Dhaka needs a mayor who can deliver real change

MIND THE GAP

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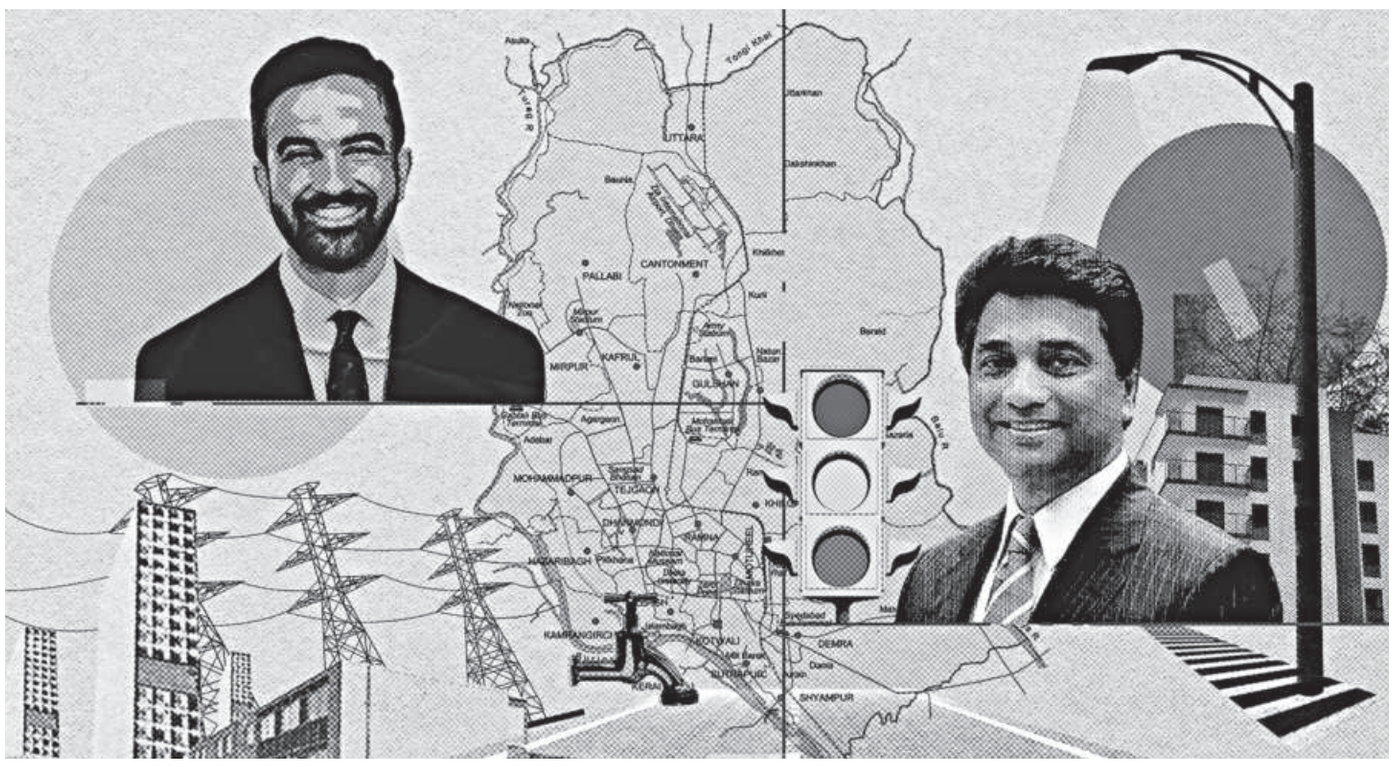
Dhaka has a new crush, his name is Zohran Mamdani, and he has somehow become the internet's latest fantasy for Bangladeshis. A few interviews, a few viral clips, a few thoughtful soundbites, and suddenly, he is being adored across timelines as if he is the long-lost protagonist of our political romance. It is charming and chaotic in equal measure. However, it is also the perfect moment to turn our gaze inward and ask ourselves a simple question that we seem to avoid every monsoon, every traffic jam, and every dengue season. How is a mayor supposed to be?

A mayor is the head of a city's local government. That sounds straightforward, but the role is the backbone of urban daily life. A mayor oversees sanitation, solid waste management, community healthcare initiatives, streetlights, drainage system, footpath management, market regulation, building permissions, and the overall civic environment that influences how a city feels to live in. They are the closest elected authority for citizens. While national leaders shape policy and strategy, a mayor influences the everyday experiences of ordinary people who want clean roads, reliable lighting, functioning drains, and a neighbourhood that does not feel like a test of character.



VISUAL: **ANWAR SOHEL**

Dhaka's two city corporations, North and South, are enormous civic engines consisting of councillors, engineers, inspectors, planners, and frontline workers who handle everything from garbage collection to health campaigns. A mayor sits at the centre of this machinery. But the job is not about heroic gestures or dramatic announcements. The real work lies in coordination. A functional city is a choreography of many bodies moving together. One department clears waste, one repairs roads, another manages markets, another supervises building compliance, and another handles disease control. A mayor's effectiveness depends on whether these parts communicate, complement, and support each other.

This conversation inevitably reminds us of the late Annisul Huq, who offered a glimpse of what an empowered, modern, and deeply humane mayor could look like. His tenure showed how energy, discipline, and a willingness to confront entrenched interests could shift a city's mood, even if only briefly. His work remains a powerful reminder of what is possible when leadership meets vision.

Yet Dhaka's challenges persist because responsibility is spread across many authorities. Urban drainage involves city engineers and national-level water agencies. Traffic depends on the city corporation, but also the police and transport regulators. Public health requires coordination between community centres and national hospitals. Urban planning touches both city-level offices and national planning authorities. For a city to work, these institutions must move in the same direction. When they do not, the mayor becomes the face of problems whose roots may lie beyond the city corporation's territory. The issue is not failure; it is fragmentation.

And nothing has made this clearer than the recent earthquake, when a few seconds of shaking reminded us how fragile this megacity truly is. Our city corporations have been warning Rajuk for years about unsafe buildings, unchecked construction, and the urgent need for responsible enforcement. Rajuk has its own demands and delays, and the corporations have their own limitations, but the lack of cooperation among these bodies is how a city becomes vulnerable. If these agencies cannot sit together to approve a Detailed Area Plan (DAP) that does not put twenty million people at risk, then no mayor, no matter how charismatic, can protect Dhaka from disaster.

The question then becomes what Dhaka needs to allow its mayors to succeed. The answer is structure, clear jurisdiction, modern data-based systems, faster approval mechanisms, properly empowered departments, transparent budgeting and regular collaboration among all agencies that touch the city. Local governance must be treated as a serious tier of authority, not as a ceremonial extension of national power. A city of more than one crore people cannot function through improvisation. It requires systems, not last-minute reactions. And those systems cannot exist unless the mayor's office is allowed to lead them with clarity and authority.

This brings us to another important point. Dhaka needs to think carefully about what kind of person should hold the mayoral offices. Not celebrity figures. Not political placeholders. A mayor must be someone who understands how cities breathe. Ideally, this is a person with a grasp of the problems Dhaka faces every single day. A mayor should understand how waste systems are modernised, how digital data can improve city management, how community health programmes work, how commercial areas grow and how public spaces can be made safe and accessible. They must know how and when to negotiate for the best of the city and its dwellers.

But technical knowledge alone is not enough. Dhaka also needs mayors who can lead with empathy. People do not experience a city through official reports. They experience it through frustration on a flooded street, fatigue in traffic, relief when a lane is finally cleared, and gratitude when a mosquito fogging drive makes a difference. A mayor must be someone who listens to these stories, understands the human side of urban governance, and responds with a sense of responsibility rather than routine.

This is why the Mamdani trend is such an interesting cultural moment. Not because Mamdani has commented on Bangladesh. He has not. But because our fascination with him reveals something about our emotional landscape. When people feel unseen locally, they project their hopes onto figures abroad. It is sweet, but it also says something important. Perhaps it is time to channel that energy towards strengthening our own city leadership instead of waiting for symbolic heroes. If we can invest so much attention into a foreign legislator's charisma, we can certainly invest the same enthusiasm into demanding a more functional, empowered, and modern local governance system at home.

Dhaka does not need a mayor who promises miracles. It needs one who knows how urban problems are solved and can turn many small improvements into a meaningful shift in how the city works. Clean streets, smoother mobility, faster responses, safer neighbourhoods—none of these changes is glamorous. But they are the foundations of dignity in daily life.

So, the next time the city is waterlogged, or the roads are chaotic, or the neighbourhood feels neglected, instead of simply asking where the mayor is, we should ask whether the city has given its mayors the support and structure needed to act. A mayor cannot build a city alone. They can only lead if the city allows them to lead. Dhaka deserves mayors with skill, vision, and humanity. And those mayors deserve a system that lets them shape the city we proudly claim as home.

Oxygen for all: Why measurement matters as much as availability

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Medical oxygen is not merely a clinical supply; it is a lifeline that sustains patients every minute in hospitals and their homes. Bangladesh has expanded oxygen plants, concentrators, and hospital pipelines in recent years. However, due to a lack of measurement, we are in the dark about whether oxygen is being used appropriately.

Oxygen is indispensable in saving lives from acute medical emergencies such as pneumonia, sepsis, obstetric complications, and trauma. The Lancet Commission on Medical Oxygen Security estimates that over 105 million people globally need oxygen for acute medical care each year, most of them in low- and middle-income countries, including about two million in Bangladesh. For surgical procedures, around five million, and for chronic respiratory diseases such as COPD, nearly 0.2 million people in Bangladesh rely on oxygen therapy every year. These numbers tell us that oxygen need is not rare, yet it remains poorly documented in the systems meant to manage it.

To understand oxygen coverage, we need to know how many patients required oxygen and how many actually received it. A multi-country study conducted in Bangladesh, Nepal and Tanzania, published in the *Journal of Global Health* in 2022, illustrated this problem. In two large Bangladeshi hospitals, oxygen was administered to almost half of the newborns treated for infection, yet very few had oxygen saturation documented in their case notes. Without pulse oximetry data, it is impossible to tell whether the therapy was appropriate or wasteful. Poor documentation could mask both under-treatment and overuse. This is not a technical oversight; it is a system-wide blind spot. The cost of this lack of documentation is substantial. In private hospitals, the cost of oxygen therapy can result in high out-of-pocket payments for the patients. For public hospitals, oxygen generation and delivery can consume a large part of total operating costs.

When oxygen is used without a clear clinical indication or documentation, both patients and facilities face unnecessary economic strain. An article published in *The Daily Star* during the pandemic shared the financial struggles of people due to the high cost of oxygen therapy. Jannatul, a 45-year-old woman, was admitted to a hospital in Chattogram with breathing difficulties and required oxygen support for 10 straight days. When the time came for discharge, her family received an oxygen-only bill of over Tk 3 lakh, while the total hospital bill exceeded Tk 6 lakh. They pointed out that hospitals had to source oxygen from private suppliers at inflated market rates. In other cases, some facilities explained that their billing systems were not designed to differentiate oxygen consumption by duration or flow rate, so fixed or estimated charges were applied to cover overall maintenance. Others emphasised that without government subsidies or price ceilings, private hospitals had little flexibility to absorb the increased costs of oxygen procurement and logistics. The scenario emphasises the necessity to ensure oxygen is given only when it is needed, and to do that, addressing the measurement gap is obligatory. When oxygen use is not measured, it not only clouds clinical judgment but also opens the door to uncontrolled costs and inequity. Therefore, both overuse and underuse stem from the same problem: lack of measurement.

Oxygen sustains life, but the absence of data on its use keeps health systems blind. Creation of a real-time oxygen measurement system that connects patient needs to oxygen delivery is as important as building new oxygen plants.

Bangladesh has made commendable progress in improving oxygen infrastructure and monitoring supply. The Directorate General of Health Services (DGHS) now publishes a daily update through its Oxygen Management Information System (OMIS), showing figures such as total oxygen availability and the number of hospital beds equipped with oxygen. These dashboards are an important step forward and demonstrate the government's commitment to data-driven decision-making. Yet, they describe only the supply side of oxygen, not who receives it. The system does not show how many patients were hypoxaemic, how many had their oxygen saturation measured, or how long oxygen therapy lasted. Without patient-level indicators, it is impossible to track coverage, identify inequities, or ensure rational use.

At the population level, surveys should include questions on hospitalisation, oxygen need, and whether oxygen was received during treatment. These additions would help capture how people access life-saving oxygen beyond facility records and highlight inequities across regions and socioeconomic groups. At the same time, facility-based systems must routinely document hypoxaemia, indication, and outcomes in real time. Linking population surveys with routine facility data will be essential to generate a complete picture of oxygen access and use in Bangladesh, as recommended by The Lancet Commission.

Oxygen sustains life, but the absence of data on its use keeps health systems blind. Creation of a real-time oxygen measurement system that connects patient needs to oxygen delivery is as important as building new oxygen plants. When we know how many patients were hypoxemic, how many received oxygen, and how long they were treated, we can allocate resources more equitably across regions and facility types. Data showing high oxygen use but low saturation monitoring in certain districts could trigger targeted training and supervision, while identifying hospitals with chronic undersupply would enable redistribution and timely procurement. Patient-level information would also improve efficiency by reducing unnecessary oxygen use, preventing wastage, and ensuring that oxygen reaches those who truly need it first. Integrating these data streams into national health information systems would transform current dashboards from inventory trackers into decision-making tools to plan, act, and save lives more effectively. When every breath counts, measurement ensures that no one is left struggling for air.