each of the barriers. For instance, the underlying issues of lack of information are illiteracy, lack of awareness, and inaccessible information.[15] The study recognized the position of WWD as "additionally vulnerable" due to their gender and, if applicable, pregnancy:

> Mobility-related barriers that fall on the demand side revolve around lack of support from family members to go to health facilities. . . . This situation is an extra worry for women seeking antenatal or maternal health care services, as they are additionally vulnerable due to both their femininity and pregnant condition.[16]

Baart and Taaka indicated some significant barriers, including inaccessible buildings and equipment, i.e., lack of ramps in a hospital or health center, inaccessible toilets and latrines, lack of sidewalks, non-functional elevator or no elevator.[17] Moreover, describing another significant barrier termed as "staff attitude," the authors listed the following examples:

> The negative attitude has been associated with the healthcare staff's lack of understanding of the needs of people with disabilities. . . . The negative attitude is also related to the mind-set that service providers have towards people with disabilities in general. For example, the popular assumption is that people with disabilities are asexual or are simply seen as clients who are incapable of marriage and giving birth.[18]

The authors recommended more research on barriers faced by people with disabilities to better understand the barriers.

[14] *Ibid* at 30.
[15] *Ibid* at 31.
[16] *Ibid* at 32.
[17] *Ibid* at 35.
[18] *Ibid* at 34.

A qualitative study by Drainoni had shown patterns in the categories of barriers experienced by focus group participants living in parts of Massachusetts in 2000.[19] In the study, health care consumers, including parents, caregivers, and advocates, took part in a two-hour focus group discussion. The researchers used the analytic technique of grounded theory to find a model to classify the responses, using the framework set forth by the Institute of Medicine (IOM).[20] The IOM is a nonprofit organization that provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to the public, including policymakers.[21]

The study's objectives were to document the significant barriers to healthcare access and ascertain the impact of these barriers on consumers with disabilities.[22] The researchers developed a comprehensive list of disability barriers to healthcare access in their study, including structural, financial, and personal barriers:

> Structural barriers, involved health insurance, policies and procedure, transportation, physical environment, communication with providers, time constraints and continuity of care. Financial barriers include providers and services, medications, equipment, repairs and supplies. Moreover, the personal barriers include insufficient knowledge, misconceptions about people with disabilities, insensitivity and disrespect, failure to take caregivers seriously, and reluctance or unwillingness to provide care.[23]

The researchers indicated transportation problems exist because of the lack of transportation providers. Consumers with disabilities often needed special forms of transport, like the Medicaid

[19] Mary-Lynn Drainoni, "Cross-Disability Experiences of Barriers to Health-Care Access: Consumer Perspectives" (2006) 17:2 *Journal of Disability Studies* at 101-115.
[20] *Ibid* at 104.
[21] Institute of Medicine, 500 Fifth Street, Washington, District of Columbia, online: <https://www.nchpad.org/Directories/Organizations/2362/Institute~of~Medicine>
[22] *Supra* note 19 at 103.
[23] *Ibid* at 105.

transit system, and they missed appointments due to delays.[24] Moreover, participants complained that they could not communicate effectively with the health service providers due to the limited time. There was also a lack of care in coordination on the part of the staff.[25] Another barrier mentioned by the participants was that they felt insensitivity and a lack of respect from the behavior of the health service providers. For example, one participant mentioned that at a particular large hospital, the front desk staff of the medical care center projected "the attitude that we're all street people."[26] Another participant with a physical disability stated that such behavior was a kind of "abuse," as the providers "acted like everything that happened to me was my fault."[27] The authors recommended a disability-friendly Medicaid program, managed care plans, and appropriate health care facilities by establishing a consumer advisory board. Moreover, removing transportation barriers, providing incentives, and a periodic rating of health plans on "disability-friendliness" were proposed in the concluding section.

Mavuso and Maharaj conducted 16 in-depth interviews of people with disabilities in Durban, South Africa. The majority of the respondents were female.[28] The respondents reported their health care experiences, including antenatal and post-natal care services. In the interviews, women shared terrible experiences in government hospitals during their delivery. Consequently, they avoided public health care institutions for their subsequent delivery and went to private medical centers. [29]

One participant stated:

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[24] *Ibid.*
[25] *Ibid* at 107.
[26] *Ibid* at 109.
[27] *Ibid* at 110.
[28] Sibusisiwe Siphelele Mavuso & Pranitha Maharaj, "Access to Sexual and Reproductive Health Services: Experiences and Perspectives of Persons with Disabilities in Durban, South Africa" (2015) 29:2 *Disability and Gender J* at 1-22, DOI: https://doi.org/10.1080/10130950.2015.1043713.
[29] *Ibid* at 12.

> "In public hospitals, it is very difficult. In my last pregnancy, I utilized the private one. They treat you with dignity because they know you paid. But in the private hospital after my last birth, I felt that I will never come back again because at the time it was even difficult for me to visit the toilet you know, because no one will take you there. No one will think that at least your bed should be closer to the toilet so that you will be able to go and do whatever. It was very difficult, it was not easy."[30]

Moreover, a few female respondents mentioned that the additional costs in transportation, architectural barriers (i.e., using stairs, no lift or elevator service in the medical institution), non-adjustable medical equipment, difficulties finding consultancy rooms, and negligent behavior of the staff should be identified as barriers.[31] Most importantly, being treated with low dignity and respect seemed a significant complaint among the respondents. One female respondent mentioned that it seemed to her that health workers were not ready to accept people with disabilities as sexual human beings, and that the 'mind-set' of the public health service providers should be identified as one of the prominent barriers.[32]

Participants mentioned that the 'unfriendly and insensitive' behavior of the nurses they encountered discouraged them from going to access health care again. For example, one participant mentioned that sometimes nurses acted surprised at a disabled woman having a partner. They sometimes even got angry and scolded them out of anger or irritation that a woman with a disability would be sexually active and fall pregnant.[33]

Participants also mentioned transportation and mobility problems, as health care centers were in different places remote from their residence. This was challenging because they had to arrange private taxis, as public transport was unfriendly. Moreover, they had to walk a long

[30] *Ibid.*
[31] *Ibid* at 14.
[32] *Ibid* at 17.
[33] *Ibid* at 13.

distance before getting public transportation. The public transportation center was also distant from their place of residence.[34]

As it is described by one participant:

> "It is difficult because from here I have to walk to Park Street to get a taxi to the clinic in market because there is no transport that comes to this side but coming back is even more difficult because there is no transport from there to here. I have to get off at West Street and have to walk . . . It is very difficult, can you imagine you are pregnant and disabled."[35]

Participants also complained about non-adjustable medical equipment causing them difficulty during the examination. They also mentioned how impatiently the medical staff acted while struggling to use the non-adjustable equipment.

One participant stated:

> "They are just bad. The beds are too high. You struggle for a long time to get onto the bed and you find that the nurse is scolding you. She scolds and says hurry up, and you cannot climb onto it quickly. It is not properly planned. There is nothing that was designed for a disabled person. There is nothing adjusted to their height, that you can climb easily. You really have to work to get onto the examination bed."[36]

The authors tried to portray the real-life experiences that people with disabilities face while accessing reproductive health care in medical centers in Durban. In addition, they recommended that proper training for health service providers would help remove the barriers discussed in the study.

Story, Schwier, and Kailes shed light on the difficulties that patients with disabilities face during examinations at medical centers. The researchers conducted focus group discussions on

[34] *Ibid* at 14.
[35] *Ibid* at 15.
[36] *Ibid* at 16.

conveniences, comforts, and difficulties they experienced regarding medical examinations.[37] The purpose of this study was to conduct focus groups to discover the most common difficulties with details from the survey to recognize critical issues related to accessibility and usability. In this study, the authors convened eight focus groups to discuss four specific categories of medical devices: examination tables, imaging equipment, medical chairs, and weight scales. The content of the script was divided into five major themes: safety issues, equipment issues, patient's issues, health care provider issues, and environmental issues.[38]

Results show that participants mentioned the discomfort and difficulty they faced because of the contact surfaces of the equipment. Moreover, they had less support while transferring their bodies onto and off the equipment. Furthermore, wheelchair scales were rarely available. In concluding the study, researchers stressed the importance of the availability of equipment with improved design to enhance the medical experiences of persons with disabilities in medical service centers.

Iezzoni et al. conducted a study on medical equipment relating to the use of medical equipment by pregnant women with mobility disabilities.[39] This study involved in-depth interviews with 22 women who had significant mobility difficulties and had given birth within the ten years preceding the study. The researchers identified themes using NVivo, a software program used for qualitative and mixed-methods research. Specifically, it is used for the analysis of unstructured text, audio, video, and image data, including (but not limited to) interviews,

[37] Molly Follette Story, Erin Schwier and June Isaacson Kailes, "Perspectives of Patients with Disabilities on the Accessibility of Medical Equipment: Examination Tables, Imaging Equipment, Medical Chairs and Weight Scales" (2009) 2 *Disabil health J* at 169-179, https://doi.org/10.1016/j.dhjo.2009.05.003.
[38] *Ibid* at 169.
[39] Lisa I. Iezzoni, Amy J. Wint, Suzanne C. Smeltzer, & Jeffrey L. Ecker, "Physical Accessibility of Routine Prenatal care for Women with Mobility Disability" (2015) 24:12 *J of Women's Health* at 1006-1012, DOI: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4683562/.

focus groups, surveys, social media, and journal articles. Results showed that obstetricians of some women had height-adjustable examination tables, which assisted their transfers for physical examinations. Other participants faced difficulties while transferring onto fixed height examination tables. Consequently, their examination was conducted while sitting in their wheelchairs. Interviewees complained about their transfer safety because they received less assistance from the medical staff. Family members and relatives helped them while transferring to and from the examination table. Moreover, some of the women were never weighed during their pregnancies.

Powell et al. conducted a qualitative study involving 25 interviews of women with physical disabilities in the United States who had had babies within the last ten years.[40] The purpose of the study was to shed light on the attitude and reactions of family members toward pregnancy that women with disabilities experienced during their maternity period. The study was conducted through semi-structured telephone interviews that lasted up to two hours. Participants in the study provided information relating to attitudes and reactions from family members, including parents, siblings, grandparents, aunts, uncles, and in-laws.[41] The researchers found six categories of reactions from family members toward their pregnancy. They are "initial negative reaction," "concern about mother's well-being," "questioning on parenting capability," "negative perception on disability," "genetic concerns," and "excited and supportive."[42]

Participants talked about how their family members reacted when they found out about the pregnancy. The study revealed a surprising finding that some family members directly discouraged one respondent from having a baby. One of the interviewees shared the initial

[40] Robyn M. Powell, Monika Mitra, Suzanne C. Smeltzer, Linda M. Long-Bellil, Lauren Smith & Lisa I. Iezzoni, "Family Attitudes and Reactions toward Pregnancy among Women with Disabilities" (2017) 27:3 Women Health Issues J at 345-350.
[41] *Ibid* at 347.
[42] *Ibid.*

reaction she received from her mother, which led her to believe that she was discouraged from having a child:

> "I mean I had – they had known that my want and need of being a mother, and every time I would talk about it my mom would just say, 'Well, someday you can adopt,' or she would just say, 'Well, you have your nieces and nephews, you're close to them.' And kind of let it go, trying to kind of get it out of my mind I think."[43]

Talking about genetic concerns, another participant recalled that their family had a negative impression in their mind that she might be pregnant with a disabled child. She felt that it was strange that they could think that the child would inherit her disability:

> "But I guess it goes back to the family's experience that they feel like that our disabilities kind of traumatize them in a way too and they feel like that they just don't understand that we have the same desires as anyone else might in terms of like to have a biological child and that we don't see our OI (Osteogenesis Imperfecta) as this terrible thing that should be avoided."[44]

The study reflected the family's reactions, responses, and concerns after being informed about the pregnancy of their female family member with a disability. The researchers exposed the attitudinal barriers, which are comprised of social stigma and distorted views on disability. The researchers urged the development of resources to provide peer support and a parenting model for disabled parents so that negative attitudes can be removed regarding their capacity for parenting.

Smith et al. conducted a qualitative study in Zambia that examined the health care system from the perspective of women with physical disabilities and the extent to which it ensures safe

[43] *Ibid* at 347.
[44] *Ibid* at 348.

motherhood. Interviews were conducted with 24 purposively selected women and 25 public sector health service providers under the ambit of the study.[45]

According to the authors:

> Qualitative in-depth semi-structured tape-recorded interviews were conducted with 20 purposefully sampled women with disability. The women with disabilities were recruited through local disabled people's organizations, health services and other interviewees. Purposive sampling was used to recruit women with differing impairments, ages, childbearing history and socio-economic status, in order to obtain data on a wide range of experiences from which commonalities and differences could then be identified.[46]

Results show that WWD encounter physical, social, and attitudinal barriers during pregnancy and while accessing safe motherhood and reproductive health services. It was also found that traditional beliefs among the medical staff create barriers to integrating WWD at antenatal clinics. For example, some medical staff had the belief that disability is transmitted and a mother with a disability will give birth to a child with a disability.[47] Furthermore, they found that "probable complications in time of delivery worsened the situation to the extent that even sometimes healthcare staff like nurses or midwives refused to provide them maternity facilities."[48]

Using the International Classification of Functioning, Disability and Health conceptual framework (ICF),[49] the authors categorized contextual barriers as "physical influences,"

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[45] E Smith, SF Murray, AK Yousafzai & L Kasonka, "Barriers to Accessing Safe Motherhood and Reproductive Health Services: The Situation of Women with Disabilities in Lusaka, Zambia," (2004) 26: 2 *Disability and Rehabilitation* at 121-127, https://pubmed.ncbi.nlm.nih.gov/14668150/.
[46] *Ibid* at 122.
[47] *Ibid* at 124.
[48] *Ibid* at 121.
[49] The International Classification of Functioning, Disability and Health, known more commonly as ICF, is the World Health Organization (WHO) framework for measuring health and disability at both individual and population levels. It is a classification of health and health-related domains. As the functioning and disability of an individual occurs in a context, ICF also includes a list of environmental factors. World Health Organization. Geneva 2001, online: <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health.>

"attitudinal influences," and "social influences." Physical influences include the physical environment, distance to health facilities, and a lack of mobility-assistive devices and public transportation, such as inaccessible minibuses. Attitudinal influences include traditional beliefs, expectations of poor care and bad attitude, the attitude of others, fear of bad reception, complications and cesarean section, unnecessary referral and lack of knowledge about disability. Social influences include poverty, transportation systems, exclusion from health education and community activities, and traditional beliefs.[50] They found that a greater understanding is required for better access to health services for women with disabilities. Such negative attitudes should be addressed by facilitating positive actions like extensive communication services.[51]

Tarasoff reviewed barriers identified in an overview of disability literature concerning perinatal care experiences of women with disabilities. The review was limited only to women with a physical disability.[52] Tarasoff found that women with physical disability experienced "attitudinal barriers," "informational barriers," "physical barriers," "financial barriers," and "systematic barriers" while accessing health care services. Overall, her findings show that women with disabilities face barriers while accessing reproductive health care services, including inaccessible equipment and facilities, limited contraceptive options, health care providers' insensitivity and lack of knowledge about disabilities, financial expenses during pregnancy. In addition, medical service providers often showed less care and had less knowledge about their unique needs.[53] Tarasoff recommended increased medical training and education in nursing school to increase nurses' knowledge and understanding about disability. The researcher also

[50] *Supra* note 45 at 126.
[51] *Ibid* at 127.
[52] Lesley A. Tarasoff, "Experiences of Women with Physical Disabilities During the Perinatal Period: A Review of the Literature and Recommendations to Improve Care" (2015) 36:1 Health Care for Women International at 88-107, DOI: https://doi.org/10.1080/07399332.2013.815756.
[53] *Ibid* at 93-95.

proposed changes in service provisions and legal provisions to ensure equitable and culturally appropriate perinatal care of women with disabilities.[54]

Another study conducted by Tarasoff sought to learn more about the perinatal care experiences and outcomes of women with physical disabilities in Ontario, Canada, as well as to identify perinatal care barriers.[55] In this study, the author mentioned that poverty, poor mental health, obesity, abuse, and a lack of emotional or social support make women with physical disabilities more prone to risk factors linked to poor pregnancy outcomes. Furthermore, women with physical disabilities report facing attitudinal, informational, and inaccessible care settings as barriers to prenatal care. Tarasoff used semi-structured interviews to obtain data for this study. Inaccessible care settings, negative attitudes, lack of knowledge and experience, lack of communication and collaboration among providers, and misunderstandings of disability and disability-related needs were identified as five interrelated themes regarding barriers to perinatal care.[56] Several individuals reported encountering inaccessible perinatal care environments, such as inaccessible washrooms and examining tables. One participant mentioned that:

> "At one point [during the postpartum hospital stay] I'm saying to my husband I want to go take a shower. So I said to them [nurses], "do you guys have a walker I could borrow, or is there anywhere in this hospital, is there a bench?" "No." … they had a floor for people that had suffered strokes, so they said, "the best we can do is you can go up there, they have a walker that's broken, and so it doesn't lock."[57]

Some participants believed that, in addition to a lack of knowledge and expertise, a lack of communication and collaboration among providers may have contributed to some of the negative outcomes that they and their infants had experienced. One participant mentioned:

[54] *Ibid* at 97-102.
[55] Lesley A. Tarasoff, "We don't know. We've never had anybody like you before": Barriers to Perinatal Care for Women with Physical Disabilities" (2017) 10:3 *Disability & Health J* at 426-433, https://doi.org/10.1016/j.dhjo.2017.03.017.
[56] *Ibid* at 427.
[57] *Ibid* at 428.

> "I asked so many times for them to touch base because I know my rheumatologist has had many pregnant women [as patients]. … He has a lot of experience but they never contacted him and I still remember, he was so angry after this whole [situation] because he came to visit me in ICU. So then they finally call me [he said]. But it was already too little, too late. I was in intensive care. I was critically ill. I think I came close to death, including my son. His Apgar score, when he was born, was 0. Luckily it went up. He wasn't breathing because I wasn't breathing."[58]

Participants also indicated that a lack of understanding of disability and disability-related requirements among perinatal care providers seemed one of the major barriers they faced. Some participants claimed that their providers seemed to neglect their disability or disability-related concerns in favor of focusing only on their pregnancy and delivery.

According to one participant:

> "I don't really feel like I was cared for my arthritis very well by the obstetrical staff. There was a risk that I would lose mobility and he wasn't interested in helping me with any of that aspect. *He was just focused on the delivery*. … I requested a prescription to go get afterwards and on the prescription pad for physio, they had put down the wrong diagnosis i.e. M S [multiple sclerosis]." [59]

Some participants said they felt dehumanized by the gestures of the providers while treating them. Further, providers were appeared as uninterested in discussing or acknowledging participants' lived understanding of disability.

One participant mentioned:

> The doctor was really, really unhelpful . . . they had me on my back and I needed to have my knees in the air but they had no equipment to help me keep my knees in the air . . . I was like you're not listening to me at all, you have no interest in listening to me and you just want to get out of here.[60]

[58] *Ibid* at 430.
[59] *Ibid.*
[60] *Ibid.*

The narratives of the participants reveal that movement and mobility constraints caused by disability are not usually the primary issue. Instead, in some cases, participants' persistent discomfort merited more attention than their limits in movement in the context of prenatal care.[61]

Iezzoni et al. conducted another qualitative study on what kinds of societal responses women with substantial mobility disabilities got from the general public throughout their time in the hospital during their pregnancies or shortly after giving birth.[62] The researchers conducted in-depth interviews with 22 women with mobility disabilities and used a mixed-methods investigation of pregnancy among women with chronic mobility disabilities. The study analyzed data of "MGH obstetrical electronic medical records; and qualitative descriptive analyses of in-depth individual interviews, considering a range of topics."[63] The researchers found that that many women with mobility disabilities said that as they became more visibly pregnant, they frequently received unsolicited messages from passers-by and strangers.[64]

Comments typically concerned questions about how the pregnancy had occurred. Strangers sometimes practically demanded responses by constant questioning, expressing emotions ranging from curiosity to animosity.[65] The researchers' analysis suggested that comments fell into six themes: "curious, intrusively and persistently curious," "hostile," "questioning the competence of woman as a potential parent," "oblivious, not recognizing visible pregnancy or motherhood," and "positive." They found that women's reactions could also be grouped into categories - namely: surprised, annoyed, angry, amused, motivated to teach, and

[61] *Ibid* at 432.
[62] Lisa I. Iezzoni, Amy J. Wint, Suzanne C. Smeltzer & Jeffrey L. Ecker, "How Did That Happen? Public Responses to Women with Mobility Disability During Pregnancy" (2015) 8:3 *Disabil and Health J* at 380-387, https://www.sciencedirect.com/science/article/abs/pii/S193665741500028X.
[63] *Ibid.*
[64] *Ibid* at 381.
[65] *Ibid* at 386.

perceived public responses as ‘‘more of the same’’ as a general reaction to their disability. The researchers categorized the results considering the nature of strangers’ statements, offering quotations that exemplify each category.[66]

The vast majority of interviewees agreed on the point that their pregnancy was a matter of curiosity to the strangers. One interviewee said that she was often asked:

> “How did that happen?” and “Are you really pregnant, or is that just a part of your disability?” [67]

Another interviewee discussed her experience where a stranger questioned both her pregnancy and her parenting abilities:

> “I’d be obviously pregnant and going to the store or going to the mall. And you’d get these people that I had one old lady walk by me, and she just had this look of disgust on her face like, “someone would have sex with you?” It was like totally judgmental, and I’m like, “Yep, look lady, it’s there.” It’s just so hard for people to comprehend that people with disabilities will have sexual needs or desires or that they’d want to have children. Curiosity and disability go hand in hand with rudeness a lot of times. Somebody was just shocked that I would consider having a baby because how could I possibly take care of a child?” [68]

Moreover, strangers appeared to be unaware that a woman with a physical impairment may be pregnant or the mother of a baby at times.[69] Lastly, the researchers stressed that such prejudices should be recognized by the doctors by developing strategies to provide the finest quality care to women with mobility disabilities. Consequently, women with mobility disabilities might be able to continue to participate as much as they wish in community life during their pregnancy if they learn ways to reduce stress while interacting with strangers.[70]

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[66] *Ibid* at 382.
[67] *Ibid* at 383.
[68] *Ibid* at 384.
[69] *Ibid* at 385.
[70] *Ibid* at 387.

In completing the literature reviews relating to barriers experienced by women with disabilities while accessing maternal health care services, I realized that every person with a physical disability in Bangladesh suffers from two major barriers which are architectural and attitudinal. It is therefore essential to the thesis that I review the literature on architectural and attitudinal barriers faced by people with disabilities in Bangladesh generally. The next section of the thesis discusses the relevant literature on accessibility in Bangladesh. Researchers worked in different places in Bangladesh to identify barriers relating to mobility in public places and transportation.

1.3 Literature Review on Accessibility in Bangladesh

A qualitative study conducted by Abir and Hoque provides useful information on appropriate engineering solutions to ensure disabled and elderly people's accessibility in Dhaka, Bangladesh.[71] The objectives of the study were to identify movement problems and access deficiencies for handicapped people, to observe the facilities and shortcomings of accessibility for disabled individuals both indoors and outdoors, and to investigate several low-cost, simple to implement accessibility-aiding features.[72] As a case study, they chose two specific areas of Dhaka city, including a center for disability in a development complex, and the Mirpur inter-zonal bus terminal area.[73]

The researchers described the methodology as follows:

> For checking the output of the two approaches, a preliminary survey and visit were conducted. The preliminary survey consisted mainly of a questionnaire survey. It was

[71] M Abir & M S Hoque, "A study on mobility problem of disabled people in Dhaka city," 2011, Bangladesh University of Engineering and Technology, *4th Annual Paper Meet and 1st Civil Engineering Congress*, ISBN: 978-984-33-4363-5, https://iebconferences.info/abir.pdf.
[72] *Ibid* at 153.
[73] *Ibid* at 157.

conducted among twenty people with different types of disabilities. The results of the questionnaire survey were basically personal experiences related to accessibility.[74]

The researchers found that the major deficiencies for accessibility in public roads included a lack of a footpath landing, a discontinuous footpath due to frequent access from road adjacent abutting properties, illegal and nuisance parking on the footpath, uneven surfaces, signboards, merchandise, and garbage on sidewalks, the presence of unwanted obstructions, disordered pedestrian movement, and improperly installed ramps.[75] Further, they found that there is no way that people with disabilities could get a seat on any public bus because there are no ticket counters for local buses and drivers slow down for loading or unloading passengers.[76]

[74] *Ibid* at 155.
[75] *Ibid* at 155.
[76] *Ibid* at 156.

(The photographs are taken from Abir and Haque 2011)

The study found that the most common constraints to accessible transportation are that most bus operators do not comply with the mandatory rule to keep seats reserved for the disabled, and accessibility is also denied by the helpers of buses. Helpers are those who work as a fare collectors and help passengers to enter into or get off the vehicle. Further, busses have high entry steps with high risers, and the distance from the ground to the first step is typically between 30 cm and 50 cm, which may be impossible for a person using a wheelchair to use. There are no ramps or grab rails at the entrance point of boarding, and the floor surfaces of the vehicles are slippery. In public buses, seat spacing is narrow, so it is inaccessible for leg or wheelchair movement.[77]

Lastly, the researchers recommended that in the process of renovation, all public places should be considered. Areas such as hospitals, including surrounding footways and bus stops,

[77] *Ibid.*

should be highlighted. Accessible environments for disabled people can be easily guaranteed with proper architectural arrangements.[78] They also emphasized social awareness among the people with disabilities to claim accessibility as their right and the imposition of legal provisions to ensure full accessibility in public places.[79]

Similarly, ABM Touhid studied the Dhaka City Corporation (DCC) area with the objective of ascertaining the accessibility condition of urban services and facilities for physically challenged people.[80] Generally, DCC is considered as one of the busiest places full of residences, offices, and other establishments. The study found that only 21.4% of bus terminals of the Dhaka city corporation area had provisions to install ramps, and only 7% of them had maintained the proper slope. Further, 60% of the road widths were not suitable for wheelchair users. Another major obstacle was uninterrupted and unsmooth footpaths and sidewalks; only 20% of the footpaths were free from obstacles.[81] He mentioned that almost 42% of the health institutions of Bangladesh do not have ramps with standard slopes, so it becomes very hard for the patients to enter the institutions.[82]

In a quantitative study by Fauzia Farzana (2018), guidelines from Bangladesh National Building Code (BNBC) 2008 and a shortened version of the *Americans with Disabilities Act Accessibility Guidelines (ADAAG)* were used to find out the accessibility challenges for wheelchair users of Khulna division. Facilities were evaluated in terms of their accessibility and usability based on a variety of factors.

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[78] *Ibid* at 161.
[79] *Ibid.*
[80] ABM Touhid, "A Study on Accessibility of Physically Challenged People to Some Selected Urban Services and Facilities in Dhaka" (2007) *Department of Urban and Regional Planning, Bangladesh University of Engineering and Technology (BUET)* at 11, http://lib.buet.ac.bd:8080/xmlui/handle/123456789/2929.
[81] *Ibid* at 30.
[82] *Ibid* at 86.

Farzana found that in Khulna, a major division of Bangladesh, only 6.7% of public buildings (five buildings among 75 buildings) had suitable access for people using wheelchairs.[83] Moreover, in 28 percent (21 buildings) of the buildings, improvements were possible that are now inappropriate for wheelchair users, After visiting the public buildings in Khulna city, including government offices, public schools, colleges and universities, hospitals, libraries, post offices and court buildings, it was found that there were fewer opportunities to access parking, ramps, elevators, doors, and essential interior facilities, like water closets and drinking-water fountains, for people with disabilities. Other than a few single-storied schools, all the buildings under the survey were multi-storied, but there were elevators in only 12% of public buildings.

Parking is available in 16 percent of public buildings, for example. However, just half of the buildings (10.7 percent of the total) meet two of the three parking requirements for wheelchair accessibility. There isn't a single public building under the survey that has an accessible parking lot with adequate signs. Only one of the buildings with ramps includes handrails, which are required for wheelchair accessibility.[84] Only two educational buildings, two hospitals, and one public bank had doors that were at least 80% accessible.[85]

According to Farzana (2018), with a few simple alterations, 24% of the listed public buildings could be made accessible and appropriate within a limited period of time. Signage, ramps with handrails, door width extensions, and lavatory renovations are all considered simple changes that can be made to make the listed buildings more accessible.

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[83] Fauzia Farzana, "Accessibility of Public Buildings in Khulna, Bangladesh for wheelchair users" (2018) 29 (4) Disability, *CBR and Inclusive Development* at 83, https://www.academia.edu/39184361/Accessibility_of_Public_Buildings_in_Khulna_Bangladesh_for_Wheelchair_Users.
[84] *Ibid* at 89.
[85] *Ibid* at 90.

Farzana concluded by emphasizing the importance of the systematic inclusion of people with disabilities into the economy and society by developing and producing barrier-free infrastructure at the national level.[86]

A quantitative study conducted by Aleya Akter and Mizanur Rahman aimed to expose the real situation of women with disabilities relating to access to public transportation and institutions.87 Data for this study was gathered through personal interviews with the Women with Disabilities Development Foundation (WDDF) personnel and Disable Peoples Organizations (DPO) activists, as well as focus groups with 50 randomly selected women with disabilities from the database of WDDF. Among the respondents, thirty percent (30%) of the women were physically disabled, and the age groups of the respondents were divided into five categories: 15-19, 20-25, 26- 30, 31-40, and over 40.[88]

It was discovered that it was often difficult for women with disabilities to access public and private transportation since they were not designed for impaired people. As a result, more than 60% of respondents were unable to take the bus because buses were not wheelchair accessible, and buses were too crowded for crutch users. The respondents' modes of transportation revealed that the majority of them relied on rickshaws to travel short distances with the assistance of friends and family. Simultaneously, they relied on trains and buses to go long distances, despite the fact that none were wheelchair accessible.[89] Further, according to the respondents who travelled by train, there was no accessible compartment on any train for women who use a wheelchair or crutches. Despite varying levels of complexity, 60% of those surveyed attempted to go by rail. Ticket desks, waiting areas, and washrooms were completely

[86] *Ibid* at 95.
[87] Akter and Rahman, *supra* note 2 at 1.
[88] *Ibid.*
[89] *Ibid* at 5.

inaccessible and unsafe for all sorts of women with disabilities, despite the fact that a small number of rail stations had built ramps.[90]

Overall, results showed that nearly 90% of public institutions, including schools, colleges, universities, technical educational institutes, hospitals, and workplaces, were unavailable to women with disabilities. Lack of access to public institutions deprives them of basic rights like access to education, government services, and amenities. Although ramps were built in less than 10% of public institutions without elevators, washrooms, waiting rooms, classrooms, and office spaces, including educational and working equipment, were inaccessible to women with disabilities, according to the respondents. As a result, a ramp at the entry was insufficient and could not provide accessibility for those with disabilities.[91]

Another important result was found that forty percent (40%) of the respondents of the study were unaware of the legislation and policies governing the accessibility of people with disabilities in public transportation and institutions, while 60% of the respondents noted that, despite the fact that several laws and policies addressing the specific needs of people with disabilities in terms of accessibility had been enacted, these laws and policies had not been implemented.[92]

The researchers recommended that to guarantee the independent and secure movement of women with disabilities, footpaths, footbridges, underpasses, and zebra crossings should be made accessible for their mobility. Women with disabilities should have access to public

[90] *Ibid* at 6.
[91] *Ibid* at 7.
[92] *Ibid* at 9.

institutions such as schools, colleges, universities, technical educational institutes, hospitals, and workplaces to get public services, including health services, as their fundamental right.[93]

They also recommended that legislation, policies, and orders for making public institutions and transportation accessible should be adopted, formulated, and modified in light of the special needs of women with disabilities. Moreover, consultation with Disabled Peoples Organizations (DPOs) should be ensured, as they can represent and contribute as a stakeholder. A strong monitoring and mechanism system should be developed consisting of city development institutions, transportation-related agencies, departments, and ministries, which should work with proper coordination.[94]

According to some media reports, despite being the capital of Bangladesh, even in Dhaka, only a few buildings have pavements and ramps for disabled persons. Some examples include the National Museum, the Parliament Building, Mirpur National Stadium, Bisso-shahitto Kendra Bhaban, the University of Dhaka, and the Daily Star Building. It has also been alleged that even in some ministry buildings, there are no ramps or lifts so that a person with a physical disability can go there.[95] It is also found from research conducted by B-SCAN that there are difficulties faced by people with disabilities while accessing public transport due to certain barriers. In the selected areas, footpaths are lower than a bus's entrance landing, with a drain between the footpath and the road. The ticket counter is too high for a wheelchair user, and there is no shade to shield from rain, sunlight, or any other adversity. Moreover, the entry to the bus stop does not have a ramp. The difference in elevation between successive strata in the entry and road is a significant impediment to independent mobility for wheelchair users and people with

[93] *Ibid* at 10.
[94] *Ibid* at 11.
[95] "Capital offers no facilities to physically challenged people", *The New Age Bangladesh* (11 October 2016), online: https://www.newagebd.net/article/607/capital-offers-no-facilities-to-physically-challenged-people.

cerebral palsy and other physical disabilities.[96] The Airport Railway Station (Uttara), Airport Bus Station (Uttara), One Individual Private Transport (Bus), Shadarghat Launch Terminal, Teachers-Students Center (TSC) of the University of Dhaka, a public toilet at Pantha Kunja, and the Head Office of Department of Women Affairs (DWA) were selected as research areas for the study. [97]

1.4 Summary of the Literature review

Some major common themes appeared from the literature review relating to the barriers to accessing maternal health services by women with disabilities. Barriers, including physical, environmental, and attitudinal, were often identified in the literature. Barriers include lack of accessible transportation, inaccessible road design, inadequate access to mobility, lack of ramps, elevators in establishments, lack of washroom access and non-adjustable medical equipment are found as structural and architectural barriers. Further, limitations of the health care system, including lack of medical professionals' knowledge and sensitivity about disability, insensitive and unfriendly attitude of the health care staff, lack of respect, lack of knowledge, and traditional beliefs of the health care staff, came into the discussion. Moreover, negative mindsets and stigmatizing women with disabilities during and about their pregnancy by their family, healthcare professionals, and the public at large were cited in several studies.

1.5 Real-life Stories:

Additionally, to get a realistic view of the barriers WWD are facing all over the world with respect to pregnancy in healthcare, some real-life stories are discussed below. The first story is of a Bangladeshi woman who shared her story with me, and the rest of the stories have been

[96] Accessibility Audit Report 2018, "Study on Situation of Access to the Infrastructures of Public Service Institutions for Persons with Disabilities" (2018), published by *B-SCAN* at 26, online: http://en.b-scan.org/study-on-situation-of-access-to-the-infrastructures-of-public-service-institutions-for-persons-with-disabilities-2018/.
[97] *Ibid* at 23.

collected from online sources.

Story 1:

X, a 30-year-old woman with a physical disability, has two children. She had her first child several years ago, and her second child was only one month old at the time when she told me her story. After marriage, she encountered discrimination and a negative attitude from her in-laws. They assumed that she could never be a mother. Some said that she might give birth to a child with a disability. However, her parents always encouraged her to have a child. She and her husband decided to do a pre-checkup before conception. The doctor told her that she was physically healthy and capable of giving birth.

The major challenge she faced during her pregnancy was mobility. She had a tough time while going to a medical center. Her husband used to take her to the hospital by pushing her wheelchair all the way. It would take almost an hour to reach the hospital using this method. Moreover, she found it hard to get to the doctor's examining room because there were stairs, and her husband needed to carry her up the stairs with the help of another person. So, without any help, she could not reach the hospital or the exam room. She mentioned that due to the lack of accessible transportation, she could not go to the government hospital, which was far from her residence. So she had to pay more to take medical treatment in a private clinic, which was near to her residence. She had no other choice to make.

Due to her physical disability, she uses a manual wheelchair. She could not afford an electric wheelchair, which may cost up to 80,000 taka (approximately $1200 CDN).

She also faced structural barriers to accessing public buildings. Even in her rented apartment, she could not move comfortably. The toilet of the apartment was not accessible, and

even in some public places, there are no toilets for wheelchair users. Surprisingly, in the hospital, she found no disability-friendly toilet.

She was happy with the treatment she received from her gynecologist during her pregnancy. However, she faced structural barriers (i.e. the door of the doctor's office was not wide enough for her to enter with a wheelchair, and she faced difficulties using the examination table). The examination table was much higher than her wheelchair, so she could not get up easily on that. She was happy with how her gynecologist assisted her during the pregnancy. But when she asked her doctor about the toilet and inaccessible medical equipment, the doctor told her that she could not do anything about it. Due to her mobility issues, she went only 4-5 times to the hospital for check-ups. She had two cesarean sections and found the service good. She mentioned that sometimes the medical staff did not listen to her when she tried to ask for some information. She felt that the medical staff was insensitive and inattentive to her needs.[98]

The experiences of the mother in Story 1 has similarities not only to the experiences reported in the literature review but also to this second story which was reported on healthtalk.org, a medical education website in the United Kingdom.

Story 2:

One mother, aged 39, thought she would never have children because she was told she had multiple sclerosis. She had to go for many medical tests to make sure that she would give birth to a healthy child, as it would be hard for her and her partner to cope if they had a child with a disability. She mentioned that it was almost like expecting a perfect child who would not need any extra care. Later, she was determined to have a baby when the doctor told her that her

[98] Interview taken on 27 April 2021; the interviewee wishes to be anonymous.

disability would not be an obstacle after all. Having a physical disability herself made her feel she could not cope with a baby with a disability, so she was very anxious about antenatal screening. Her feelings about it were different from many of her friends. They understood her condition and gave her mental support. She would have liked more contact with other pregnant women, but this was sometimes difficult. For instance, there was no wheelchair access to local National Childbirth Trust (NCT) antenatal classes where she stayed. Practical advice from her local hospital and the Disabled Parents Network helped her. The Disabled Parents Network also advised her on cots and pushchairs.

She pointed out that she received some negative comments from her acquaintances about the complications of having a child. However, she found it helpful to talk to other women with disabilities having a baby and got some helpful tips about pregnancy. She also mentioned her horrible morning moments and noted the importance of having company and family support during the period of pregnancy.[99]

The mother of the second story had hesitation while deciding on having a child which is also found in Story 3. But both of them eventually decided with the help of an efficient medical team though they had to face anxiety and negative comments from some people surrounding them.

Story 3:

Alyssa, a woman with spinal cord injury living in the United States, celebrated her pregnancy after giving birth to a boy. Her spinal cord injury (SCI) is severe (c1, c2), and for that, the left side of her body is weaker than the right side of her body.

[99] Pregnancy with another condition or disability, *Healthtalk.org.*, online, <https://healthtalk.org/pregnancy/pregnancy-with-another-condition-or-disability>.

In 2018, she got married, and from the beginning, she was worried about whether her spinal cord injury and having one ovary would affect her pregnancy, so she went for a check-up with the doctor. The doctor assured her that she could have a baby, though she might have difficulties conceiving. She got negative feedback from other people around, but she decided to have a baby.

She documented her pregnancy on Instagram,[100] attracting 51 000 followers. She communicated with other women through Instagram and shared her experiences, including complications. In addition, she inspired other women with spinal cord injuries to have babies and go to doctors to seek medical advice.

She gave birth to a boy in spring 2021 during the COVID-19 pandemic. She asked people "to see the person, not the wheelchair" and is trying to break down the society's stigma by encouraging women with wheelchairs to get pregnant and have babies. She mentioned on her social media that having a child is not brave; it is about being "normal", and people using wheelchairs are "normal". She said she had to take many precautions because of her disability, but every woman carrying a child worries about her unborn child. It is a part of pregnancy to be worried, but it does not mean that every woman will have the same difficulty. She stressed that awareness about pregnancy must be brought to women with a disability so that they know they can carry a baby. She tried to show the able-bodied people that women with disabilities can do anything they set in their minds to do.[101]

[100] Alyssa Higgins, "wheel.life.in.the.wheel.world", *Instagram Account www.instagram.com*, online: https://www.instagram.com/wheel.life.in.the.wheel.world/?hl=en.
[101] People are Wholesome. "Woman with Spinal Cord Injury Celebrates Getting Pregnant After Years of Uncertainty" (January 18, 2021) Video 5:10, online: <https://www.youtube.com/watch?v=Ec_agYuEsM4>.

The mother of Story 4 had to face a similar attitudinal barrier from her health care professional in the first instance. Though later, she regained her confidence when the specialist medical team took charge of her pregnancy. She had experienced structural barriers like accessible medical equipment as well.

Story 4

E. Erin Andrews shared her pregnancy experiences in the American Psychological Association newsletter. She mentioned some challenges she faced as a pregnant woman with a disability. When she found out about her pregnancy, she was excited. Still, being a wheelchair user, she had concerns about people's attitudes towards her pregnancy. She was surprised when her first gynecologist did not expect the news of her pregnancy and was uncomfortable with the fact that she was having a baby. She referred her to a high-risk specialist, assuming that her pregnancy would be complicated. Moreover, Erin was also referred to meet a genetic counselor, though she knew that there was no genetic component to her disability. However, after examining her, the perinatologist told her that everything was going well, and she might try for a vaginal delivery rather than a caesarian section. Later, she was treated by a knowledgeable and supportive specialist team, who assisted her and gave her confidence in this period. The health care team provided her with information relating to potential adaptive tools and strategies to assist with pregnancy and parenting. The multidisciplinary health care team made her delivery easy and took postpartum care of her.

However, she faced physical barriers when went for obstetrical and gynecological care. She was disappointed that her office did not have an accessible scale or exam tables that could be

adjusted for easier transfer. She expected adaptive equipment (i.e., wheelchair-accessible cribs and changing tables) in the examining room of her gynecologist. [102]

1.6 Summary of the Real-life Stories

So, from the real-life experiences, it is understandable that women with disabilities face similar challenges while receiving maternal health treatments regardless of jurisdiction. They highlighted their dissatisfaction with the architectural and physical barriers they encountered in establishments, public transportation, roadways, healthcare facilities, and even physicians' offices. Furthermore, they exposed attitudinal hurdles they encountered with insensitive behavior and a poor perception of their disability from their family, acquaintances, and health professionals.

This chapter has mainly focused on the prominent barriers faced by WWD while accessing maternal health services. From the literature review and real-life experiences I have tried to find out the legal issues and framework to address these challenges which will be discussed in Chapter two and three. In the next chapter, provisions of the international law on disability that are relevant to removing these above-mentioned barriers under the human-rights approach will be discussed.

[102] E. Erin Andrews, "Pregnancy with a physical disability: One psychologist's journey" (2011) *Spotlight on Disability Newsletter* , online: https://www.apa.org/pi/disability/resources/publications/newsletter/2011/12/pregnancy-disability.

Chapter-2

Significance of the United Nations Convention on the Rights of Persons with Disabilities (CPRD) and Models of Disability

From the discussion in the previous chapter, it is apparent that there are significant barriers to maternal health services facing women with disabilities. To see those barriers through the human rights lens and find practical solutions, international human rights law must be discussed, as it constitutes a legal frame of reference. In this regard, this chapter discusses the relevant provisions of CRPD that are relevant to the thesis and how these provisions relate to the perspective of Bangladesh. Moreover, provisions relating to state obligations have also been discussed, as they assist to develop legal and policy reform suggestions to Bangladesh that take into account the best practices of Canada. Further, to understand the paradigm shift (major change in notions) in the development of the disability discourse, the significance of the convention and models of disability have been discussed with reference to the academic literature.

2.1 Relevant Provisions of the CRPD relating to Maternal Healthcare Services of Women with Disabilities

The *United Nations Convention on the Rights of Persons with Disabilities*, [103] which will be referred to for the discussion, henceforth, as the CRPD. Because of its broad scope, global acceptability, and noble objectives it is considered as one of the most important treaties that

[103] CRPD, *supra* note 1at Art.1.

United Nations ever drafted.[104] Moreover, it has illuminated that individuals with disabilities have the right to equality, education, housing, employment, dignity, and independence.[105]

Before the convention, seven United Nations treaties protected the rights of people with disabilities, referred to as "soft laws." [106] Michael Waterstone discusses the factual background, mentioning that in 2001, the United Nations Ad-hoc Committee considered drafting a new human rights instrument, and from 2002 to 2006, it had eight sessions. In 2006, for the first time in UN history, the convention and its optional protocol were adopted. On the day of its adoption, the convention had the highest number of signatory states, demonstrating the importance of such a convention.[107] At the end of December 2007, 120 states had signed the convention, and 67 states had signed the optional protocol.[108]

The CRPD refers, in its purpose section, 'people with disabilities' as including people who have long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.[109]

Further, the CRPD outlines that the purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity. This article implies an obligation of the states to comply to promote (encourage recognition of), safeguard (avoid

[104] Marc Stolman, "International Disability Law: A Practical Approach to the United Nations Convention on the Rights of Persons with Disabilities", (2019) 34: 9 *Disabl & Soc* at 1518-1520, https://www.tandfonline.com/doi/full/10.1080/09687599.2019.1623526?scroll=top&needAccess=true.
[105] *Ibid.*
[106] Michael Waterstone, "The Significance of the United Nations Convention on the Rights of Persons with Disabilities" (2010) 33:1 *Loyola Int'l & Comp L Rev* at 1.
[107] *Ibid.* at 2.
[108] Report of the Secretary General as to the Statute of the Convention on the Rights of People with Disabilities and Optional Protocol, 14 August 2007, A/62/230 at para 4.
[109] CRPD, *supra* note 1 at Art.1.

interference with), and ensure (allow the realization of) human rights and fundamental freedoms of PWD.[110] It signifies that states must adopt the convention's terms in national laws, policies, and programs and repeal any national legislation in conflict with the convention.[111]

Additionally, the convention proposes the following principles, which provide a list of propositions that states must observe. The principles are:

a. Respect for the inherent dignity and individual autonomy, including the freedom to make one's own choices and independence of persons;
b. Non-discrimination;
c. Full and effective participation and inclusion in society;
d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
e. Equality of opportunity;
f. Accessibility;
g. Equality between men and women; and
h. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.[112]

In addition to that article 5 of the convention discusses the principle of equality and non-discrimination:

> 1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
>
> 2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
>
> 3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
>
> 4. Specific measures which are necessary to accelerate or achieve *de facto* equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

[110] See CRPD, *supra note 1* at Art. 4.
[111] *Ibid.*
[112] *Ibid* at Art. 3.

This article broadens the official definition of discrimination, by embracing all forms of discrimination and requiring signatory states' governments to make necessary changes and adaptations to remove barriers that impede people with disabilities from enjoying equal access to human rights. Thus, the government of Bangladesh must take active measures not only to remove and eradicate structural, environmental, and communicative barriers but also to make Bangladeshi society more accessible for people, including women, with disabilities.[113]

In defining the term "discrimination," the convention incorporates certain forms of discrimination: direct discrimination, indirect discrimination, denial of reasonable accommodation, and harassment.[114] Moreover, through the convention, a new paradigm called 'inclusive equality' has been established. It elaborates the content of equality in certain ways: (a) a fair distributive dimension to address socio-economic disadvantage, (b) a recognition dimension to combat stigma, stereotype, and prejudice, (c) recognition of human dignity and intersectionality; and (d) full recognition of humanity through social participation.[115]

Further, Article 6 of the CRPD specifically refers to women with disabilities (WWDs) as a group. States parties must refrain from discriminatory actions and take affirmative measures to empower WWDs, increase their self-confidence, and give them more power and authority to make decisions as distinct right holders.

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[113] Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh, A report submitted to the Office of the High Commissioner on Human Rights (OHCHR) in accordance with Article#35 Paragraph#1 of the CRPD, August 2010, Published by *National Disabled Development Foundation*, online: https://jpuf.portal.gov.bd/sites/default/files/files/jpuf.portal.gov.bd/page/bf5ce7bb_e218_4526_90f1_1129defe4cfa/Report%20of%20UNCRPD%20(1).docx.

[114] UN Committee on the Rights of Persons with Disabilities (CRPD), "General comment No. 6 (2018), Article 5: on Equality and non-discrimination", 26 April 2018, CRPD/C/GC/6 at 3, online: https://digitallibrary.un.org/record/1626976?ln=en.

[115] *Ibid* at 4

It is assumed that women would be able to enjoy the rights outlined in the convention if states parties worked towards achieving and encouraging these aims using suitable means in all of the Convention's areas of concern.

Specifically, Article 6 of the CRPD mentions that:

> 1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
>
> 2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.[116]

The general comments published by the UN Committee on the Rights of Persons with Disabilities mentioned that discrimination against disabled women and girls could take various forms, including direct or indirect discrimination, discrimination by association, denial of reasonable accommodations, structural and systemic discrimination, and so on.[117] Wrongful stereotyping of disability and gender is a form of discrimination that negatively influences sexual and reproductive health and rights, as well as the ability to have a family. Harmful stereotypes regarding disabled women include ideas that they are asexual, inept, irrational, weak, or hypersexual.[118]

This article is focused on the perspective of Bangladesh because, in Bangladesh, women with disabilities are being treated as a burden on the family. Being women and disabled, they suffer from intersectional discrimination on account of their gender and disability. Due to lack of

[116] See CRPD, *supra* note.1 at Art. 6.
[117] UN Committee on the Rights of Persons with Disabilities (CRPD), "General comment No. 3 (2016), Article 6: Women and girls with disabilities", 2 September 2016, CRPD/C/GC/3 at 6, online: https://www.refworld.org/docid/57c977344.html.
[118] *Ibid* at 11

accessibility and stigmatization, they are not encouraged to go to school, health care centers, or even to a relative's house. In Bangladesh, I have seen that WWD are not encouraged to get married or form a family because people have a misconception that disability is contagious. They are also often treated as weak, abnormal, or problematic. Such harmful stereotypes may lead to discriminatory behavior by the family and public officials, including health service providers and social service providers.

Also relevant to the discussion, the convention describes the term 'accessibility' as follows:

> To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:
>
> a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
>
> b) Information, communications and other services, including electronic services and emergency services.[119]

Further, it also emphasizes that states parties must ensure minimum standards for accessibility for people with disabilities, along with training for stakeholders. Accessibility provisions include public signage in Braille, easy-to-read forms, guides, readers, professional sign language interpreters, and access to communication technologies.[120]

This article is relevant to the obligation of the Bangladesh government to create an accessible environment, including public spaces, including roads, establishments and service

[119] See CRPD, *supra* note 1 at Art. 9.
[120] *Ibid.*

centers. Moreover, it focuses on the special needs and specific arrangements for people with a particular disability that Bangladesh must provide, based on its signed formal agreements.

Next, Article 20 of the Convention is directly related to this thesis in relation to personal mobility. It proposes the following state obligations:

> States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:
>
> a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at an affordable cost;
>
> b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at an affordable cost;
>
> c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;
>
> d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities. [121]

This article is very important to comply with because WWD faces mobility barriers that prevent them from accessing public services in Bangladesh, including maternal health services. Thus, the article confers liability to Bangladesh to adopt effective steps to ensure personal mobility for persons with disabilities with the greatest possible independence at a reasonable cost. Moreover, it stresses the accessibility training of mobility aid services providers and staff, and makes mobility aids and devices available and affordable to people with disabilities.

Further, Article 23 of the convention also mentions the advancement of respect for family life and the implications of reproductive health care:

> 1. States Parties shall take effective and appropriate measures to eliminate

[121] *Ibid* at Art. 20.

> discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:
> a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;
>
> b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;
>
> c) Persons with disabilities, including children, retain their fertility on an equal basis with others.
>
> 2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

Another article most relevant to this thesis is Article 25, which provides a comprehensive overview of the health rights of people with disabilities. It states that:

> States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:
>
> a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
>
> b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
>
> c) Provide these health services as close as possible to people's own communities, including in rural areas;
>
> d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by,

inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

e) Prohibit discrimination against persons with disabilities in the provision of health insurance and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.[122]

These two articles oblige states parties, including Bangladesh, to take all necessary steps to ensure that people with disabilities have full access to gender-sensitive health services, including health-related rehabilitation. Moreover, persons with disabilities must have access to the same range, quality, and level of free or affordable health care and programs as other people, including sexual and reproductive health. The state is also bound to make those health care services accessible, and appropriate health programs should be designed from the early identification to minimize and prevent further disability.

Additionally, they must get quality service from health care professionals and services according to their needs and must be treated with dignity and without any discrimination. So any discriminatory denial of health care or health services should be prohibited by the state.

According to Article 33 of the Convention, state parties, including Bangladesh, are obliged to maintain, strengthen, designate, or establish independent mechanisms, including coordination mechanisms within government for matters relating to the implementation of the present Convention. Moreover, the government should give due consideration to the establishment or designation within the government to facilitate appropriate action in different sectors and at different levels according to their status and functions. Moreover, disability

[122] *Ibid* at Art. 25.

organizations should be included in the monitoring process of government as representatives of people with disabilities for authentic feedback.

It is mentioned as that:

1. States Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention. When designating or establishing such a mechanism, States Parties shall take into account the principles relating to the status and functioning of national institutions for protection and promotion of human rights.
2. Civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process.[123]

The CRPD was ratified by Canada on 11 March 2010, and it entered into force on 12 April 2010. Later, on December 3, 2018, Canada ratified the Optional Protocol to the Convention on the Rights of Persons with Disabilities. Bangladesh became a signatory state party of CRPD on 9 May 2007 and ratified the convention on 30 November 2007. Further, Bangladesh signed the optional protocol as the 16th member on 12 May 2008. So, if Canadians and Bangladeshi people consider their rights under the CRPD to have been violated, they now have the option to file a complaint.

2.2 Why was the CRPD needed?

In the United Nations report published in 2002, the authors Quinn, Degener, and others described the potential of the United Nations human rights instruments in the context of disability. [124] The authors, through the report, discussed shifting to a human rights model of

[123] *Ibid* at Art. 33.

[124] Anna Bruce, Gerald Quinn, Theresia Degener, Christine Burke, Shivaun Quinlivan, Joshua Castellino, Pradaic Kenna, and Ursula Kilkelly, "Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the Context of Disability", (2012) *United Nations Press*, online: https://www.ohchr.org/Documents/Publications/HRDisabilityen.pdf.

disability, evaluated other human rights instruments existing at that time, examined the prospects of a new convention, and recommended one.

The convention was substantially considered for the first time at a worldwide summit of the World Program of Action in 1987 when Italy developed a draft treaty and presented it to the General Assembly. International disability NGOs from different countries and other stakeholder groups have supported the notion of a new convention since then. Later, in 2000, an international summit on disability was held in Beijing, where the participants passed a declaration known as the Beijing declaration. This declaration is still considered today as the moral authority to the idea of drafting a new international convention.[125] The declaration stated that:

> 5. We share the conviction that the full inclusion of the people with disabilities in society requires our solidarity in working towards an international convention that legally binds the nations . . .
>
> 6. We believe that the inception of the new century is an opportune time for the people with diverse disabilities and their organizations . . . members of the United Nations system . . . to collaborate closely in an inclusive and wide consultation process aimed at the development and adaptation of an international convention…
>
> 7. We therefore urge all heads of the state and governments . . . to immediately initiate the process for an international convention…
>
> 9. We hereby send out a call to action . . . to ensure the adoption of an international convention on the rights of all people with disabilities.
>
> 10. We commit our respective organizations to strive for a legally binding international convention . . .[126]

Moreover, the authors provided reasons in the last chapter of the report for why a new convention was needed. First, they mentioned the 'visibility' argument. The debate about 'visibility' was symbolic, and it meant that the episodic scrutiny of six distinct treaty monitoring

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[125] *Ibid* at 293.
[126] *Ibid* at 234.

procedures does not provide justice to 600 million people.[127] So, a unique convention would at the very least send a message to the rest of the world that this group of people exists and has equal rights, ambitions, dreams, and aspirations.[128] Second, the authors of the report argued that condensing the necessary human rights standards into a single legal instrument would work much better. It would clarify the obligations of States Parties and provide a clear aim for disability NGOs to work for disability rights in a holistic sense. Third, they argued that the connected human values of dignity, autonomy, equality, and social solidarity principles that cut across all six documents would be amalgamated into one.[129] Fourth, civil and political rights, on the one hand, and economic, social, and cultural rights, on the other, are linked and interrelated. So, combining those rights into one convention would emphasize the need for a holistic approach to disability. [130] Fifth, one comprehensive convention on disability would not affect the earlier provisions of the mainstream human rights instruments or nullify them. Still, it would enhance the chance of implementation of the rights.[131] Sixth, the adoption of a new convention could be perceived as a victory for the logic and spirit of the Standard Rules on equalization of opportunities for people with disabilities.[132]

So it was the necessity of time to draft a new convention that could fully cover the human rights and values to protect people with disabilities from inequality and discrimination.

Now this section provides an overview of the shift to the human rights model as described by the key scholars in the field. As their work highlights, the move to the human rights model

[127] *Ibid* at 295.
[128] *Ibid.*
[129] *Ibid* at 296.
[130] *Ibid.*
[131] *Ibid* at 297.
[132] *Ibid.*

emphasizes dignity and autonomy and the possibility of more effective disability advocacy for people with disabilities.

2.3 Significance of the CRPD

It has been widely accepted by United Nations organizations, stakeholders, academicians, and professionals that the CRPD has shifted the perception of disability. The main reason behind the shift is the incorporation of the human rights model into the convention.

While describing the significance of the CRPD, Kayess and French mentioned that the UN Secretary-General claimed that the convention could be considered as the "dawn of a new era," and that in this era, no people with disabilities would endure discriminatory practices and attitudes.[133] Later, the European Disability Forum president, Yannis Vardakastanis, speaking at a disability forum, referred to the English translation of the following lines from "The Ballad of Mack the Knife" from The Threepenny Opera in 1928:

> Some there are who live in darkness
> While the others live in light
> We see those who live in daylight
> Those in the darkness out of sight.
> This convention to bring those in darkness into light. [134]

Moreover, in the course of negotiations, the chairman of the Ad-hoc committee that developed the convention's text described the CRPD as representing a "paradigm shift" away from social welfare response to a rights-based approach. The convention had rejected the "view of persons with disabilities as objects of charity, medical treatment and social protection." It

[133]Rosemary Kayess & Phillip French, "Out of Darkness into Light - Introducing the Convention on the Rights of Persons with Disabilities" (2008) 8:1 *Hum Rts L Rev* at 3.
[134] *Ibid.*

affirmed the projection of persons with disabilities as "subjects of rights, able to claim those rights as active members of society." [135]

The authors also mentioned that the paradigm shift included the notion of effective and meaningful participation of national and international disability organizations in the implementation process of CRPD, which is based on the principle of 'nothing about us, without us.'[136]When discussing the struggles of the twenty-five years before CRPD, the authors mentioned that the existing human rights instruments, i.e., The Universal Declaration of Human Rights (1948),[137] International Convention on Civil and Political Rights (1966),[138] and, International Convention of Economic, Social and Cultural Rights (1966) [139] failed to recognize disability rights, so there were 'missing pieces' in the human rights framework. Moreover, there were no equality clauses in the bill of rights, and these human rights instruments mentioned people with disabilities as a 'protected category' only.[140]

Later on, in 1993, the United Nations General assembly adopted Standard Rules on the Equalization of Opportunities for Persons with Disabilities [141] and ensured the right to equality:

> The principle of equal rights implies that the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies and that all resources must be employed in such a way as to ensure that every individual has equal opportunity for participation.[142]

In conclusion, the authors also emphasized the participation of disability rights activists to secure the potential contribution of the convention.

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[135] *Ibid.*
[136] *Ibid* at 4.
[137] GA Res. 217 A (III), 10 December 1948.
[138] 999 UNTS 171.
[139] 993 UNTS 3.
[140] *Supra* note 133 at 12.
[141] Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993, https://www.un.org/esa/socdev/enable/dissre00.htm
[142] S*upra* note 133 at 16.

In discussing the significance of the CRPD, Theresia Degener considered the convention as a central piece of international human rights law. In her 2016 academic journal publication, she stated that the CRPD had impacted both disability law and human rights law.[143]

Mentioning the models of disability, she describes that there have been many distinct models of disability in scientific literature since the 1960s. Medical (bio) models, social models, economic models, minority group models, universalist models, Nordic relational models, capabilities models, and others are among them.[144] In the English-speaking world, the medical and social models of disability have been the most influential models of disability. During the 1970s and 1980s, in the United Kingdom and the United States, disability studies experts created both approaches. Later, a new model of disability evolved with the passage of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which is the human rights model of disability.

According to Degener:

> The human rights model focuses on the inherent dignity of the human being and subsequently, but only if necessary, on the person's medical characteristics. It places the individual centre stage in all decisions affecting him/her and, most importantly, locates the main "problem" outside the person and in society. The "problem" of disability under this model stems from a lack of responsiveness by the State and civil society to the difference that disability represents. It follows that the State has a responsibility to tackle socially created obstacles in order to ensure full respect for the dignity and equal rights of all persons. [145]

The author compared the social model and the human rights model of disability under six propositions and concluded that between these two models, the human rights model is the

[143] Theresia Degener "Disability in a Human Rights Context" (2016) 5:3 Laws at 1-24, online: <http://dx.doi.org/10.3390/laws5030035>.
[144] *Ibid* at 2.
[145] *Ibid* at 3.

developed one. While defining the social model of disability, she mentioned that discrimination and oppression explain disability as a social construct in the social model of disability. It is more concerned with society than with individuals. The social model distinguishes between disability and impairment. While the term 'disability' refers to a physical or mental ailment, the second term 'impairment' is considered the result of how society and the environment react to such handicap. The political analysis of disabled people's exclusion from society is based on hurdles and prejudice.[146]

Degener mentioned that though the human rights model builds on the social model, the human rights model has acquired further development. In support of this point, she presented six propositions:

> First, the human rights model can vindicate that human rights do not require a certain health or body status, whereas the social model can merely explain that disability is a social construct. Secondly, the human rights model encompasses both sets of human rights, civil and political as well as economic, social and cultural rights and thus not only demands anti-discrimination rights for disabled persons. Thirdly, the human rights model embraces impairment as a condition which might reduce the quality of life but which belongs to humanity and thus must be valued as part of human variation. Fourthly, the human rights model values different layers of identity and acknowledges intersectional discrimination. The fifth proposition is that, unlike the social model, the human rights model clarifies that impairment prevention policy can be human rights sensitive. Lastly, it is opined that the human rights model not only explains why 2/3 of the world's disabled population live in developing countries, but that it also contains a roadmap for change. [147]

In concluding, the author mentioned that the CRPD also encompassed the ideas of equality and emphasized that states parties have legal, procedural, and transformative equality obligations. States parties are required to eliminate both direct and indirect discrimination against

[146] *Ibid* at 3.
[147] *Ibid* at 19.

people with disabilities and provide access and reasonable adjustments.[148] She also stressed the meaningful participation of the disability organizations to monitor the state's activities as a part of the implementation process of the convention.

Similarly, Paul Harpur's work focused on describing the significance of the convention on the rights of persons with disabilities and how the convention can be used as a motivation for change. He showed that the CRPD empowers people with disabilities by creating a new disability rights paradigm, explaining how the rights are to be realized.[149] Moreover, the CPRD has provided substantive rights of people with disabilities, including the respect for inherent dignity, equality, and non-discrimination, full participation, and inclusion in society and accessibility. He mentioned that under this paradigm shift, people with disabilities are considered entitled to the same human rights as people without disabilities.[150] So now, the rights are applied to focus upon true equality because the traditional human rights instruments enacted previously provided people with disabilities nominal protection.

The author here took the right to work as a case study and showed how incorporating the CPRD can make positive changes to implement the right to work.[151] The author also stated that it was logically expected by disability rights activists that there should be a separate rights-based instrument not only to guarantee equality and non-discrimination in society but also to implement the civil, political, economic and social rights of people with disabilities.

[148] *Ibid* at 20.
[149] Paul Harpur "Embracing the new disability rights paradigm: the importance of the Convention on the Rights of Persons with Disabilities, Disability & Society" (2012) 27:1 *Disability and Society* at 1, https://www.tandfonline.com/doi/abs/10.1080/09687599.2012.631794.
[150] *Ibid* at 5.
[151] *Ibid.*

The author analyzed the two major reasons that the CRPD creates 'a prospective for transformation' in disability rights discourse.[152] He mentioned that the convention had created some incidental rights, and with collaboration with the existing rights, the horizons have been expanded. Further, the rights gained more clarity and importance through the convention, which provided a legal mandate for disability advocates and academicians to hold the state parties responsible for ensuring those rights. The other reason was that CRPD had established a disability rights discourse so that the advocacy groups working on disability could be formally involved in the convention process. This official role requires the United Nations and signatory states to provide representatives who are people with disabilities from each state to incorporate the notion that there should be 'nothing about us without us.' [153]

As Harpur mentioned,

> With the advent of the CRPD, scholarship concerning the rights of persons with disabilities and disabled people's organizations can increase the focus upon implementation and use the CRPD as a catalyst for change and a benchmark for good governance. The CRPD re-articulates existing rights, provides clarity on how those rights should be realized for persons with disabilities and provides disabled people's organizations a voice in the implementation of the convention. It now falls to disability rights advocates and scholars to harness the potential of the CRPD and use this resource to agitatefor change.[154]

Finally, the author discussed why the rights-based model of disability is stronger than the medical model of disability. He observed that though the medical model of disability is still popular in medical schools and medical research, it focuses on disability as a problem and looks

[152] *Ibid* at 2.
[153] *Ibid.*
[154] *Ibid* at 11.

for a cure. Certain features of the medical model can be considered significant, but it overlooks the holistic approach to ensure disability rights.[155]

Agustina Palacios and Maria Walls also explored the changing paradigm towards the human rights approach, including the discussion on models of disability, analysis of the definition of disability, and the forces that created the drive for the convention. They interpreted the provisions of the convention through the lens of the substantial key rights of equality, participation, protection and basic social rights.[156] They conclude that the new paradigm shift towards a human rights perspective introduced through the CRPD was based on a concept of human dignity that must lead the way to independent autonomous living of a person with a disability like any human being.

The authors firstly examined the factors that led the way to draft a new convention to ensure the rights of people with disabilities.[157] Then they discussed three models of disability, including rehabilitation or the medical model, the social model, and the human rights model of disability. Defining the rehabilitation model, they outlined the historical event of the First World War and government responses towards the injured soldiers of the war. The states took on medical expenses of the soldiers, and if the injuries led to permanent disabilities, the soldiers were awarded rehabilitation facilities and suitable employment opportunities.[158] As they mentioned:

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[155] *Ibid* at 2. The problem with policies guided by the medical model is that such policies place undue attention upon 'fixing persons with disabilities'. Medical model policies often do not recognize that a person with a disability has the capacity to live a fulfilling life with a disability. Such policies continually try to 'improve' a person's physical or mental state rather than focusing on other important public issues such as the removal of environmental barriers in society or providing support to enable the person to exercise other rights.

[156] Agustina Palacios and Maria Walls, "Changing the Paradigm- the Potential Impact of the United Nations Convention on the Rights of Persons with Disability" (2006) 1 *Irish YB Int'l L* at 121.

[157] *Ibid* at 122.

[158] *Ibid* at 123.

> It happened that from that moment disability began to be related to those injured in War and it was seen as insufficiency, a deficiency to be overcome. As such injuries were acquired, not through an individual's own fault but through the 'serving of country'. Within the scope of law, this meant the implementation of legislative policies destined to guarantee social services for war veterans with disability, which somehow reflected the belief that there existed an obligation on behalf of the states to compensate these persons through invalidity pensions, rehabilitation benefits and employment quotas. [159]

Then the authors described the social model of disability, which originated from the denial of the rehabilitation model of disability. The vital supposition of the model was that individual impairment was not the central issue but the limitation of a society that lacked appropriate equipment and services.[160] The authors stated:

> Thus, activists with disabilities and organizations for disabled people took the political initiative and condemned their status as 'second class citizens'. They turned attention to the impact of social and environmental barriers, such as transportation and non-accessible buildings, discriminatory attitudes and negative cultural stereotypes, which, they made plain, disabled persons with impairment.[161]

The new paradigm shift towards a human rights perspective had been introduced through the incorporation of the CRPD. It was based on the concept of human dignity that must lead the way to independent autonomous living of a person with a disability like any human being. The authors referred to three principles or values which are interlinked: dignity, autonomy, and independence.[162] They also indicated that human dignity is foundational and should reinforce the idea that people with disabilities have a role in society independent of utilitarian views.[163]

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[159] *Ibid.*
[160] *Ibid* at 124.
[161] *Ibid* at 125.
[162] *Ibid* at 136.
[163] *Ibid* at 138. The notion of human dignity is the foundation stone upon which human rights are established. The idea of human dignity should reinforce the idea that persons with disability have a role in society, which must be considered absolutely independent from any consideration of social or economic utility. . . . These three values dignity, autonomy and independence constituted the principles enshrined in Article 3 (a) of the convention should be understood as the basis upon which the instrument is interpreted and applied.

In concluding, the authors found that the convention shifts the paradigm and creates a new world vision of disabled people's rights. The convention suggests a strong moral and political commitment to act to protect and advance the rights of disabled persons. It gave the people the power to bargain with any government, ratified or not. It gave the chance to usher in an era in the rights of people with disabilities with a legal mandate.[164]

Don MacKay discussed the significance of the CRPD in a thematic way, starting with narratives of historical events. He mentioned that the CRPD covers a wide spectrum of real-life events of people with disabilities, including personal mobility, education, health, accessibility, employment, and rehabilitation. [165]

Referring to the three themes of the CRPD, he explained the first theme as "inclusiveness," which refers to community inclusion. It is essential because individuals with disabilities have been treated differently for a long time, and the exclusion affected the growth of the state. So, they must be established in society for the sake of the state's best interests. It is necessary to ensure their accessibility and support so that they can participate in all aspects of the community.[166]

The second theme is to change people's attitudes and eliminate stereotypes. The convention argues that the problem can be solved by proper and meaningful interactions between people with disabilities, governments and communities. To break stereotypes, people with disabilities and organizations working for disabled people must regularly negotiate with governments and communities. The convention's third theme is accessibility, which includes

[164] *Ibid* at 165.
[165] Don MacKay, "The United Nations Convention on the Rights of Persons with Disabilities" (2007) 34:2 Syracuse *Journal of International Law and Commerce* at 323.
[166] *Ibid* at 329.

practical initiatives. It includes architectural accessibility in buildings and other ways, accessibility to get information, and communication technologies. The convention also ensures the facilities for independent life by using assistive devices and mobility aids.[167]

Peter Mittler's work mainly focused on the monitoring process of the CRPD, where he mentioned that the CRPD is more than just the latest in a long line of UN declarations. It has the potential to inspire a radical reappraisal of policy and practice among governments and organizations of disabled people and service planners as well as providers, members of professional and voluntary organizations, the research community, and society as a whole. The countries that have ratified the CRPD have agreed to provide full reports to the UN Human Rights Commission's CRPD Committee under international law.[168] Following ratification, the states party's government is required to provide a detailed progress report to the Office of Commission of the Human Right's CRPD Committee every two years for the first two years and then every four years for the next four years on activities taken to implement according to the Convention's general principles and particular provisions.[169]

The author also mentioned that there are chances given to the international disability organizations and other national disability organizations to submit independent reports to the committee, so follow-up actions on a national level can be monitored properly.[170]

He also discussed the obstacles on the way to implementation and tried to find out their outcomes. He mentioned that lack of political will and commitment of the national governments,

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[167] *Ibid.*
[168] Peter Mittler, "The UN Convention on the Rights of Persons with Disabilities: Implementing a Paradigm Shift" (2015) 12:2 *Journal of Policy and Practice in Intellectual Disabilities* at 79, https://onlinelibrary.wiley.com/doi/abs/10.1111/jppi.12118.
[169] *Ibid.*
[170] *Ibid* at 81.

constraints within the national disability organizations, lack of data and research, lack of awareness in the monitoring process hinder the way of implementation of the provisions of the convention. [171]

Lastly, he concluded that the researchers must adopt proactive approaches at the national, regional, and international levels to incorporate the 'research to practice' approach to strengthen the monitoring process of the convention in a true sense. He quoted Gerard Quinn in the last part of the article signifying the importance of CRPD and the commitment to change.

> The UN CRPD is a mirror to society. It makes us face up to our own values and it forces us to acknowledge the large gap that still exists between the "myth system" of our own values… and the "operations system" of how these values are dishonored in daily practice. Thus the Treaty is a force for rationality as well as a vehicle for carrying these values squarely to the heart of the disabilities field. As with all mirrors, we can refuse to look into them or we can look at them but ignore their reflection or we can take notice of our reflection and commit to a process of change.[172]

2.4 Summary

From the above discussion, it is clear that the CRPD was considered as a desired international document for the PWD because the other international human rights instruments fail to amalgamate all necessary rights and privileges to them. The Convention took the disability movements to a certain height that international communities were compelled to see the people with disabilities not as an object of charity rather active members of the society. The CRPD made it clear that the horizon of existing rights must be expanded and enforced to ensure their inclusiveness in the society. Further, it has given the emphasis on equal treatment and made it compulsory for the signatory states to treat PWD without discrimination. It has given stress on

[171] *Ibid* at 84.
[172] *Ibid* at 87. The quotation is taken from the article of Mittler quoting Gerard Quinn. Also cites in:
Gerard Quinn, "Bringing the UN Convention on Rights for Persons with Disabilities to Life in Ireland" (2009) 37 *British Journal of Learning Disabilities* at 245–249.

the implementation rights of PWD without by removing discriminatory practices, laws and policies. Moreover, it obliges the governments to enact laws, policies and regulations to uphold human dignity and to ensure the social inclusion of the PWD in every section of society. The CRPD mainly focuses on the change of attitudes and stigma attached with disability through incorporating anti-discriminatory laws, and policies. Moreover, the monitoring mechanism of the CRPD makes the government responsible to submit reports informing about the developments in national life. It has made the Convention a watchdog for checking the moral and political standpoint of the governments. So there are provisions and obligations to its signatory states, including Bangladesh, to remove barriers to persons with disabilities. This includes women with disabilities, and would encompass the situation of accessing maternal health services.

In the next chapter, I will examine how and to what extent the government of Bangladesh is ensuring these rights in their legal jurisdiction and whether the government has implemented the human rights model into the legal diagram or not. Further, the Bangladesh's national accessibility legislation, judicial decisions and scope of representation of people with disabilities in the policy-making process will be explored to find out the legal lacunas of the legal framework of Bangladesh. Furthermore, recommendations will be made discussing some of the Canadian best practices that might be suitable and helpful to women with disabilities who require maternal health services if adopted into the legal framework of Bangladesh.

Chapter-3

Laws and Policies in Bangladesh to Remove Barriers to Access Maternal Health Care Services: Critiques and Recommendations

The first chapter of the thesis shows that women with disabilities face architectural built environment and attitudinal barriers to access maternal healthcare services in Bangladesh. The second chapter described the international laws on disability along with relevant provisions to this thesis. Now in this chapter, I discuss the laws and legal lacunas of Bangladesh related to the maternal healthcare rights of women with physical disabilities. This chapter discusses the legal provisions relating to accessibility and medical services under the existing legal framework of Bangladesh. The major argument of the chapter concerns the inadequate extent to which the laws and policies are removing barriers to accessing maternal health services in Bangladesh. Not all of the laws and policies discussed directly affect access to maternal health care services – some deal with a broader constitutional right to equality. But there are also some relevant provisions in certain laws and policies that protect the health care rights of people, including women, with disabilities which are examined.

3.1 Development of disability laws and relevant policies regarding women with disabilities in Bangladesh

In 1993, Bangladesh first adopted the United Nations General Assembly's Standard Rules on the *Equalization of Opportunities for Persons with Disabilities* (1993), which included rules relating to the accessibility of medical care. According to these rules, states should ensure the provision of effective medical care to persons with disabilities.[173] Moreover, all medical and

[173] United Nations General Assembly adopted Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 1993, A/RES/48/96,at Rule 2, online: https://www.un.org/development/desa/disabilities/standard-rules-on-the-equalization-of-opportunities-for-persons-with-disabilities.html.

paramedical personnel are to be adequately trained and equipped to give medical care to people with disabilities, and states have responsibilities to provide regular medical treatment and medicine to preserve or improve their level of functioning.[174] Moreover, states have a responsibility to ensure accessibility by removing barriers in the physical environment. Further, the participation of representatives from disability organizations should be ensured by the states when developing accessibility requirements into designs and construction planning. [175] It was the first international instrument on disability which Bangladesh incorporated in the *National Disability Policy 1995* of the state.

3.1.1 National Disability Policy 1995

On the basis of the United Nations Declaration on the Rights of Disabled Persons (1975) and UN Standard Rules of 1993 on the Equalization of Opportunities, Bangladesh enacted its first policy to ensure several rights for people with disabilities in 1995.[176] This policy recognized disability issues, mentioning the constitutional provisions including Articles 15, 17, 20 and 21 of the constitution of Bangladesh. Under those constitutional provisions, the state is under an obligation to ensure the standard of living and fundamental rights of all citizens of the state.

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[174] *Ibid.*

[175] *Ibid* at Rule 5 (a) Access to the physical environment: 1. States should initiate measures to remove the obstacles to participation in the physical environment. Such measures should be to develop standards and guidelines and to consider enacting legislation to ensure accessibility to various areas in society, such as housing, buildings, public transport services and other means of transportation, streets and other outdoor environments. 2. States should ensure that architects, construction engineers and others who are professionally involved in the design and construction of the physical environment have access to adequate information on disability policy and measures to achieve accessibility. 3. Accessibility requirements should be included in the design and construction of the physical environment from the beginning of the design process. 4. Organizations of persons with disabilities should be consulted when standards and norms for accessibility are being developed. They should also be involved locally from the initial planning stage when public construction projects are being designed, thus ensuring maximum accessibility.

[176] National Disability Policy *Chancery Law Chronicles*, First Bangladesh Online Case-law Database, online: http://www.clcbd.org/document/39.html.

This policy is the first where the process of identification and prevention of disability at an early stage of disability was prescribed for people with disabilities. In the policy, medical facilities, including special training on disability and liability of medical professionals were included, so it can be said that this policy actually emphasized the medical model of disability.[177] Further, it was mentioned that accessibility must be ensured in public places so that people with disabilities may obtain all public services and facilities, including transportation and medical care.[178] It also mentioned that special laws must be enacted to ensure accessibility in roads and transportation, and reforms should be made to building codes to ensure accessibility in establishments.[179]

Still, the National Disability Policy of 1995 can be criticized on the ground that it only provided total 14 policies in short form without elaboration and proper explanation. Moreover, the medical model of disability is found in the policies as majority of them stress on establishing medical rehabilitation centers, providing assistive devices and medical treatment to prevent further disability.

3.1.2 Disability Welfare Act, 2001

The Government of Bangladesh enacted the *Disability Welfare Act, 2001* with the purpose of protecting the legal rights of persons with disabilities and guaranteeing their involvement in society. On April 4, 2001, the Bangladeshi Parliament passed the Disability Welfare Act (DWA) 2001, establishing statutory recognition for the rights of people with disabilities for the first time in the state's history. This Act was essentially welfare-based, with a focus on the individual's limitation rather than societal and environmental barriers. This Act

[177] *Ibid at* policy no. 1 & 6.
[178] *Ibid at* policy no. 10.
[179] *Ibid.*

could not address the dignity of people with disabilities and was insufficient to represent the interests of disabled individuals. As a result, the Act does not meet the aspirations and desires of many Bangladeshi persons with disabilities.[180]

Further, when the legislation was introduced as a bill in parliament, the government of Bangladesh lacked data on the actual number of people with disabilities in the country, which was also mentioned in the law. Critics claim that this might be a big point of contention in terms of how a law can be drafted without knowing all of the necessary information about people with disabilities. Critics further claim that this law is primarily concerned with the charity and medical models of disability.[181]

Other major problems with the Act were that it did not provide a comprehensive complaint mechanism, including inadequate representation of persons with disabilities, overly broad scope of the authorities' power, and so on. But the main objection against the Act was that the title of the Act itself represents that the law had incorporated the medical model of disability where persons with disabilities were treated as a subject of welfare.

3.1.3 National Women Development Policy 2011

The *National Women Development Policy* is the first policy in which women with disabilities were categorized as a vulnerable category of population in Bangladesh.[182] It emphasized that programs and support services should be designed to address the diversity of

[180] *Supra* note 4 at 215.
[181] Munzur-E-Murshid & Haque Mainul, "Disability brief in single chapter and Bangladesh perspectives: A rapid overview" (2020) 10: 2 *Advances in Human Biology* at 41-50, online: <https://www.aihbonline.com/article.asp?issn=23218568;year=2020;volume=10;issue=2;spage=41;epage=50;aulast=Munzur-E-Murshid,#google_vignette>
[182] National Women Development Policy, Government of the Peoples' Republic of Bangladesh, *Ministry of Women and Children Affairs*, March 2011, http://mowca.portal.gov.bd/sites/default/files/files/mowca.portal.gov.bd/policies/64238d39_0ecd_4a56_b00c_b834cc54f88d/National-Women-Policy-2011English.pdf.

positions and needs of women, including women with disabilities.[183] Moreover, following the CRPD, a separate standalone part was inserted.[184] This policy stressed the acknowledgement of women with disabilities' honour and dignity, as well as their full engagement in all aspects of life. It stated that more appropriate institutional initiatives for the education, treatment, training, and rehabilitation of disabled women should be implemented. It also highlighted the importance of establishing accessible frameworks, facilities, and services for women with disabilities.[185]

As mentioned earlier, Bangladesh ratified the United Nations Convention on the Rights of People with Disability (CPRD) in 2007. It is the prime international document that emphasizes the protection of the rights of persons with disabilities. So, the signatory state parties cannot deny their international obligation to insert new disability-friendly rules and policies into their national plans and actions.

Bangladesh ratified the treaty as the sixteenth member state along with the optional protocol.[186]

3.1.4 Protection of the Rights of the Persons with Disabilities Act, 2013

In response to the CRPD, in 2013, the Act titled, *Rights and Protection of the Persons with Disabilities Act 2013* [187] was passed and enforced. The bill of the Act was passed in the parliament on 3rd October 2013. The government reported that:

> The President of the People's Republic of Bangladesh approved the enactment and on 9th October, the Act was passed through gazette notification. This new legislation

[183] *Ibid* at policy no. 28.
[184] *Ibid* at policy no.39.
[185] *Ibid.*
[186] Implementation of the Convention on the Rights of Persons with Disabilities in Bangladesh, A report submitted to the Office of the High Commissioner on Human Rights (OHCHR) in accordance with Article#35 Paragraph#1 of the CRPD, August 2010, Published by *National Disabled Development Foundation*, https://jpuf.portal.gov.bd/sites/default/files/files/jpuf.portal.gov.bd/page/bf5ce7bb_e218_4526_90f1_1129defe4cfa/Report%20of%20UNCRPD%20(1).docx.
[187] *Rights and Protection of the Persons with Disabilities Act 2013,* Act of 39 of 2013, Legislative and Parliamentary Affairs Division, 9 October 2013, online: http://bdlaws.minlaw.gov.bd/act-1126.html.

has opened a new era in the establishment of rights and fundamental freedoms of all persons with disabilities in Bangladesh.[188]

This Act has been enforced to preserve and ensure the rights and dignity of people with disabilities. The latest enacted law has repealed the former *Disability Welfare Act, 2001*. The purpose of the Act is to provide assurance and legal direction to people with disabilities so that they can join the mainstream population of the country. In connection with that Act, the government passed a Rule, titled the *Rights and Protection of People with Disabilities Rule, 2015*.

The Act of 2013 acknowledges certain rights of people with disabilities, including women with disabilities, whereas the previous Act only dealt with provisions under the title of "welfare." The government claimed in the report of 2017 submitted to the OHCHR that the shift from the titles of the two Acts, "welfare" to "rights and protection" reflected the commitment of the government to ensure disability rights.[189]

The law has specified a total of 21 rights for people with disabilities, including women with disabilities. The provisions relating to rights relevant to the thesis are mentioned below:

Every person with a disability shall have the following rights:

1. To survive and grow in full with legal recognition in every sphere of life and have access to justice

3. To live in society with parents, legitimate or legal guardians and children, and to have marital relations and to form families

4. Fully and effectively access and participate in social, economic, and state

[188] Report on the Implementation of the Convention on the Rights of Persons with Disabilities (CRPD), published by the *Government of the People's Republic of Bangladesh*, Submitted to the Office of the High Commissioner on Human Rights (OHCHR) in accordance with Article #35 Paragraph #1 of the CRPD, April 2017 at 8, <https://www.blast.org.bd/content/CRPD/CRPD_BGD-Initial-Report-for-participants.pdf.>
[189] *Ibid.*

activities according to the type of disability

8. Subject to availability, access to the highest quality of health services

10. To get appropriate service and rehabilitation to attain the physical, mental, and technical capacity to fully integrate into all aspects of society.[190]

Although it is claimed by the government as a rights-based law, but some provisions have legal ambiguities and insufficiencies. Mainly, reservation on the equality clause of the Act confirms that the law did not incorporate human rights model within the framework. Later in the thesis, certain provisions are examined that have been selected because of their relevance to the thesis.

Provisions relating to accessibility in establishments, public transport, and the health care laws of Bangladesh relating to maternal health services will next be discussed. Moreover, provisions relating to equality and non-discrimination will be discussed too because these provisions are crucial to removing attitudinal barriers towards people, including women with disabilities. Further, best legal approach adopted by Canada, the *Accessibility for Ontarians with Disabilities Act* and *Integrated Accessibility Standards Regulation* [191] *(*AODA IASR*)* has been chosen for discussion to recommend legal reforms necessary for Bangladesh.

The AODA IASR has its limitations and challenges especially in terms of meeting timelines and its enforcement. But the reason behind its selection is that with this legislation, Ontario became the first province in Canada and one of the first locations in the world to enact a particular accessibility law with a goal and timescale.

[190] The Act of 2013, *supra* note 187 at S 16 (1).
[191] See AODA IASR. *supra* note 8.

In the thesis, I tried to find an analysis model, but it was quite hard to find one. Due to the difference in legal advancement, economic status, and political will of the government to ensure disability rights, the gap between the two legal systems of Canada and Bangladesh is quite wider. Bangladesh has got its liberation in 1971 but till 1995 there was no government policy relating to disability rights. The first policy on disability has been enacted in 1995 and the Act of 2001 is considered as the first legislation enacted by the parliament. So the curve of legal advancement started from a later period. Further, within the government institutions, there is a tendency to avoid issues relating to disability which represents the stereotype mentality of the public authorities. Moreover, the budget allowances of the national budget for disability-related sectors are not adequate compared to the needs of people with disabilities.

So first, I have discussed the existing legal provisions of Bangladesh where there are deficiencies and loopholes. Then, I consider the prospect and possibilities in Bangladesh and the potential in law to adopt the best legal approaches of Canada.

3.2. Provisions Relating to Accessibility in Establishments

The definition of accessibility is found in the section 2 (13) of the *Rights and Protection of the People with Disabilities Act, 2013* defines "accessibility" as the right of every person with a disability to receive equal access and equal treatment in all facilities and services available to the public, including physical infrastructure, vehicles, communication, information, and information and communication technology.

It has been incorporated in the Act of 2013 that public establishments must be accessible to people with disabilities. Provisions relating to the accessibility of people with disabilities in public establishments have been discussed below:

(1) Notwithstanding anything contained in any other law for the time being in force, the Building Construction Act, 1952 (East Bengal Act II of 1953) and the rules made thereunder shall be followed to ensure the accessibility of persons with disabilities to public administration.
(2) Notwithstanding anything contained in sub-section (1), all such existing public bodies by public passage shall, as soon as possible and as far as possible, be made suitable for the ascent, movement and use of persons with disabilities.
[Explanation: In this section, to say 'mass establishment' is to make public movement].[192]

The provisions of the *Building Construction Act 1952* are now in force due to the Act of 2013 which requires that every establishment should be designed such that it is accessible to people with disabilities. As well, there must be usable toilets for people with disabilities in every public establishment, especially for students.[193] In addition, the *Dhaka City Building Construction Rules 2008* (adopted under the *Building Construction Act, 1952*) recognized the concept of 'universal design' and mentioned that universal design must be followed where the necessity of people with disabilities must be considered.[194] Moreover, article 2 of the CPRD provides the definition of 'universal design' of accessibility, which includes the design of products, environments, programs and services to be usable by persons with disabilities to the greatest extent possible.

Further, *Dhaka City Building Construction Rules, 2008,* have specified the accessibility standards for physically challenged people to all urban services and facilities. They include physical accessibility in entry-exit points where ramps, handrails and lifts must be installed in all commercial buildings, shopping complexes, health institutions, and educational institutions. Special consideration has been given to accessibility to toilets or washrooms and parking

[192] The Act of 2013, *supra* note 187 at S 34.
[193] *Building Construction Act 1952* (Act no. 2 of 1953) at S 39.
[194] *Dhaka City Building Construction Rule 2008* (Act No. 120 of 2008) at Rule 2.

facilities of the establishments.[195] The rules specify that there must be one accessible toilet on every floor (which will be at least 5% of total toilets) in public establishments. The same rule applies to parking spaces (5% of total parking) in public establishments.[196]

Also, nine sectors have been identified that should be designed using universal design for people with disabilities: doors, railings, stairs, ramps, lifts, toilets, parking and sitting areas.[197] In the schedule, nine sectors have been included with description which has been provided in Appendix- I.

Moreover, in the case of public constructions, the Department of Architecture under the Ministry of Housing and Public Works is entrusted with the responsibility to ensure the universal designs of roads, footpaths, highways, and other public constructions.[198] But it is alleged that visible wheelchair-friendly road design and environment are absent. When it comes to the footpaths of roads, people with wheelchairs in Bangladesh do not have easy access to move around.[199] Further, with factors like the absence of curb ramps at zebra-crossings (which is known as pedestrian road crossings), the absence of tactile surfacing, disordered movement of pedestrians, inappropriately installed ramps, and disrespect by drivers of approaching vehicles, people with disabilities face difficulties to move on roads on a regular basis in Bangladesh. [200]

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[195] *Ibid* at R 64.
[196] *Ibid.*
[197] *Ibid* at Sch. 2.
[198] Major Jahirul Islam, "Universal Access is the Demand of the Hour", *The Oporajeyo, A Quaterly Magazine of Bangladesh*, 23 March 2015, https://oporajeyo.com/2015/03/23/%E0%A6%B8%E0%A6%B0%E0%A7%8D%E0%A6%AC%E0%A6%9C%E0%A6%A8%E0%A7%80%E0%A6%A8-%E0%A6%AA%E0%A7%8D%E0%A6%B0%E0%A6%AC%E0%A7%87%E0%A6%B6%E0%A6%97%E0%A6%AE%E0%A7%8D%E0%A6%AF%E0%A6%A4%E0%A6%BE-%E0%A6%8F%E0%A6%96/.
[199] S Sakaki & J Gomes, "Too often, Dhaka remains inaccessible for people with disabilities" *World Bank Blogs*, worldbank.org, October 31(2018) , online: https://blogs.worldbank.org/endpovertyinsouthasia/too-often-dhaka-remains-inaccessible-people-disabilities.
[200] Y Takamine, "Disability Issues in East Asia: Reviews and Ways Forward", Published by *the World Bank*, July 2003, online: https://hpod.law.harvard.edu/pdf/DisabilityIssuesTakamine.pdf

On the other hand, in Ontario, the *Ontario Building Code* section 2.2 lists 'accessibility' as one of the objectives of the building code, including barrier-free paths of travel and accessible facilities for people with disabilities.[201] Further, the AODA IASR has provisions relating to accessibility in public establishments and public spaces,[202] but those are elaborate and specific in nature. After examining the accessibility standards for the built environment under the AODA IASR 2005, I have found some provisions that can be inserted in the building construction rules of Bangladesh to ensure mobility access in public spaces, which are currently missing.

Under the AODA IASR, exterior paths of travel must be developed or redeveloped by obligated organizations after meeting specific requirements. [203] Moreover, it is mentioned that where an exterior path of travel is equipped with a ramp, the ramp must have a minimum clear width of 900 mm. The surface of the ramp must be firm, stable and slip-resistant. The ramp must have a maximum running slope of no more than 1:15. Furthermore, the ramp must be provided

[201] *Ontario Building Code, 1992,* S.O. 1992, c. 23.
[202] See AODA IASR; *supra* note 8 at Part- IV.1 Design of public Spaces Standards (Accessibility Standards for Built Environment).
[203] *Ibid* at S 80.21. When constructing new or redeveloping existing exterior paths of travel that they intend to maintain, obligated organizations, other than small organizations, shall ensure that new and redeveloped exterior paths of travel meet the following requirements: 1.The exterior path must have a minimum clear width of 1,500 mm, but this clear width can be reduced to 1,200 mm to serve as a turning space where the exterior path connects with a curb ramp. 2.Where the head room clearance is less than 2,100 mm over a portion of the exterior path, a rail or other barrier with a leading edge that is cane detectable must be provided around the object that is obstructing the head room clearance. 3.The surface must be firm and stable. 4.The surface must be slip resistant. 5.Where an exterior path has openings in its surface, i. the openings must not allow passage of an object that has a diameter of more than 20 mm, and ii. any elongated openings must be oriented approximately perpendicular to the direction of travel. 6.The maximum running slope of the exterior path must be no more than 1:20, but where the exterior path is a sidewalk, it can have a slope of greater than 1:20, but it cannot be steeper than the slope of the adjacent roadway.7.The maximum cross slope of the exterior path must be no more than 1:20, where the surface is asphalt, concrete or some other hard surface, or no more than 1:10 in all other cases.
8.The exterior path must meet the following requirements: i. It must have a 1:2 bevel at changes in level between 6 mm and 13 mm. ii. It must have a maximum running slope of 1:8 or a curb ramp that meets the requirement of section 80.26 at changes in level of greater than 13 mm and less than 75 mm. iii. It must have a maximum running slope of 1:10 or a curb ramp that meets the requirement of section 80.26 at changes in level of 75 mm or greater and 200 mm or less. iv. It must have a ramp that meets the requirements of section 80.24 at changes in level of greater than 200 mm. 9. The entrance to the exterior path of travel must provide a minimum clear opening of 850 mm, whether the entrance includes a gate, bollard or other entrance design. O. Reg. 413/12, s. 6; O. Reg. 165/16, s. 14.

with a landing, which must be at the top and bottom of the ramp, where there is an abrupt change in the direction of the ramp, and at horizontal intervals not greater than nine metres apart.[204]

Moreover, obligated organizations shall ensure access aisles (the space between parking spaces that permit persons with disabilities to get in and out of their vehicles) for outdoor street parking facilities. They must have a minimum width of 1,500 mm.[205]

It is also mentioned that service areas, including service counters and waiting areas, should be designed as accessible. Where there are several queue lines and service counters, there must be at least one service counter that accommodates a mobility aid for each type of service given. The service line must be clearly recognized with signage. Where a single queue line serves a single or several counters, each service counter must accommodate mobility aids.[206] It is also mentioned that when building a new waiting area or redeveloping an existing waiting area with fixed seating, a minimum of three percent of new seating must be accessible, but no less than one accessible seating place must be provided.[207]

These are some the provisions that might be inserted in the law of Bangladesh for building or designing accessible public spaces. Without such provisions, Bangladesh will not be able to incorporate universal design in public spaces. Due to the absence of such provisions, wheelchair users currently cannot use public transport and public places for necessity or entertainment. Even so, it has become hard for them to access private transport due to the lack of space in public places like footpaths, paths of travel and parking areas. Moreover, due to the

[204] *Ibid* at S. 80.24.
[205] *Ibid* at S.80.35.
[206] *Ibid* at S. 80.41.
[207] *Ibid* at S. 80.43.

absence of ramps, running slopes, curb ramps, and pedestrian control signals on public roads, the situation has gotten worse.

3.3 Provisions relating to Accessibility in Public Transport

There are two pieces of legislation that deal with the accessibility of people, including women, with disabilities, in public transport in Bangladesh. The *Rights and Protection of People with Disabilities Act 2013*, and the latest *Road Transport Act 2018*, provide regulations relating to the reservation of seats in public transport and consequences for noncompliance. Requirements for favorable facilities in the public transport and sanctions for misconduct or harassment of any person with a disability in transportation have been added as new provisions.[208]

Bangladesh is *Road Transport Act 2018* states as general instructions for motor vehicle movement that 'favourable facilities' must be provided for the disabled passengers in public transport, and no other passenger shall be seated in a seat reserved for women, children, the disabled and the elderly.[209] Sanctions for noncompliance are imprisonment of not more than three months or a fine, not more than 10 thousand takas or both.[210]

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[208] The Act of 2013, *supra* note 187 at S 32. The provisions are:
(1)Notwithstanding anything contained in any other law for the time being in force, the owner or authority of all public transport shall reserve 5 (five) percent of the total number of seats for persons with disabilities within the period prescribed by notification in the Official Gazette by the Government.
(2)If the owner or authority of a public transport does not take or refrain from taking the action referred to in sub-section (1) or if the driver, supervisor or conductor of a public transport does not assist a disabled person to take a seat in a reserved seat or obstructs him from taking a seat. If so, the Committee shall, after due diligence, verify its authenticity and make recommendations to the appropriate authorities for cancellation of the registration of such transport.
[Explanation: In this section, 'public transport' means any general transport which transports passengers in exchange for rent by land, water and air
[209] *Road Transport Act 2018* (Act No.47 of 2018) at S. 49 (1).
[210] *Ibid* at S. 92 (1).

Further, no owner, driver, conductor, person, or organization of any public transport is legally entitled to claim or collect the additional fare from any passenger,[211] including people with disabilities. If they do so, they will be punishable by simple imprisonment, not more than one month or a fine not than 10 thousand takas or both.[212] This provision can be considered as a favorable provision because I have personally observed that additional fare is generally taken from people with disabilities when they access public transportation.

The Bangladesh Road Transport Corporation (BRTC) [213] is the public organization that regulates the public bus routes and buys buses from other states for internal use. There are currently 348 identified routes for BRTC buses, and a total of 1182 buses are running all over the country.[214] The regulated bus services under BRTC are ordered to keep reserved seats for disabled persons and to sell tickets at a 50% discount price when an identity card is shown. Besides, all express inter-city trains have two reserved seats at a 50% discount price. Bangladesh railway has also started to give rebates for passengers accompanying people with disabilities.[215]

Unlike Bangladesh, accessibility provisions in Canada are more attuned to the needs of people with disabilities, as there are forty-seven sections in the transportation standards provided by the government of Ontario through the Accessibility for Ontarians with Disabilities Act, 2005. In Ontario, there are also three kinds of transport service providers, including

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[211] *Ibid* at S. 34.
[212] *Ibid* at S. 80.
[213] Bangladesh Road Transport Corporation, Government of the People's Republic of Bangladesh, http://www.brtc.gov.bd/.
[214] Passenger Transport Services, Bangladesh Road Transport Corporation, Government of the People's Republic of Bangladesh, http://www.brtc.gov.bd/site/page/4111a8b9-3e61-479c-9798-4a35a55702a5/%E0%A6%AF%E0%A6%BE%E0%A6%A4%E0%A7%8D%E0%A6%B0%E0%A7%80-%E0%A6%AA%E0%A6%B0%E0%A6%BF%E0%A6%AC%E0%A6%B9%E0%A6%A8-%E0%A6%B8%E0%A7%87%E0%A6%AC%E0%A6%BE
[215] The Report, *supra* note 188 at 18.

conventional, specialized, and alternative service providers. But there are no such classifications found in the jurisdiction of Bangladesh.

I think that although there are similar provisions in both jurisdictions for the allocation of reserved or priority seating arrangements on public transport, fare deduction, and ensuring favourable facilities on transport, there are no elaborations on certain terms in Bangladeshi law, such as "misconduct," "harassment," or "favourable facilities". Due to the absence of the terms without proper explanation under Bangladeshi law, the transport providers do not get enough direction while treating a person with a disability using transport.

As relevant to the findings of the thesis, from among the better practices followed by Canada relating to the accessibility of its transportation system, I have selected some prominent sections of the AODA IASR that can be inserted into the Bangladeshi laws and policies as possible remedies within a short timeframe to ensure accessibility in public transport.

3.3.1 Modifications in Public Vehicles

In the public buses of Bangladesh, there are only handholds on the entrance door found in almost all operating buses, but the height of the handholds makes it impossible for a person using a wheelchair to reach. Handholds are also found inside the buses, but those are only for standing passengers.

The AODA IASR, by contrast, under the transportation standards, states that every conventional transportation service provider shall ensure vehicles are equipped with grab bars, handholds, handrails or stanchions that are provided at appropriate locations where passengers are required to pay fares; each mobility aid securement position.[216] It also states that each priority

[216] See AODA IASR, *supra* note 8 at S.53 (1).

seating area is intended for use by persons with disabilities; and each side of any entrance or exit used by persons with disabilities.[217] The location of the equipment must be distributed, as appropriate to the vehicle's design, throughout the vehicle to support independent and safe boarding, on-board circulation, seating and standing assistance and deboarding for persons with disabilities.[218]

Due to the lack of monitoring by the responsible authority, the Bangladesh Road Transport Authority (BRTA),[219] there is no public transport provider in Bangladesh that provides buses with low-floor accessible ramps, elevators, grabrails, or handrails. Such modifications inside the vehicles (at the entry and exit points of the transport and near the seating area) and outside at the transportation boarding areas, including ticket counters, waiting stops, should be redeveloped or re-constructed. The inclusion of such provision will assist people, including people with disabilities, in asserting their right to use public transportation within the shortest period. It may drastically change the present scenario in Bangladesh.

3.3.2 Clearly marked sitting arrangements

The AODA IASR mentions that every conventional transportation service provider must ensure that there is clearly marked priority seating for persons with disabilities on its transportation vehicles, and the priority seating shall be located as close as practicable to the entrance door of the vehicle.[220]

Though it is mentioned in the law of Bangladesh to keep reserved seats for 5% of the total seats on public transport, marking them clearly is not mentioned. Provisions for the disabled

[217] *Ibid,* S 53 (2)
[218] *Ibid* at S. 53 (3)
[219] Bangladesh Road Transport Authority (BRTA), Government of People's Republic of Bangladesh, <http://www.brta.gov.bd/>
[220]See AODA IASR, *supra* note 8 at S.49.

would be easy to understand by the general public if those seats were separately marked. Separate seats near the entrance should be kept for people with disabilities for easy access. Moreover, the insertion of such provision will oblige the transport service providers to obey it as a mandatory obligation.

3.3.3 Identifying Safest Locations for People with Disabilities

The AODA IASR transportation standards mention that if the official stop is not accessible, the conventional transportation service providers, including operators, are obliged to locate the safest closest locations for persons with disabilities from where it would be easy for them to board or deboard. [221]

In Bangladesh, there are no official stops for people with disabilities to access public transport. In most cases, they do not get any chance to board public transport. Further, there is a scarcity of public buses in major cities, including Dhaka city.

As a result, even sometimes, people without disabilities find it hard to board on public buses due to overcrowded situations. So, this provision would help people with disabilities to access specific boarding points for safe boarding and deboarding.

It would also build social awareness because the general public would realize that public transport should be accessible to all citizens of Bangladesh, irrespective of their physical condition and other factors.

[221] *Ibid* at S.47.

3.3.4 No fare for support persons

The AODA IASR transportation standards state that conventional transportation service providers, including specialized transportation service providers, must not charge a fare to a support person who is accompanying a person with a disability on vehicles where the person with a disability has a need for a support person. The person with a disability has the responsibility to provide evidence regarding his need of a support person to the transport service providers.[222]

It is an affirmative policy that the government of Ontario has taken through the Act that can be included in the Act of Bangladesh. In Bangladesh, wheelchair users have no chance to move outside without the help of any other person. Moreover, other than close friends and family, people are not interested in assisting disabled persons due to travel expenses. So this kind of initiative will make other people interested in helping people using wheelchairs.

3.3.5 Conveying information on accessibility equipment and features

The AODA IASR mentions that all conventional transportation service providers and specialized transportation service providers are bound to convey current information on accessibility equipment and features of their vehicles, routes and services to the public.[223] They must also provide the information to anyone upon request.[224]

BRTA is the authority that monitors and regulates public and private bus service companies. As a result, the inclusion of such a provision in the Road Transport Act will obligate them to disseminate information to the general public, including WWD, about new accessibility

[222] *Ibid* at S. 38 (1).
[223] *Ibid* at 34 (1).
[224] *Ibid* at S. 34 (2)

equipment and features, routes, and services. It is also found in the research that women with disabilities are not aware of their policies regarding their rights and accessibility services.

3.3.6 Providing mobility aid spaces and lighting arrangement in the transport

There are provisions relating to mobility aid spaces where it is mentioned that every conventional transportation service provider shall ensure that all of its transportation vehicles have two or more allocated mobility aid spaces, with each space being a minimum of 1,220 millimetres by 685 millimetres for vehicles designed to have a seating capacity of 24 passengers or less, and 1,220 millimetres by 760 millimetres for vehicles designed to have a seating capacity of more than 24 passengers.[225]

Moreover, the AODA IASR mentions that every traditional transportation service provider must ensure that all of its transportation vehicles have lights 'above or beside each passenger access door that are illuminated when the door is open' and illuminate the lifting device, ramp, portable bridge plate, or step nosings.[226] When the door is open, the light above or beside it must illuminate the ground surface for at least 0.9 meters perpendicular to the bottom step tread or lift outside edge, and it must be protected to protect the eyes of passengers entering and exiting. [227]

In Bangladesh, lighting arrangements inside transport including public buses, minibuses, and automobiles are not satisfactory for safe boarding or deboarding. For that reason, a woman with a disability might not be interested in avail of them because it may cause physical injury to her. At night time, it would be very hard for her for safe boarding or deboarding. Moreover, the seats of the buses are congested, so it becomes hard for a person with a disability to move inside

[225] *Ibid* at S. 55.
[226] *Ibid* at S.57 (1)
[227] *Ibid* at S.57 (2)

the vehicle with her wheelchair or any other mobility aid. These provisions must be inserted into the laws and make them obligatory upon the service providers. If these changes can be made by the transport providers within a short period of time, it will immensely help WWD to access public transport easily.

3.3.7 Accessibility Training

Moreover, the AODA IASR mentions that every organization shall provide training to employees, volunteers, and policymakers; conventional transportation service providers and specialized transportation service providers are bound to conduct employee and volunteer accessibility training.[228] The accessibility training shall include training on the safe use of accessibility equipment and features; acceptable modifications to procedures in situations where temporary barriers exist or accessibility equipment on a vehicle fails; and emergency preparedness and response procedures that provide for the safety of persons with disabilities. [229] Additionally, they must keep a record of the training.[230]

These provisions should be brought into the law of Bangladesh because such a training program for transport service providers would not only help women with disabilities access transport services but also build awareness in society at large. If transport providers and workers obtain training on a regular basis through a human-rights approach relating to the needs and realities of people with disabilities, it will help them to understand that people with disabilities are equally entitled to get access to public transport like others. Because most transport workers in Bangladesh have poor literacy or have little knowledge of disability, they must be trained to

[228] *Ibid* at S. 36 (1).
[229] *Ibid* at S.36 (2).
[230] *Ibid* at S. 36 (3).

increase their capacity to understand accessible equipment, modifications, and emergency responses for passengers with a disability.

3.3.8 Participation of People with Disabilities in Accessibility Plans

Customer feedback and participation in the accessibility planning of conventional and specialized transportation service providers can be considered as one of the best practices followed by Canada. In their accessibility plans, conventional and specialized transportation service providers need to identify the process for managing, evaluating, and taking action on customer feedback. Moreover, they must annually hold at least one public meeting connecting persons with disabilities to ensure that they have an opportunity to participate in a review of the accessibility plan and to provide feedback on the accessibility plan. [231]

In Bangladesh, the passenger and freight transport committee is legally capable of receiving complaints from passengers using public transport. There is no other way to get feedback from the passengers. So a provision of this kind should be inserted into the policies of Bangladesh. Moreover, annual public meetings can be called by the BRTA where passengers, including people with disabilities, can express their complaints, problems and expectations to the transport service providers. Otherwise, BRTA may make rules transferring the responsibility to the transport service providers to arrange public meetings on their own. It will ensure the effective participation of people with disabilities in the transport service sector.

In regards to the complaint procedure, another lacuna of the laws of Bangladesh is that it would be difficult for a person with a disability to file a complaint under the two laws because there are two different authorities to whom a complaint can be filed. Under the Road Transport Act, the "Passenger and Freight Transport Committee," and under the *Protection of the Rights of*

[231] *Ibid* at S. 41.

Persons with Disabilities Act 2013, the district, upazilla, and town committees have jurisdiction to adjudicate a complaint filed by a passenger of public transport. Hence, there should be no ambiguity within the legal provisions relating to filing a complaint by a person with a disability using public transport.

In Canada, including Ontario, there are concerns about how people with disabilities can make complaints. The procedures in both Ontario and at the federal level are either nonexistent or extremely complex. Further, within the province of Ontario, the Office of the Ontario Ombudsman ("the Ontario Ombudsman") has the legal mandate to enforce the provision of its transportation accessibility services in accordance with the AODA IASR which is quite specific.[232] So, in the jurisdiction of Bangladesh, legal authorities should be specific about who has the jurisdiction to deal with complaints from disabled passengers using public transport.

3.4 Provisions relating to Equality and Non-discrimination

In Bangladesh, there are constitutional provisions that are relevant to human dignity, equality and non-discrimination. Article 11 of Bangladesh's Constitution, Part II, refers to a democratic republic in which human dignity and fundamental human rights, as well as freedom for everyone, are respected. The main point of Article 11 is that respect for human rights is relevant to disabled people who deserve the state's protection of their dignity. Although the Fundamental Principles of State Policy enumerated in this Part are not enforceable in a court of law, they do form the foundation of the Constitution of the People's Republic of Bangladesh.

According to Article 8, the legislature and the court must follow the rules in Part II before adopting new legislation or interpreting any provisions of law. Furthermore, Article 27 of the

[232] Accessibility Standards, Ombudsman Ontario, online: <https://www.ombudsman.on.ca/what-we-do/about-our-office-en/policies-and-procedures/accessibility-standards>

Constitution indicates that everyone is equal before the law, but Article 28(4) states that the government has the authority to make special legislation for the improvement of the underprivileged. These are some of the fundamental rights guaranteed by the Bangladeshi Constitution, a violation of which entitles the aggrieved person to seek redress in the Supreme Court of Bangladesh under Article 102 read with Article 44. As a result, as Bari and Jahan have argued, it would not be inaccurate to assert that these rights and principles are equally applicable to persons with disabilities in preserving their rights under our country's constitutional mandate.[233]

Moreover, there is a subsequent clause found that ensures the right to equality and non-discrimination while preserving the rights provided by the previous clause:

> No person, institution, authority or body may discriminate or discriminate against a person with a disability in relation to the rights referred to in section 16 (1).[234]

In another section of the Act, detailed provisions have been given relating to the complaint mechanism if a person with a disability faces any form of discrimination or deprivation of the rights guaranteed in section 16 (1) by any person, institution or authority. Applications and complaints can be made to the concerned district, national executive committee for appropriate compensation.[235] There is another full section on how a person with disabilities might go for a legal remedy to the court if any person or authority violates the rights provided under the Act of 2013. It also includes punishment provisions for the discriminatory acts and behaviors towards them. But unfortunately, this Section 36 (provided in Appendix-II) of the

[233] K. M. Ashbarul Bari and Nusrat Jahan, "A Legal Assessment of the Rights of the Persons with Disability: Bangladesh Perspective" (2015) Human Rights law, Law of the Disabled, *Dhaka law Review*, <https://www.dhakalawreview.org/blog/2015/07/rights-persons-with-disability-901>.
[234] The Act of 2013, *supra* note 187 at S 16 (2).
[235] *Ibid* at S 36.

Rights and Protection of the People with Disabilities Act, 2013, is considered as a 'reserved section'. It is mentioned in the first part of the Act that until the government publishes an official gazette declaring its effectiveness, people with disabilities might not ask for legal grievance against any discriminatory behavior or action of any person, institution, or authority.[236] So, disabled people will have little resort if they experience discrimination without the publication of the government gazette.

Challenging the reservation, in a writ petition,[237] it was mentioned that despite the fact that the law has been in effect for almost a year and a half, no gazette notification bringing Sections 36 into effect has been published. It was argued by the applicants of the writ petition that that sections 2(1) (b) of the Act, as well as sections 31 and 36 of the Act, are critical for the 2013 Act's proper implementation. The failure to apply these parts results in the denial of legal rights and benefits to people with disabilities. The petitioners, BLAST, NGDO, and NCDW, issued a demand for justice against the respondents, which included the Secretary of the Ministry of Social Welfare and Ministry of Law, Justice. They did not, however, receive an answer.

On the 18th of May 2015, a division bench of the High Court (Mr. Justice Moyeenul Islam Chowdhury and Mr. Justice Ashraful Kamal) issued a Rule Nisi directing the respondents to show cause why an Order should not be made directing them to publish a gazette notification activating sections 31 and 36 after forming the necessary committees under the *Rights and Protection of People with Disabilities Act 2013*. The Rule was made returnable within four

[236] *Ibid* at S 1.
[237] BLAST, NGDO and NCDW v Bangladesh and Others, Writ Petition No 5025 of 2015.

weeks. But still, the next hearing is pending because the government is not submitting the show cause.[238]

On the other hand in Canada, the *Charter of Rights and Freedoms*, which is part of the Constitution of Canada and applies to all government actions, gives all individuals fundamental freedoms and rights. It includes an explicit provision of the right to equality for people with disabilities. Section 15(1) states that "every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age or mental or physical disability".[239] Further, the Ontario Human Rights Code ensures the provision of equality and non-discrimination with respect to services, goods and facilities irrespective of race, sex, color, place of origin, age, marital status or disability.[240]

The AODA IASR 2005 also mentions that it recognizes the history of discrimination against persons with disabilities in Ontario, and the purpose of the Act is to benefit all Ontarians by developing, implementing, and enforcing accessibility standards to achieve accessibility for Ontarians with disabilities withrespect to goods, services, facilities, accommodation, employment, buildings,structures and premises.[241]

Moreover, judicial decisions were found where the principle of equality and non-discrimination had been held high for a very long time. For example, *Eldridge v. British Columbia (Attorney General)*[242] was one of the most important of the few Canadian Charter

[238] Bangladesh Legal Aid and Services Trust (BLAST), https://www.blast.org.bd/issues/disabilityrights/305.
[239] The Charter, *supra* note 6 at S. 15 (1).
[240] *Human Rights Code,* R.S.O. 1990, c. H.19 , S.1.
[241] See AODA IASR, *supra note* 8 at S.1.
[242] *Eldridge v. British Columbia* (Attorney General), [1997] 3 S.C.R. 624 [Eldridge].

issues pertaining to disabled people's access to health care.[243] This case is crucial for this thesis topic because it demonstrates that people with disabilities have an inherent right to receive the same healthcare services as everyone else, as well as the accommodations needed to guarantee that these services are available equitably. In another case,[244] filed to the Human Rights Tribunal of Ontario (HRTO), the complainant Quesnel experienced Spinal Muscular Atrophy. She was a wheelchair user and, when she arrived for an appointment at the respondent's chiropractic clinic, discovered that there was no ramp, lift, or elevator that could accommodate her wheelchair. So, she was unable to enter the building. Afterwards, the owner of the facility and the chiropractor offered to carry Ms. Quesnel up the stairs or make a house visit during a phone call. Both offers were turned down by the plaintiff. For grounds linked to the assault on the complainant's inherent dignity, the alternative of lifting was rejected. Moreover, off-site treatment practices such as a home visit by the chiropractic facility in the neighborhood were also ruled out. It was finally settled by the tribunal that treatment facilities should be provided to all with equality and non-discrimination without offering alternatives.

In Bangladesh, the existing provision under the Act of 2013 to ensure equality and non-discrimination is under reservation, which means that people, including women with disabilities, will be unable to go to court if they are subjected to discriminatory treatment by any other person, authority, or institution. But there is only one resort, which is the Supreme Court of Bangladesh, where a person with a disability or disability organizations may file a writ petition if the right to equality provided in Article 27 is violated. But it is a matter of dissatisfaction that the status of some writ petitions is still pending. On the contrary, Canadian courts were proactive in ensuring equality provisions decades ago, as the case decisions mentioned above were from 1995

[243] Jacobs, *supra* note 9 at 33.
[244] *Quesnel v. London Educational Health Centre* (1995), 28 C.H.R.R.D/474.

and 1997. So, there is a huge legal gap in the case of implementing equality provisions between Bangladesh and Canada.

3.5 Provisions relating to Health Care Professionals

In Bangladesh, women with disabilities are not receiving proper medical treatment or maternal health care, which is a part of the overall medical scenario. It is alleged that due to overpopulation and a lower number of doctors and medical professionals, the situation is not improving. On the other hand, there are misconceptions and superstitions relating to disability that prevail among health care professionals and other caregivers as well. As a result, complaints are sometimes found when women with disabilities go to health care centers to access maternal health services.

Medical ethics in the jurisdiction of Bangladesh is found through the Hippocratic Oath[245] around 2200 BC, which was formulated in ancient Greece where doctors were treated as demi-gods whose decisions were considered as conclusive.[246] This imposed an immense duty over them to take an oath where they committed themselves to act with the highest diligence, capacity, and honesty. Bangladesh adopted the oath in their medical jurisprudence through the consensus taken at the third General Assembly of the World Medical Association in 1948. Every medical member of Bangladesh must take the oath to maintain medical ethics after registering himself in the Medical and Dental Council. The medical and dental councils are the regulatory bodies of Bangladesh to regulate the conduct of medical professionals.[247] They are legally empowered to form committees and take actions against medical professionals for any violation

[245] The language of the Hippocratic code is, "I pledge to consecrate my life to the service of humanity. I will not use knowledge contrary to the laws of the humanity. I will maintain the utmost respect of human life from the time of conception."
[246] R E Mahbub, "Medical Ethics in Bangladesh" (2012) 41(1) *Bangladesh Medical Journal* at 7, DOI: http://dx.doi.org/10.3329/bmj.v41i1.18771.
[247] *Ibid.*

of the ethical code or malpractice. The council can punish the guilty medical professional by cancelling his or her registration for a short time or permanently.[248] So there are legal provisions to make complaints against any medical professional for his or her misconduct or unethical action towards their patients. People, including women with disabilities, may file a complaint against her health professional if she encounters any misconduct or discriminatory or unethical behavior from her doctor.

Though the punishment is severe in nature, the real problem lies in the understanding and ignorance of the medical ethics code by medical professionals in Bangladesh. A recent study found that medical professionals do not have satisfactory knowledge of ethical codes. The study objective was to find the level of understanding regarding medical ethics among health care professionals. Results showed that among 400 respondents, 32% had ethical knowledge, 35% had very little knowledge, and 46% had average knowledge on ethical law.[249] The authors recommended that responsible authorities like the Bangladesh Medical and Dental Council (BMDC) and professional bodies like the Bangladesh Medical Association (BMA) should consider the inclusion of medical ethics in undergraduate and postgraduate education programs. Unfortunately, now medical students only get 12 hours of lectures on medical ethics in the course named medical jurisprudence in their third and fourth years.[250] So, medical courses that increase medical personnel's ability to apply ethics effectively are recommended.

3.6 Law and Policy Implications and Recommendations for Bangladesh

There are allegations that in Bangladesh, in the realm of public services, people, including women with disabilities, are often treated as a subject for charity and welfare. Still, the

[248] *Medical and Dental Council Act 2010* , Act No. 61 of 2010 at S. 23.
[249] MU Jahan & SMM Rahman, "Understanding of Professional Ethics Among a Sample of Medical Practitioners in Bangladesh", (2020) 46:00, *Bangladesh Medical Res Counc Bull*, DOI: https://doi.org/10.3329/bmrcb.v46i3.52251.
[250] *Ibid.*

sector for the development of people with disabilities is regulated by the ministry of social welfare. It actually reflects the expression of the medical model of disability, which still exists in the policies and laws of Bangladesh. Due to the traditional approach followed by lawmakers as well as the general public, the vulnerability of people with disabilities is attributed to a lack of proper health and disability services.[251] So it is time to re-evaluate the existing legal provisions, find the loopholes, and reform laws and policies according to the needs and desires of disabled people, including women with disabilities.

3.6.1 Special provision on WWD including Medical Assistance

Women with disabilities of Bangladesh are encountering barriers while accessing maternal health services, but it is a matter of fact that they start facing barriers from the very early stage of their lives. It begins in early life, with their families as the starting point. It was found that 94% of people with disabilities expressed that their family homes do not have a disabled-friendly washroom or toilet, and only 6 % said that they have access to an adapted washroom or toilet in their family homes. Additionally, public health centers, such as upazila health complexes and district general hospitals, remain inaccessible to them due to structural barriers.[252] Moreover, it was found in another study measuring inequality and disability that in Bangladesh, women are suffering more disability than men.[253]

Findings show that in Bangladesh, poor nutritional status is one of the major health issues. Nutritional deficiencies and micronutrient deficiencies are especially dangerous for young children and women of reproductive age. Furthermore, women in Bangladesh have a

[251] Hussain, *supra* note 3 at 17.
[252] *Ibid* at 18.
[253] Md. Ismail Tareque, Sharifa Begum & Yasuhiko Saito, "Inequality in Disability in Bangladesh", *PLOS ONE*, 2014, online: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0103681#references>

reduced social position, which denies them access to many essential necessities, such as food, nutrition, health care, a secure existence, a respectable life, mental calm, and an absence of violence.[254] These factors may have an active role in their poor health. In this study, the gender gap in disability was found, so it is recommended that specific emphasis should be given on policy reforms prioritizing women.

In the *Rights and Protection of People with Disabilities Act, 2013*, there are no provisions addressing special attention towards the health care of women with disabilities, which is obligatory upon the state under Articles 6, 23 and 25 of the CPRD. The Act of 2013 does not provide women with disabilities all those rights, including their gender-based aspect including special health care, which is another imperative under the Convention. So, a specific and separate provision should be inserted considering the special needs, including medical care of women with disabilities. A new provision must include compulsory financial medical assistance for WWD as of right. In fact, now the government is providing disability allowances through the Department of Social Service under the Ministry of Social Welfare. The monthly rate of the disability allowance is 750 taka (equivalent to 10 Canadian dollars).[255] In a study on a large government medical college hospital in Bangladesh, the researchers tried to find out what occurred to poor women in Bangladesh once they arrived at a hospital that provided complete Emergency Obstetric Care (EmOC), as well as to discover support systems.[256] Interviews with staff and women using the unit, as well as their caregivers, were conducted during an ethnographic observation in an obstetrics ward. It was found that women had to mobilize

[254] *Ibid*
[255] Allowance Program for Persons with Disabilities, *Department of Social Service*, Government of People's Republic of Bangladesh, < http://www.dss.gov.bd/site/page/a8c37128-200f-4cfe-9836-1d1ac7737e91>
[256] Pitchforth E, van Teijlingen E, Graham W, "Getting women to hospital is not enough: a qualitative study of access to emergency obstetric care in Bangladesh" (2006) 15(3) BMJ *Quality & Safety* at 214. http://dx.doi.org/10.1136/qshc.2005.017285.

significant financial and social resources to cover out-of-pocket expenses, according to the findings. Poorer women had a harder time getting treatment since their families couldn't afford to pay for it. The official financial assistance system was inefficient and ineffective in emergency situations. To assist the poorest women, doctors maintained a less official 'poor fund' scheme. There was no formal poverty assessment; instead, doctors made their own discretion of women's need for assistance based on the severity of their condition and the presence of friends and relatives.

The government must understand that providing allowance through the national budget won't change the situation of women with disabilities in Bangladesh. They must legally incorporate the provision of financial assistance within the legislation so that women with disabilities might have the assistant as a right, not a privilege.

Otherwise, incorporating a health care insurance plan could be considered as a possible solution too. In the Canadian health care law, a health care insurance plan has been considered as one of the best provisions for people, including women with disabilities provided under the *Canada Health Act 1984*. Hospital services include accommodation and meals at the standard or public ward level, nursing service, laboratory, radiological and other diagnostic procedures, together with the necessary interpretations, drugs, biological and related preparations when administered in the hospital.[257] Moreover, use of an operating room, case room and anesthetic facilities, including necessary equipment and supplies, use of medical and surgical equipment and supplies, radiotherapy facilities, physiotherapy facilities, and remuneration of the service providers are included under hospital services. These services will be provided for the purpose of

[257] The Act, *supra* note 7 at S 2.

maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.[258] So insertion of such provision might change the scenario of maternal health services of WWD in Bangladesh.

3.6.2 Withdrawing Reservations on Provision relating to Equality and Non-discrimination

In my opinion, a reservation on a provision asking for equal treatment can be considered as a direct form of discrimination done by the government of Bangladesh. The government should publish a government notification withdrawing the reservation on Section 36 of the Act of 2013 so that people, including women with disabilities, may file litigation if any person, including family members or health professionals or transport service providers, acts with inequality and discrimination. In the Act, the term "discrimination" has been defined as "unfair treatment of persons with disabilities as compared to the general public, and one or more of the following activities shall include such unfair treatment including deprivation of the rights of persons with disabilities, to be biased, refusal to provide any facilities or benefits due to disability or to provide fewer facilities and, any other activities prescribed by the government."[259] Thus, there are contradictory provisions found within the Act. So without withdrawing the reservation, the whole purpose of the law can be frustrated because without punishing the wrong-doers for their discriminatory practices and behaviors, justice will not be ensured.

3.6.3 Incorporating Accessibility Standards in Public Spaces, Establishments and Transports

Standards relating to accessibility in public spaces and establishments must be ensured. In my opinion, the concept of 'public space' should be introduced in the building code in a

[258] *Ibid.*
[259] *Ibid* at S. 2 (20).

separate part so that it gets more attention. The accessibility in public spaces for people with disabilities is one of the most critical factors for their social inclusion. [260] Public space is defined as open or closed areas that are built for the use of all people without regard for their age, social status, and physical condition. For the continuation of a smooth public life, a barrier-free built environment is a must. So the issue cannot be disregarded in any way.[261] Especially exterior path of travel including running slope and curb ramp, outside street parking areas including aisles and, service area for accessing public services including waiting area must be inserted in the code.

The building code, building construction rules and Road Transport Act should be revised to comply with universal design. Research should be conducted on buildings and public spaces where immediate modifications are possible. Similarly, public health institutions like hospitals, clinics and diagnostic centers should be selected as 'priority' establishments and made accessible for WWD. Modifications must be done to the buildings as well as adjustable medical equipment should be installed in the centers. Additionally, BRTA should modify public buses to make them accessible or take the initiative to import accessible buses for people, including WWD.

3.6.4 Incorporating 'accessibility plan' and 'accessibility training' provisions into the law of Bangladesh

Like Canada, Bangladesh should insert provisions relating to accessibility plans[262] and accessibility training[263] provisions in the Act of 2013, which may change the situation within a

[260] Meltem Yilmaz, "Public space and Accessibility", *International Journal of Architecture and Planning*, (2018) 6: Special Issue at 1-14 , https://www.researchgate.net/publication/327349344_Public_Space_and_Accessibility.
[261] *Ibid* at 3.

[262] See AODA IASR, S 4 mentions that: (1)The Government of Ontario, Legislative Assembly, designated public sector organizations and large organizations shall, (a) establish, implement, maintain and document a multi-year accessibility plan, which outlines the organization's strategy to prevent and remove barriers and meet its requirements under this Regulation; (b) post the accessibility plan on their website, if any, and provide the plan in an accessible format upon request; and (c) review and update the accessibility plan at least once every five years. (2) The Government of Ontario, Legislative Assembly and designated public sector organizations shall establish, review and update their accessibility plans in consultation with persons with disabilities and if they have established an

shorter period of time. Consequently, the public sector organizations and large organizations are legally bound to establish, implement, maintain and document a multi-year accessibility plan to prevent and remove barriers and follow its requirements. They have to change their strategies and policies and review the plans after consultation with persons with disabilities.

Moreover, providing accessibility training to all people in public organizations, including employees, policymakers, or goods, services, or facility providers on behalf of the organization can make a huge difference. Stigma and discrimination against people with disabilities among public service providers, including the transport and the health sectors, can be removed through regular training programs. In Bangladesh, law and policymakers, engineers and health care professionals who are highly educated and in a position to take affirmative action must understand that disability is not a medical condition. They must exercise their powers to perform duties to ensure the constitutional rights of people, including women with disabilities.

On the other hand, transport workers who directly work on roads and in transportation, as well as health care providers, i.e., nurses or ward boys, have poor literacy or minimum

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accessibility advisory committee, they shall consult with the committee. (3) The Government of Ontario, Legislative Assembly and designated public sector organizations shall, (a) prepare an annual status report on the progress of measures taken to implement the strategy referenced in clause (1) (a), including steps taken to comply with this Regulation; and (b) post the status report on their website, if any, and provide the report in an accessible format upon request.

[263] See AODA IASR, S 7 mentions that: (1) Every obligated organization shall ensure that training is provided on the requirements of the accessibility standards referred to in this Regulation and on the Human Rights Code as it pertains to persons with disabilities to, (a) all persons who are an employee of, or a volunteer with, the organization; (b) all persons who participate in developing the organization's policies; and (c) all other persons who provide goods, services or facilities on behalf of the organization. (2) The training on the requirements of the accessibility standards and on the Human Rights Code referred to in subsection (1) shall be appropriate to the duties of the employees, volunteers and other persons. (3) Every person referred to in subsection (1) shall be trained as soon as practicable. (4) Every obligated organization shall provide training in respect of any changes to the policies described in section 3 on an ongoing basis. (5) The Government of Ontario, the Legislative Assembly, every designated public sector organization and every large organization shall keep a record of the training provided under this section, including the dates on which the training is provided and the number of individuals to whom it is provided.

educational qualifications. For these workers, regular training programs should be arranged so that they have a better understanding of disability and disability-related issues**.** Additionally, training programs should be arranged for health professionals, including gynecologists, by the Ministry of Social Affairs so that they can treat WWDs during their pregnancy period with due care and attention, understanding their special needs.

3.6.5 Necessary Reforms of the Act of 2013 for Proper Functioning

Excessive dependence on the executive, in my own opinion, is a primary factor that frustrates the desires of people with disabilities. Further, in the *Rights and Protection of the People with Disabilities Act 2013*, a long list of committees and other bodies were formed to enforce disability rights,[264] but there is no indication of action measures for failing to maintain the proper functioning of these bodies. Accountability mechanisms, including grounds for disqualification of committee members that may lead to vacancies in seats, should be included. Moreover, although there is an obligation upon the town committee to submit an annual report to the district committee, to the district committee to the national executive committee, and to the national executive committee to the national coordination committee, in order to report the activities adopted and performed to protect the rights of persons with disabilities, the consequence of non-submission of reports to the higher authorities has not been specified. So, the consequence for non-submission must be specified in the Act so that the committees submit them on time.

Another major shortcoming of the Act of 2013, deals with remedies. The disabled person or their family, or any organization, can apply to the committees if any right under the Act is violated, which implies that the committees (comprised of executive members) shall have

[264] The Act of 2013, *supra* note 187 at S 17-28.

jurisdiction to adjudicate by making inquiries and holding hearings. But in my opinion, it is a matter of argument that for public officers having no judicial capacity, such adjudications can be toothless.

Further, in the Act of 2013, it is said that for the purpose of identification and registration, the disabled person or any other person on their behalf must apply,[265] which does not comply with the socio-economic situation of Bangladesh. It is the responsibility of the government to identify and screen all children at least once a year to identify "at-risk" cases. So the early detection of disabilities should be done by a medical board, and a 'disability certificate' should be issued (at the time of birth and early stages of childhood) for future legal privileges. In examining not only this provision but also other provisions, it seems that there is a tendency in the Act to confer responsibility to the families or organizations of the disabled persons to get identification rather than taking responsibilities on the shoulders of the concerned local authority. Moreover, this section has also been reserved by the government, which hinders the process of early detection. The long-term effect would be to make it nearly impossible to get accurate data on people, including women with disabilities, in the future.

3.6.6 Ensuring Availability of Mobility Aids and Assistive Devices and Information Relating to the Services

In Dhaka city, there are only five to eight private device stores that sell mobility aids. But the cost of those devices is high and poor people can't afford them. However, there is a probability that it can be a good business, as many disabled people need mobility aids like standing frames, balanced chairs and wheelchairs. Because the government has given a rebate for the import charges of assistive devices and mobility aids for people with a physical disability,[266]

[265] *Ibid* at S 31.
[266] Existing Govt. & Non Govt. Facilities for Persons with Disabilities &Referral Service, *Employment and Re-*

some NGOs like CRP Bangladesh [267] and Handicap International [268] are trying to provide such help. They are producing assistive devices such as wheelchairs, artificial limbs, and hand splints for people with disabilities. Through these programs, many persons with disabilities have been able to gain more functionality, participate in community activities, and become less socially isolated. But a problem lies in the lack of communication and information of such facilities to the people, including women with disabilities. In this respect, awareness programs, including locality-oriented public meetings, should be arranged by the Ministry of Social Welfare, and regular circulation of information should be published on websites.

3.6.7 Incorporating the Medical Code of Ethics

Medical courses relating to medical ethics and codes should be discussed more in-depth so that future medical professionals get to know their duty towards their patients, irrespective of their sex, age, gender, religion, and physical capacity. Treating their patients with equality and non-discrimination must be a part of their education. Moreover, training, workshops, and seminars should be arranged for health professionals on a regular basis relating to the medical code and ethics as well. A study in India revealed that tools of the humanities (storytelling, visual art, poetry, narratives, and Forum Theatre) used in modules in medical studies had the potential to explore the struggles and oppression faced by people with disabilities and to expose discriminatory attitudes.[269] Findings showed that learners were able to think beyond the hegemony of normalcy and show an understanding of diversity, dignity, autonomy, disableism,

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habilitation Center for the Physically Handicapped (ERCPH), http://www.ercph.gov.bd/site/page/5c0f9eef-27af-48e7-b3de-8ce90d1e6b12/-.

[267] Center for the Rehabilitation of the Paralyzed (CRP), https://www.crp-bangladesh.org/.
[268]Handicap International, Humanity and Inclusion, https://www.hi-us.org/about.
[269] Satendra Singh, Amir Maroof Khan, Upreet Dhaliwal & Navjeevan Singh, "Using the Health Humanities to Impart Disability Competencies to Undergraduate Medical Students" (2021) 101218, *Disabl and Heal J*, https://pubmed.ncbi.nlm.nih.gov/34620568/.

social inclusion, equity, and universal design better than before.[270] Moreover, the medical students also admitted to the misunderstandings they carried and showed interest to be supporters of change.[271] So such a humanistic approach should be incorporated in the curriculum of medical syllabus and modules to make the medical students understand disability-related issues.

3.7 Limitation of the Research

The fundamental constraint of the study is that in Bangladesh it was quite hard to collect official documents and conduct interviews in government and non-government workplaces because of Covid-19 pandemic-related rules of social distancing. Furthermore, several Bangladesh-related resources were not available on the internet, so it was difficult to gather sufficient resources to evaluate some specific legal provisions.

[270] *Ibid.*
[271] *Ibid.*

Conclusion

The laws and policies for removing barriers for WWD while accessing maternal health services are still in their infancy in Bangladesh, whereas the Canadian laws and policies are well-developed. In Bangladesh, insufficient, inappropriate, and discriminatory policies persist. The main laws on disability have reservations on the equality clause which directly hinders the way for implementing disability rights.

While examining the laws and policies of Bangladesh, I found that the incorporation of disability policies was done in late 1990s. From the very beginning, the government did not show interest to enact separate policies and statutes for people with disabilities. Later on, an Act was enacted in 2001 but the Welfare Act failed to meet the needs and desires of the people with disabilities. Lastly, the Act of 2013 was enacted inserting the term "rights and protections" which gave hope in the minds of people including women with disabilities that this Act might fulfill their necessary and special needs within the legal framework. But as mentioned earlier, the reservations of certain provisions have frustrated the purpose of the Act.

Although in Canada, there are issues related to implementation, the existing laws address structural and attitudinal barriers encountered by people, including women, with disabilities. For example, in 2019, a new law titled the Accessible Canada Act[272] has been enacted focusing on accessibility for people with disabilities because of Canada's commitment to equality.[273] Within the federal domain, the basic idea of the Act is to remove existing barriers and avoid the construction of new hurdles for individuals with disabilities. But most relevant to the thesis,

[272] *Accessibility Canada Act* S.C. 2019 c.10, < https://laws-lois.justice.gc.ca/eng/acts/A-0.6/>
[273] Laverne Jacobs, Martin Anderson, Rachel Rohr & Tom Perry, The Annotated Accessibility Canada Act , The Law, Disability and Social Change Project, https://scholar.uwindsor.ca/lawpub/126/

certain provisions of the AODA IASR have been discussed. This law, enacted in 2005, also addresses accessibility barriers, at the provincial level, in Ontario. In Bangladesh, new changes cannot be made by overnight that is why I have chosen some feasible and possible legal initiatives from Canada which could be inserted in Bangladeshi laws and policies.

New provisions relating to public space including the exterior path of travel, outdoor parking areas and service areas of public service providers should be inserted into the Building Code. Changes should be made in laws and policies relating to public transportations where modifications of public vehicles providing mobility spaces, lighting arrangements, and clearly marked sitting areas should be incorporated. Moreover, providing mobility aids in the transportation and fare exemption for the support persons should be inserted.

New provisions such as accessibility policies (including accessibility training) should be included in the Act of 2013 which may bring a huge change in the mindset of people. Public institutions proving public services must incorporate accessibility plans and policies relating to their goods, services and facilities for people with disabilities. They also should circulate the news relating to the products, services and facilities in a wider scale so that people with disabilities may avail them easily. Moreover, regular public meetings should be arranged with people with disabilities to make inquiries about their needs and necessities. Through these initiatives, negativity and stigma towards disability can be removed from the minds of people. Most importantly, accessibility training might be shown to be one of the most effective initiatives to fight discrimination and social stigma towards people including women with disabilities.

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APPENDIX- I

Dhaka City Building Construction Rule 2008

(Schedule -2)

1. General rules for each room, there should be a minimum space (1500 mm X 1500 mm) for moving/rotating a wheelchair by the user. No obstacles should be kept in the entry and exit points of a room, and every room must be open and adequately illuminated. No establishments are to be made that are higher than 2 meters from the ground and, if made, require a colored or signboard to bring attention to ramps. The highest height of the bevel should be 1:2; otherwise, ramps should be installed.

2. Every door of public establishments should be 800 mm wide, and it must not be moving. There should be enough open space on both sides of the door, and on both sides, there should be 1200 mm X 1200 mm open space for opening and closing. The height of the handle or lock of a door will not exceed 85-mm-900 mm from the ground, and it should be flexible and easy to open.

3. Handrails and grab rails shall be round with an outer diameter of 31-36 mm. It shall be far from the adjacent wall, the distance must be from 36 mm-50 mm from the adjacent wall, but it cannot be in any way obstruct the way, which is necessary for a barrier-free movement. The entire length of the handrail will be from 800-900 mm; above or below this; additional handrails can be provided for special needs. The edges of the handrail will be rounded or curved in this way towards the wall or floor. It should be inserted so that it does not cause any danger on the way.

4. All along the stairs, the size of the tread and riser should be balanced and unchanged. Stair treads should be a minimum of 260 mm. deep, and the size of every riser should be from 125 mm-165 mm. In each tread, there should be a round nozzle coming out, which should be of a maximum of 36 mm. There will be handrails on both sides of the flight, and at the end of the stairs, they will be extended to a minimum of 300 mm. At the beginning of a tread, the depth should be 300 mm. and should be horizontally extended. The floor of the stairs should be made of opaque material, and the place should be well illuminated.

5. A ramp should have a maximum proportion of 1: 2 with a balanced slope not exceeding 12 meters on one side. If the ramp is longer than 1800 mm, handrails should be provided on both sides at the height of 800-900 mm. At the beginning and end of this rail ramp, another 300 mm should be increased horizontally. The distance

between the handrails on both sides cannot be less than 1200 meters. The open end of the ramp should be raised at least 75 mm from the floor and marked with a different color. At the beginning and end of any ramp, and if the ramp is 9 mm longer than this or if the direction of the ramp is to be turned, then 1.5 mm X 1.5mm space should be kept for a landing. There should be kept 2.25 mm X 2.25 mm space for electric wheelchairs. The width of the landing cannot be less than the width of the ramp, and the length of the landing cannot be less than the width of the ramp by turning 180 degrees. The ideal width of the landing is at least 1500 mm.

6. Elevators' lobbies should be accessible, illuminated, and installed horizontal and minimally (1.5 mm X 1.5 mm) unobstructed. Lift control buttons must be located within 890-1200 mm. The gazette value of the lift cabin will be 1500mmX 1200 mm, and the minimum width of the door will be 800 mm. If lift installation is not possible, a platform lifting device of the same size should be used.

7. At least one on each floor or 5% (whichever is more) of the total number of toilets should be made accessible for the disabled. There should be a minimum of 1.5 m X 1.5 m unobstructed space inside the toilet and a minimum of 900 mm open space from the adjacent wall on one side of the water closet. The handrail should be extended to the back wall, which will be 400 mm high and 300 mm far from the seat of the water closet. The height of the water faucet should be 850 mm from the floor. And the pipes of the basin should be in such a way that the wheelchair can reach. The bath area shall be 1.15 square meters with a width of 1.0 m, and there will be no enclosure in the bathroom.

8. There should be at least one parking space for the public with disabilities. The width of this parking space should be at least 3.2 meters.

9. Seats suitable for a certain number of wheelchair users are to be reserved at different public assembly venues. It should be evenly distributed, easily visible, and accessible from the entrance. To get to these seats, there will be a barrier-free space of 900 mm to X 1500 mm. The seats shall be at one side of a row, which will be at least 1200 mm wide. The reserved seats shall be in the same row as the other seats, and that other common seats may not be a hindrance to use.

APPENDIX- II

Rights and Protection of the People with Disabilities Act 2013

(Section-36)

36. (1) Notwithstanding anything to the contrary in any other provision of this Act, no person or institution or authority or body may discriminate or discriminate in respect of the rights of persons with disabilities.

(2) If any person or organization or authority or organization shows any kind of discrimination or discriminatory behavior or by any act or refrains from doing any work or any disabled person is harmed due to deprivation of any of the rights mentioned in this Act. An application can be made to the concerned district committee demanding appropriate compensation against him.

(3) In case of any application for compensation under sub-section (2), the district committee shall, if necessary, in due course, inquire into the matter and take up the matter, within the time limit fixed by it, to eliminate the discrimination mentioned in that sub-section or, as the case may be issue orders to the person or organization concerned.

(4) If the inequality mentioned in sub-section (2) is not eliminated or, as the case may be, the rights are not exercised within the time limit specified by the District Committee under sub-section (3), the district committee shall determine the extent of the victim and determining the amount of compensation, considering the capacity, may issue an order to the person or organization responsible for the payment of compensation.

5) If any person is disturbed by any order made by the District Committee under sub-section (4), he may appeal to the National Executive Committee within 30 (thirty) working days from the date of issuance of such order:

Provided, however, that if the National Executive Committee is satisfied that the appellant has not been able to file an appeal within that time for reasonable reasons, the Committee shall, in its discretion, accept the appeal within not more than 30 (thirty) days after the expiry of that time.

(6) The National Executive Committee shall, within 45 (forty-five) days after receipt of the appeal under sub-section (5), if necessary, after hearing the matter in the prescribed manner, issue the necessary order in favor of the appellant or, if not admissible, dismiss the appeal.

(7) The decision of the National Executive Committee given under sub-section (6) shall be final and binding on all parties concerned.

(8) If an order is made to pay compensation under this section, the responsible person or organization shall be obliged to pay the compensation to the applicant within the period specified in the relevant order.

(9) If any compensation payable under this Act is not paid within the stipulated time, it shall be recovered from the concerned person or organization in the manner in which the arrears of land revenue are recovered in accordance with the provisions of the Public Demands Recovery Act, 1913 (Act IX of 1913). And will be paid to the disabled person.

(10) The National Executive Committee may request the concerned bank to freeze the bank account of the person, authority or institution concerned in order to facilitate the recovery of the compensation imposed under this Act.

(11) Notwithstanding anything to the contrary in this section, if a person is disabled due to negligence, neglect or any other act of a person or organization, a suit may be filed in the appropriate court against the person or organization directly or indirectly liable for appropriate compensation.

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