Why Bangladesh needs a civil legal framework for adoption

MIND THE GAP



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Recent reports about children being sought or sold for money, both online and offline, should force Bangladesh to confront a long-standing gap in its legal framework: the absence of a comprehensive civil law governing adoption. A recent Prothom Alo investigation found Facebook groups in which children were being offered, sought and, in some instances, negotiated over for substantial sums of money. Of the 288 posts examined by reporters, 63 offered children and 34 sought them. Some involved newborns or pregnant women, while discussions included payments running into lakhs of taka. Separately, another investigation in Kishoreganj reported allegations that five children from a single village had been sold by their parents over the last six years. Poverty and parental drug addiction featured in accounts surrounding some of these cases.

These reports do not establish that every informal transfer of a child is criminally motivated, nor should we assume that every missing child has been sold or trafficked. What they demonstrate is that children are moving between families outside a clear, uniform, and accountable legal structure. As already noted, there is currently no comprehensive adoption law applicable to all citizens. Adoption is largely governed by personal and religious laws, while guardianship is regulated primarily by the Guardians and Wards Act, 1890. The Children Act, 2013 also provides mechanisms for alternative care for children in need of care and protection. These protections are important, but guardianship and adoption are not legally interchangeable.

Guardianship concerns responsibility for and authority over a child. Adoption, where legally recognised, creates a permanent parent-child relationship and consequently raises wider questions of parentage, identity, birth records, inheritance, consent and long-term legal status. The shortcomings of the present system become obvious in the absence of clear answers to basic questions: who may lawfully arrange the permanent placement of a child with another family? How is the free and informed consent of biological parents established? What safeguards apply where poverty, addiction, coercion or financial inducement may influence that consent? Who assesses prospective parents? Who preserves the child's original records? And who determines that the arrangement is genuinely in the child's best interests?

A modern child protection system should have clear answers. Where formal pathways are uncertain or inaccessible, informal mechanisms fill the gap. Social media groups, private intermediaries, personal connections, and informal agreements begin performing functions that belong within a regulated child protection system. At its most dangerous, the distinction between finding a family for a child and finding a child for a family becomes blurred. This is why the absence of a civil adoption framework is not just an inconvenience for prospective parents but it fundamentally affects a child's safety and well-being.

Any reform must nevertheless begin with an important qualification: poverty should never become a mechanism for permanently separating children from their families. A parent unable to feed or educate a child should, wherever reasonably possible, receive support rather than be placed in circumstances where surrendering that child to another family appears to be the only solution. Family preservation, kinship care, and properly regulated foster care must remain part of the same conversation. There will, however, be children who cannot safely remain with their biological parents, cannot appropriately be placed with relatives, or have been abandoned or orphaned. Bangladesh needs a credible legal answer for them too. Institutional care should not become the automatic destination for a child simply because the legal system has failed to develop sufficient family-based alternatives.



A child is not property to be transferred by contract. PHOTO: MAGNIFIC

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In this regard, a question may arise as to whether a civil legal framework for adoption can coexist with Bangladesh's religious and personal laws. It can, provided we stop treating religious freedom and access to a civil arrangement as mutually exclusive.

We confronted a similar argument in discussions over the recently passed Property Transfer (Amendment) Act, 2026—particularly its provision for a distinct form of property transfer (beyond heba and other recognised methods) that allows donors, including potentially vulnerable elderly parents, to retain lifetime usufruct rights. In response to criticism that this violates sharia provisions on property transfer and inheritance, proponents of the amendment have argued that people should remain free to follow religious rules while also having the option of choosing a lawful civil arrangement outside those rules. "There is no reason to turn these two rights into enemies," as a columnist of this daily wrote.

This same principle has even greater force where vulnerable children are concerned. A civil adoption framework need not compel anyone to adopt in a manner contrary to their religious beliefs. Nor must it abolish guardianship or arrangements recognised under personal law. Those wishing to follow the rules applicable to their faith should remain free to do so, but those who prefer a regulated civil arrangement should also have that option. Such a framework could establish a central authority responsible for adoption and permanent placement, require judicial or independent approval, prescribe assessments of prospective parents, establish procedures for informed parental consent, prohibit the sale or purchase of children as well as unlicensed intermediaries, preserve accurate birth and identity records, and provide appropriate post-placement supervision.

It should also determine the legal consequences for parentage, maintenance, nationality, and inheritance, protect a child's ability to access information about their biological origins where appropriate, and ensure that the child's views are considered according to age and maturity. Most importantly, every placement would leave an accountable legal and administrative trail.

That said, a child is not property to be transferred by contract. No private agreement, affidavit or payment can substitute for an independent determination of that child's best interests. This principle must sit at the centre of reform. An adoption law should not be constructed around an adult's supposed right to obtain a child; it should be constructed around a child's right to protection, stability, and family life. The primary objective should be to find suitable families for children who need them, not children for adults who want them.

Bangladesh already has laws addressing trafficking, child protection, and guardianship, but these separate mechanisms do not amount to a coherent system regulating permanent family placement. That gap creates vulnerability on every side, as the recent reports amply suggest. Prospective parents face uncertainty over how to proceed lawfully. Biological parents in desperate circumstances may be vulnerable to exploitation. Authorities lack a single transparent process through which placements can be scrutinised. Children, who exercise the least control over these decisions, naturally carry the greatest risk.

A civil framework on its own will not eliminate trafficking, poverty, addiction or abandonment. But a good law can establish who may make decisions concerning a child, create safeguards against abuse, impose accountability when those safeguards are breached, and provide a legitimate route for families acting in good faith. The recent reports should, therefore, provoke a discussion larger than whether individual Facebook groups should be closed or particular intermediaries prosecuted. These measures only address symptoms. It is the underlying legal vacuum that must be addressed.

If our civil law can evolve to provide greater security to elderly parents or grandparents, it should certainly be able to provide it to children who have little power to protect themselves. For them, legal certainty is not an abstract jurisprudential concern. It determines who they call family, what identity they carry, what rights they possess, how they grow up, and even whether the state knows where they are at all.

Better healthcare needs clearer communication with patients



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Imagine leaving a hospital with a prescription but still wondering: which medicine should I take first? The information is on the prescription, but communication failed. At the heart of healthcare is a goal: better health and wellbeing. Information, concerns, instructions, and decisions exchanged between patients and healthcare professionals must therefore be "translated" into understanding and appropriate action.

There is evidence from Bangladesh that medical language can create real difficulties for patients. In a 2019 exploratory study published in BJGP Open, Badrul Alam Bhuiyan and colleagues surveyed 50 Bangladeshi adults online. Of the respondents, 44 percent identified English as the language used in prescriptions, while 26 percent reported a mixture of Bangla and English. Around 30 percent could not understand the medical language used by doctors. More broadly, many participants felt that medical language was affecting the treatment process, with 48 percent identifying it as a barrier to effective healthcare. The small, non-representative sample means these figures cannot be treated as a national estimate, but the study raises an important question: what is the value of medical instructions if the patient cannot understand them?

But the problem can begin even before a prescription. Gastroenterology, neonatology, or internal medicine—a specialist's title can be medically precise yet meaningless to someone unfamiliar with it. Moreover, patients need to know not only the possible side effects of medicines, but what they mean and what action they require. Without adequate counselling, someone may be worried about an expected reaction, stop a medicine without consulting a professional, or fail to recognise an urgent symptom.

The need for clear communication becomes even more evident in the process of informed consent. A 2019 study of 190 mothers at two tertiary hospitals in Dhaka, published in the European Journal of Midwifery by Md Abdul Karim and colleagues, found that although consent was obtained from 95 percent of mothers before vaginal delivery, the process did not ensure informed consent, with mothers given no opportunity to express their preferences or choose alternatives. The study was limited to two hospitals and involved data collected in 2015, but it illustrates a crucial distinction: obtaining a signature is not the same as achieving informed participation.

Similarly, a 2021 mixed-method study published in Reproductive Health examined physician-patient communication around Caesarean-section decisions in eight district public hospitals in Bangladesh. Sathyanarayanan Doraiswamy and colleagues observed 306 labour situations and found that 92.5 percent of encounters received low overall scores for shared decision-making, which included presenting options, discussing advantages and disadvantages, eliciting patient preferences, and incorporating them into decisions. The researchers also identified several other factors influencing Caesarean-section decisions, including patient perceptions, physician attitudes, and health-system constraints. The findings nevertheless reinforce the importance of meaningful dialogue and patient participation.

This is closely connected to "health literacy". The World Health Organization defines health literacy in terms of accessing, understanding, appraising, and using health information and services to promote and maintain health and wellbeing. Health education, therefore, should not stop at delivering information; it should help people understand and use it. Health promotion similarly seeks to enable people to exercise greater control over their health.

The same principle extends beyond the bedside. Public health constantly requires translation: research evidence into policy, policy into programmes, health messages into community understanding, and community concerns back into health-system decisions. What begins as information must eventually be translated into something people and institutions can understand and act upon.

There are practical ways to support this. Specialist designations on doctors' nameplates, for example, could use familiar, organ- or disease-based terms alongside clinical jargon, helping patients understand whom they are consulting. Where possible, a bilingual approach can be adopted. In diagnostic test reports, findings and their interpretation can be presented in the standard local language. Along with the results, appropriate reference ranges or clinical decision limits can be provided, with their sources identified where relevant, followed by a note such as, "Talk to your doctor to understand what these results mean for your health." This type of written report can prompt meaningful discussion between patients and doctors. Patient instructions and discharge information can likewise use clearer, more accessible language. After providing a prescription or specific verbal instructions, healthcare professionals can use teach-back by asking patients to explain in their own words how they will follow the advice, allowing any misunderstandings to be clarified. Health literacy skills can receive greater attention in professional education and training. Informed-consent processes can likewise place greater emphasis on explanation, questions, and participation in language that patients can comfortably understand.



VISUAL: MAGNIFIC

This is particularly relevant to nursing, where professionals often explain medicines, provide discharge instructions, answer questions, and notice when patients are uncertain. Such communication is not secondary to care; it is part of enabling safe and meaningful care.

The larger lesson is that translation is not merely changing the language of information. It is about carrying meaning across the boundaries between information and understanding, understanding and action, and action and better health. The UN resolution speaks of clarity, dialogue, understanding, and cooperation; healthcare can apply these principles at the bedside, in health education, and across public-health systems.

The question should therefore not stop at whether information has been delivered. We should ask whether the patient has understood it, had an opportunity to question it, and knows what to do with it. A prescription that cannot be understood is incomplete communication. Healthcare professionals need not only clinical knowledge, but the ability to translate that knowledge into language, explanations, and actions that patients, families, and communities can understand. Because in healthcare, communication is not separate from care—it is part of care.