Oral history, 1971, and the danger of erasing memory

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On January 14, the Ministry of Liberation War Affairs quietly made a decision that should unsettle us. About 14,640 video interviews of surviving freedom fighters, recorded as part of a state-funded project launched in 2022, were cancelled. As per the ministry's decision, the interviews will not be archived. The contractors will not be paid. And the entire project has been shelved, leaving question marks even on the 12,788 video recordings that had been previously accepted for preservation. The official explanation for this is familiar but deeply troubling: that the testimonies did not present the "accurate history" of the Liberation War. Apparently, there were multiple inconsistencies, and freedom fighters' experiences were not properly reflected. All this, we are told, could mislead the future generations.

In reality, what we are witnessing here is an act of silencing.

Bangladesh has never had a stable relationship with its past. Since 1971, the history of the war has been repeatedly edited, reshaped, amplified, or muted, often depending on who governs. Textbooks change. Emphasis shifts. Some figures rise, others fade. Certain narratives are foregrounded while others recede. Over time, this culture has encouraged the perception that history itself is provisional. What distinguishes the present moment, however, is not reinterpretation but removal. These interviews were not selectively archived, annotated, or contextualised; they were cancelled in their entirety. Such a step demands careful scrutiny, because once historical material is abandoned or destroyed, it may not be recovered.

First of all, the ministry's decision raises questions about evaluation processes that go to the heart of historical integrity. In oral history, a project's credibility is inseparable from transparency. Decisions about evaluation and preservation must be grounded in clear methodological standards and expert consultation. The question is, did the ministry consult professional historians, archivists, or trained oral historians before cancelling the interviews and the project? Oral history is a specialised field with established ethical guidelines, including the principle of shared authority, which recognises that the stewardship of public memory must involve trained experts alongside institutions. The apparent absence of such consultation suggests a departure from this standard.

Equally important is the question of provenance. What were the qualifications of those serving on the subcommittee that assessed the interviews? What historiographical or methodological expertise did they bring to the evaluation of oral testimony? Media reports indicate the presence of freedom fighters on the subcommittee, but none with a public record of historiographical expertise, so it is difficult to determine whether the eventual decision rested on scholarly judgement or administrative discretion. Equally importantly, on what scholarly basis were the 14,640 interviews discarded? In professional historical practice, when limitations are identified in a primary source, the standard response is not destruction, but contextualisation through annotation, metadata, and interpretive framing. By opting for wholesale cancellation rather than nuanced review, the ministry has bypassed academic rigour in favour of archival erasure, setting a troubling precedent.

We must recognise that the Liberation War is not a distant past yet. It is still a living memory, ageing, fragile, and finite. Every year, more freedom fighters pass away. With them disappear stories that have never been written down, never archived, never professionally documented. Once lost, they are gone forever. Historians often speak of closing archives, points at which access to lived memory disappears permanently. Bangladesh seems to be standing at that edge now. Abandoning an entire oral history project at this moment is not just careless; it could be historically irreversible.

VISUAL: **SALMAN SAKIB SHAHRYAR**

The ministry's justification rests on the belief that history must be tidy, consistent, and ideologically aligned in order to be valid. But history does not work that way, especially oral history which, by its very nature, captures contradiction. People remember events differently. Trauma can reshape memory. Fear, pride, regret, and silence all leave traces in it. These are not methodological flaws, but evidence of how history is lived and remembered over time. Modern historiography has long grappled with this tension. In *That Noble Dream*, Peter Novick demonstrated that objectivity in history is not an attainable condition of neutrality, but an ethical aspiration that disciplines historical practice. A mature historical culture understands this. It does not demand a flawless or uniform recollection of the past; it demands an honest and methodologically sound engagement with it.

One freedom fighter might recall confusion instead of clarity. Another might speak of internal disagreements, regional neglect, or post-war disillusionment. Some testimonies may complicate heroic narratives. States that prioritise control over inquiry tend to find these voices uncomfortable. But silencing ambiguity does not strengthen history—it narrows it. When a state decides which memories are acceptable before historians can properly evaluate them, the boundary between scholarship and censorship collapses.

This episode also exposes a deeper structural weakness: the fragile state of public history in Bangladesh. Unlike many post-conflict societies, the country has failed to build a strong public history culture that connects historical scholarship with everyday citizens. History here largely remains confined to textbooks, state ceremonies, and official statements. Museums are limited, while archives are difficult to access. Oral testimonies rarely move beyond symbolic recognition. When people cannot encounter history as a living, contested process, it becomes easier to revise, simplify or erase it. Public history exists to bridge this gap, bringing scholarship into public space through archives, exhibitions, oral history projects, and digital platforms.

The importance of grounding history in lived experience has been powerfully articulated by Dipesh Chakrabarty, who argues that history loses ethical depth when it is reduced to abstract national narratives detached from everyday life. It thus becomes an instrument of authority rather than a space of inquiry. Oral history restores this ethical relationship by anchoring national narratives in memory, locality, and human experience. It does not dictate meaning. It invites engagement. It allows freedom fighters, witnesses, and ordinary people to remain active participants in the making of national memory.

So, if the interviews in question were methodologically weak, the solution was scholarly review, contextualisation and correction, not blanket cancellation. If there are inconsistencies, historians know how to annotate them. If memories conflict, that conflict itself is historically meaningful. If the contracting firm responsible for the interviews has failed to meet any condition or follow the prescribed criteria, the agreement could be revoked and replaced without summarily abandoning all interviews or the project itself. So, where do we go from here?

The authorities still have a choice. The witnesses are still here. The recordings may yet be recovered. Scholars can still be engaged and trusted for necessary follow-ups. But if Bangladesh wishes to secure a durable civic future rooted in proper historical awareness, it must begin listening to history in all its complexity. The question is no longer whether those recorded voices are comfortable, and consistent. The question is whether we can afford to lose them.

Why nutrition should be integrated into primary care

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Bangladesh has made notable progress in improving many health outcomes. Yet, primary healthcare services remain insufficient in both rural and urban areas. The Health Sector Reform Commission submitted its report last year, recommending a constitutional amendment to recognise primary healthcare as a basic human right. Such a move would create a legal obligation to ensure access to and efficient delivery of primary care for all citizens. However, the report does not explicitly address the integration of nutrition into primary healthcare.

Poor nutrition is a major contributor to preventable diseases and is responsible for nearly half of all deaths among children under five years of age. Yet, nutrition is often inadequately addressed in healthcare settings, leading to slow progress towards achieving universal health coverage. Integrating nutrition into primary care offers the opportunity to improve diagnosis, promote health for all, and transform preventive care at the population level. It can also yield benefits by raising awareness, enabling early diagnosis, and initiating preventive measures earlier, leading to broader improvements in the health and well-being of the nation.

Malnutrition increases the risk of infectious diseases and worsens clinical outcomes. In Bangladesh, the scale of the problem is alarming. Nearly one in four children under five is stunted, one in eight is wasted, and more than one in five is underweight. These numbers represent children who are more likely to be hospitalised and more at risk of death from preventable diseases. Height, weight, mid-upper arm, waist, and hip circumferences are among the most reliable predictors of health outcomes in children with malnutrition, including nutritional recovery and mortality risk. Therefore, timely and accurate assessments are essential for identifying at-risk children and guiding appropriate, individualised care.

Despite their importance, these measurements are not taken or are frequently delayed in primary care facilities due to a lack of tools, poor functionality of existing equipment, and the shortage of trained healthcare personnel. These assessments are fast, painless, and inexpensive, but save lives by enabling earlier detection and personalised care of the nutritional impairments.

Primary care settings should also be equipped with facilities to screen for anaemia and common micronutrient deficiencies, which affect millions of children and women in Bangladesh. Point-of-care devices can be used to detect anaemia and micronutrient deficiencies with a small drop of blood, without the need for advanced laboratories or highly skilled staff. Early detection allows early treatment, especially in resource-limited settings where people may not otherwise seek care.

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Bangladesh also faces a growing burden of chronic diseases such as diabetes, high blood pressure, heart disease, and non-alcoholic fatty liver disease (NAFLD). Nearly 23 percent women and almost 17 percent men in the country live with high blood pressure. Diabetes is also widespread, affecting 17 percent of women and 15 percent of men aged 18 years and above. Alarmingly, nearly one-third of the population suffers from NAFLD. Together, these diseases, increasingly linked to poor diets and nutrition, and their complications, account for almost half of all adult deaths in the country. Primary care facilities should be equipped to screen for these illnesses using simple, cost-effective and validated diagnostic tools and medical devices.

One of the major challenges in primary care, especially in rural areas, is the shortage of doctors and nurses. Without trained clinicians, physical exams and proper diagnosis become difficult. The government must find ways to attract and retain physicians in hard-to-reach areas. Offering incentives, better job security, and contractual recruitment for hard-to-reach areas, along with safety measures to prevent workplace violence, could help in addressing the workforce shortages in primary care settings.

Nutrition is also about what people eat. Primary care facilities should routinely assess dietary intake. Digital tools that reflect local foods, recipes, and portion sizes could make this process faster and more accurate. Screening for food insecurity should also be part of this effort, since lack of access to food is also linked with increased risk of malnutrition, illness, and premature death.

Primary care can also strengthen existing programmes. Vitamin A supplementation, deworming, and other nutrition interventions can reach more children if they are delivered through primary care facilities. The country made notable progress in some of these areas, but primary care offers a way to address the remaining gaps.

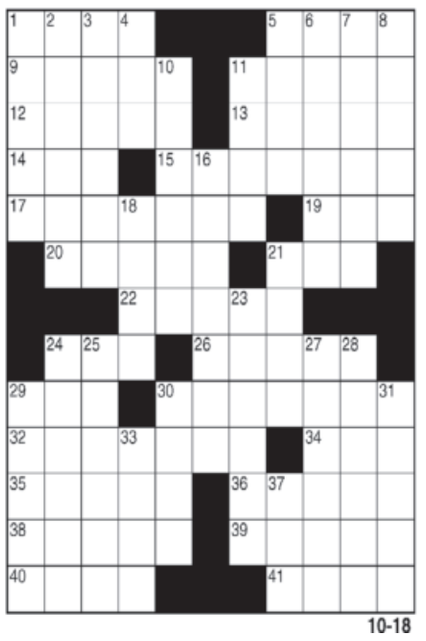
Nutrition counselling and health education must become a core component of primary healthcare. Healthcare providers should be able to guide families on healthy diets, physical activity, and lifestyle choices, including the harms of consuming tobacco and alcohol. None of this will succeed without adequate training. Healthcare providers need skills not only in measurement and diagnosis, but also in counselling, behaviour change communication, and respectful care. With proper training, healthcare providers in primary care settings can act as a powerful frontline against malnutrition and its lifelong consequences.

Malnutrition and its adverse consequences are not inevitable. Integrating nutrition into primary care, with basic screening tools, point-of-care diagnostics, essential medicines and supplements, a trained workforce, and strong political commitment, can help ensure optimal growth in children, reduce the burden of anaemia, micronutrient deficiencies, and chronic diseases, prevent disability and premature deaths from nutrition-related non-communicable diseases, and ease the financial strain on families and health systems.

CROSSWORD
BY THOMAS JOSEPH

ACROSS
1 Play parts
5 Visibility lessener
9 Cut off
11 Printer need
12 Ship of 1492
13 Heart, e.g.
14 Words with pickle, stew or jam
15 Dessert tube
17 Packing plant
19 Fish eggs
20 Kick off
21 Diet no-no
22 Hit's counterpart
24 Mornings: Abbr.
26 Bath bars
29 Relaxing retreat
30 Choral composition
32 Southwestern bar
34 Fireplace item
35 Quartet doubled
36 Scottish lord
38 First odd prime
39 Devoured
40 Bulls or Bears
41 Final, for one

DOWN
1 Jellied dish
2 Porcelains for dishes
3 Lease signer
4 Plopped down
5 Rhino feature
6 Soft wool
7 Fanatic
8 Bert's buddy
10 Indy autos
11 Theater prize
16 Craftsman
18 Collars
21 Accomplishment
23 Be generous
24 Cochise's people
25 Chanted word
27 Sense of taste
28 Gems
29 "Ivanhoe" writer
30 Refer to
31 Deal maker
33 Abound
37 Bowler or boater



10-18

YESTERDAY'S ANSWERS

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