The future is female, but so was the past

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AVIA NAHREEN

Women today can vote, own property, leave non-serving marriages, own credit cards (as recently as in 1971, women couldn't own credit cards in the US), and run for presidential offices. It seems we are evidently moving away from the shackles of patriarchy and gradually, but assuredly, moving towards universal progress for all women.

But what if one argues that women in indigenous, prehistoric, and precolonial societies, across all continents, were in positions of power and privilege?

Were societies always assembled in ways where men held positions of economic and political privilege? Historical records and contemporary practice show that Native American women, before the arrival of European colonists, had more rights, respect, and power than women in the US today. In the Haudenosaunee Confederacy (an alliance of six Native American nations), women enjoyed far more privileged positions compared to their Caucasian counterparts. Clan matriarchs had the power to choose, remove or keep male chiefs in political positions. In the beginning of the 18th century, when White women in the US were still fighting for voting rights, many of their Native American counterparts were enjoying full political participation in their governments. In fact, many early US suffragettes were inspired to fight for more rights when they came in close contact with Native American women and witnessed their elevated positions in their own societies.

VISUAL: **SALMAN SAKIB SHAHRYAR**

Gender relations in some parts of precolonial Africa were also more equitable, with men and women enjoying differentiated roles yet equal degrees of social power. Gender equity was a feature of many large, prominent African tribes where it was the elderly matriarchs who were at the centre of the clans. In precolonial India, matrilineal family and land ownership structures abounded. From Kerala in the south to Meghalaya in northeast, women in India were heads of clans and households, and property ownership was passed down from the mother to daughters. In Bhutan today, matrilocality (living with or near the wife's home after marriage) and matrilineality (passage of land inheritance from mother to daughter) continue being widely practised.

Latest anthropological research has also shattered the popular trope of men being hunters and women being gatherers. A 2023 research article titled "The Myth of Man the Hunter: Women's contribution to the hunt across ethnographic contexts" provided archaeological evidence showing that women habitually used specialised tools and weapons to hunt big and small animals, and were often buried with their revered hunting tools. In Bangladesh, the Garo and Khasi communities continue to be predominantly matrilineal, with children taking the names of their mothers, and land being passed down from mothers to eldest daughters. This is not to say that in these societies females dominate the male members, but rather both male and female members assume distinct positions of power and privilege, which is more egalitarian.

It is a fallacy to assume that women's lives have become better with time and that women must be content with their seemingly enhanced rights and responsibilities. The phrase "the future is female," which originated during Hillary Clinton's US presidential bid, has become a rallying cry among feminists to realise a world where leadership positions will be shared by more women. However, going by facts, it can be argued that our past, too, was female. Instead of looking at women's rights as justices that are progressively being achieved, one can also look at rights gained now as rights recovered from the past centuries of colonial and capitalist subjugation.

It becomes easier to envision a "female future" once it is known that the past was also female. A more egalitarian society is not only possible but was the norm across almost all geographical regions. To confront the patriarchal forces stopping women driving cars or taking full ownership of their bodies, there is a need to demonstrate that there was a world once where women enjoyed more rights in all spheres of society. To challenge colonial narratives of women's status being improved since feudalism, one must point towards non-Eurocentric, pre-colonial societies where women enjoyed better lives. Women's equal participation in society is not an anomaly or a modern, Western conception, but a worldview and practice experienced for centuries across thousands of cultures.

Colonial powers not only extracted resources and labour for their consumption and commerce, but also forcibly pushed their conceptions of gender and gender roles on more egalitarian worldviews and pluralistic systems. Contrary to the narrative they peddle regarding their contributions to female emancipation, European colonists brought with themselves extractive practices and narrow gender-role conceptions. The powerful and egalitarian lives of women in pre-colonial and even prehistoric Asia, Africa, Americas, and Australia could be potent motivations to pursue more rights for women and to take stand against a patriarchal system that is increasingly being recognised as a recent Euro-Asian invention.

Healthcare in Bangladesh need not be so costly

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AM SHAMIM

The right to healthcare is enshrined in the Constitution of Bangladesh. However, despite considerable development in this sector over the last decade, the nation is still far from ensuring quality healthcare for all.

The towering and ever-increasing cost of healthcare is a constant headache for people in the country, making on-demand, quality healthcare virtually out of reach for most. The fact that almost 70 percent of all healthcare costs in Bangladesh are paid out of pocket, and that public spending on healthcare in this country as a percentage of GDP is the lowest in South Asia, only exacerbate this problem. In addition to low public spending, there are other factors contributing to the high cost of healthcare that need to be understood with their nuances.

A significant portion of the healthcare budget fails to reach target citizens due to corruption, wrong priority setting, and sub-optimal implementation. The combined effect is an acute lack of accessibility to points of care. A large number of facilities (such as community clinics) are sitting idle due to lack of resources, whereas a few specialty centres (such as public medical colleges or district hospitals) are beset with overcrowding and poor service delivery. This forces people, especially lower-income groups who are more likely to flock to subsidised government facilities, towards private healthcare providers, creating a heavy burden on their finances.

Meanwhile, every year, an average of 700,000 people travel abroad for healthcare needs, spending a mammoth Tk 350 crore. Although patients going abroad spend around Tk 5.5 lakh on average, in many instances this cost can be substantially higher, especially for complicated and lengthy procedures. Besides, treatment expense in countries like Singapore can reach up to 10 to 15 times of what it costs in Bangladesh, while in India it can cost two to three times more. So, pursuing treatment abroad can severely dent people's finances, even for those with higher incomes.

Also, for conditions requiring lengthy treatments, like cancer, patients and their attendants often have to stay away from family and work for extended periods of time, thus negatively impacting their professional positions. This is an indirect cost of seeking treatment abroad, which again adds to the burden of already high healthcare costs. Plus, especially among middle- and lower-income individuals, discontinuation of treatment due to socioeconomic reasons or a lack of awareness is common. Incomplete treatment means the patient, in all likelihood, will fall ill again from the same or related cause(s), thus incurring a huge waste of resources.

Due to the absence of a comprehensive and consistent regulatory regime surrounding healthcare and a national accreditation system for health service providers, the pricing of health services becomes arbitrary.

Also, due to the lack of national health insurance, there is no large purchaser (either insurance companies or the government) that can bargain with health service providers to set rational pricing of services. Thus, health service market in the country is dominated by providers who put individual consumers under a heavy burden of differing prices.

As individuals, we have important roles to play in acquiring control over healthcare costs, such as keeping all our medical and health records in one place, putting aside at least three percent of one's monthly income for future health needs, having a doctor or a healthcare worker as a friend to get advice from for sudden healthcare needs, getting a health check-up every year and focus on prevention, maintaining a proper lifestyle to prevent and manage lifestyle diseases like asthma, diabetes and hypertension, and adhering to doctors' advice from the early stages of any disease.

However, to solve the healthcare problem at the national level, the government needs to undertake some initiatives.

The towering and ever-increasing cost of healthcare is a constant headache for people in Bangladesh, making on-demand, quality healthcare virtually out of reach for most. The fact that almost 70 percent of all healthcare costs in Bangladesh are paid out of pocket, and that public spending on healthcare in this country as a percentage of GDP is the lowest in South Asia, only exacerbate this problem.

Solving the healthcare puzzle for Bangladesh's 170 million citizens is not a one-day job.

FILE PHOTO: **AMRAN HOSSAIN**

Making public sector spending efficient

It is important to bring transparency to the process by ensuring accountability and the involvement of stakeholders, especially health professionals. Similarly, introducing a healthcare official for the job and streamlining the regulatory structure surrounding healthcare will make the sector more transparent and efficient. If done properly, an additional one to two crore people, especially from lower-income strata, can be brought under healthcare services.

Health insurance and universal health coverage

This could be a system to which everyone contributes according to their means, while the government gathers both public and private resources in a unified manner to ensure on-demand, essential health services for all.

Activating community clinics

Managing thousands of community clinics spread across Bangladesh properly, with community involvement and proper training, can be a real game-changer.

Building and maintaining trust in our own healthcare system

A nationwide healthcare accreditation system could be implemented to monitor quality as well as classify providers into service bands (A, B, C, etc). This will ensure that services are provided as per the respective charter and also allow the government to set prices for healthcare services in a comprehensive manner.

Proper referrals and keeping electronic medical record (EMR)

Introducing a well-organised referral system backed by an NID-based, interoperable EMR will create a first line of health service providers in the form of community clinics and general physicians, who will be the primary custodians of individuals' health at the grassroots level. This will take care of the bulk of their healthcare needs at a minimal cost while only referring a small number of patients (who require specialised care) to the district- or national-level facilities.

Solving the healthcare puzzle for Bangladesh's 170 million citizens is not a one-day job. It will require clear-eyed national planning led by the government in conjunction with private and non-profit players—with national interest at its core—implemented in a sustained, transparent, and non-partisan manner over 5 to 10 years' time with the participation of individuals, who are our primary concern.

CROSSWORD
BY THOMAS JOSEPH

ACROSS
1 True thing
5 In the past
11 Back
12 Counterpart
13 Base group
14 Garden pavilion
15 Spinning toy
16 Thin coin
17 Flat fish
19 That fellow
22 Garden pest
24 Rental contract
26 "Hold on!"
27 Movie mutants
28 Land units
30 Used a sponge
31 By now
32 Calls it a day
34 Psychologist Carl
35 Little jump
38 Put another way
41 Singing star
42 Asylum seeker
43 Persia, today
44 Cruise treasurer
45 Turn to liquid

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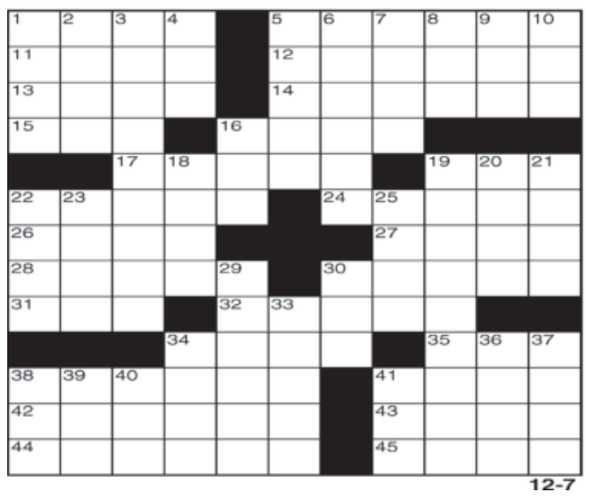
1 Greek group
2 Flying: Prefix
3 Garment with a notched collar
4 Take a stab at
5 Knock off work
6 Tooth part
7 Disconcert
8 Bullring cry
9 Hold up
10 Freud topic
16 June honoree
18 Toy with a tail
19 Sheep breed
20 "Got it"
21 Fix
22 Not at home
23 Speed
25 Stage direction
29 Knight's attendant
30 Costume part
33 Lower than
34 Benders
36 Track shape
37 Gasp for air
38 Workout unit
39 Flightless bird
40 Knight's address
41 Underlit



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YESTERDAY'S **ANSWERS**

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