‘The energy crisis is not in our control, but our response is’

Dr Khondaker Golam Moazzem, *research director at the Centre for Policy Dialogue (CPD), speaks with* **Naznin Tithi** *of* **The Daily Star** *about how the government should respond to the ongoing global energy crisis affecting Bangladesh, its rationing plans, and what additional steps it can take to address the situation.*

The energy crisis caused by the US-Israel war against Iran has already hit Bangladesh. We have witnessed a spike in panic buying. Some have called for priority-based distribution among industries. The government, meanwhile, has assured that it holds sufficient fuel reserves but rationing still continues. How do you view this situation?

The global energy supply chain is facing disruptions due to the crisis in the Strait of Hormuz, resulting in a significant level of supply uncertainty. In this situation, even paying higher prices does not necessarily guarantee access to fuel, prompting countries to seek alternative sources of energy imports. Being an import-dependent country, Bangladesh has introduced rationing measures to extend the use of its current stock of fuels. This is a crisis management strategy. There is indeed a supply shortage in the market; the usual level of fuel supply cannot be ensured at present. The aim is to ensure that all sectors receive at least some fuel, even if in smaller quantities.

Energy is a fundamental input in nearly all forms of economic activity. When supply is restricted, it inevitably has a negative impact across sectors. Right now, this is the reality we face. We should not expect normal conditions during this period. The government is working to distribute the limited supply across sectors, prioritising certain areas where necessary and making adjustments to manage the situation as effectively as possible.

Do you think the government is adequately addressing the situation, i.e. with rationing and price control?

The course of the war is shifting almost daily, making it uncertain as to how long the conflict will continue. In my view, prolonging the war offers little gain for either side. Just as Iran is unlikely to achieve significant benefits by extending the war, so are the United States and Israel. Nevertheless, the government must plan its strategies according to the scale of the crisis. Initially, it introduced rationing but simultaneously sought to secure energy from alternative sources. For example, two contracts were finalised for LNG import at more than double the usual prices, which was a logical and necessary decision under the circumstances. At this stage, spot purchases to manage the crisis are reasonable, even if they come at a higher cost. Likewise, refined petroleum can be sourced from neighbouring or Southeast Asian countries, and China has also offered cooperation. These initiatives demonstrate proactive government action, and in my assessment, the efforts have so far been positive.

It is important, however, that short-term crisis management is not conflated with long-term strategic planning. Some have suggested creating a strategic reserve and investing in it. I do not believe this should be based on fossil fuels.

If domestic gas exploration in the Bay of Bengal—which previous governments neglected—had been pursued, the country would be in a stronger position to manage this situation. For example, rather than relying on diesel-powered irrigation for the upcoming Boro cultivation, it would have been better to expand renewable energy-based or solar-powered irrigation. Currently, we have around 13 lakh irrigation pumps, of which only about 13,000 are equipped with solar panels. Expanding this number could have significantly reduced diesel demand. Similarly, a gradual transition to battery-operated vehicles would increase electricity demand but reduce the need for diesel and petrol.

Strategically, long-term objectives must not be sacrificed for short-term demands. This is crucial. The government should continue following a rolling plan—monitoring daily developments, assessing changes, and adjusting initiatives accordingly. In my view,

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Dr Khondaker Golam Moazzem

the government’s rolling plan has so far been largely on track. Unfortunately, people tend to be highly susceptible to rumours and have limited trust in official data. This increases the tendency towards hoarding. The reality, however, is that operations must continue with limited supply, and normal economic activity cannot be fully maintained. This is a reality that all consumers must understand.

Given the concerns surrounding rationing and priority-based distribution, who do you think should be prioritised?

Determining who should be given priority is a highly sensitive issue, particularly when it comes to fuel supply. However, it is clear that industries should be included on the priority list. This is because they are connected with production, employment, exports, foreign currency earnings, and the balance of payments. So industries, especially the export-oriented one, must be a priority. In addition to small- and medium-sized industries, a large number of motorbike riders depend on fuel for their livelihoods, who should also be considered carefully. Public transport should be given higher priority, while large vehicles—whether government-owned or privately operated—should be given lower priority. Priority should go to those engaged in production-related work in factories, whose income relies on fuel and whose livelihoods are closely tied to fuel-dependent activities.

It is somewhat reassuring for the government that diesel demand remains low at present, as Boro irrigation has not begun yet. However, in the next month or so, diesel demand is likely to increase when irrigation will be required for Boro cultivation. Hopefully, the war will not continue till then.

The government has introduced some austerity measures such as the closure of universities, requesting shopping malls to reduce the use of lighting, and so on. Could it have done more? Government officials are still using vehicles without restraint, a practice the authorities could have restricted.

In our country, apart from announcing austerity measures and relying on people’s personal sense of responsibility, little else is done. By contrast, in many developed countries, we observe that drivers switch off their engines while waiting at traffic signals, reducing both pollution and fuel consumption. Unfortunately, that culture does not exist here. As a result, energy is often used neither cost-effectively nor efficiently. Electricity consumption is similarly inefficient. If we had a modern fuel supply and electricity infrastructure, distributors and suppliers could exercise far greater control. But that infrastructure does not exist here. Consequently, energy usage depends almost entirely on individual discretion—on how much a person chooses to use or conserve.

At a minimum, the government can ensure that the measures it has already announced—such as reducing diesel consumption, limiting fuel use in government offices, and curbing lighting—are properly implemented. By reporting regularly on these measures and informing the public about the actions taken against those who fail to comply, it can raise awareness and encourage more responsible energy use.

There are concerns that inflation could rise further as a result of the war. We already saw inflation exceeding nine percent in February, the highest in 10 months. In this situation, what should the government do?

The entire situation is beyond our control. Ordinary people are bearing the brunt of other countries’ strategic wars and territorial conflicts, which is unacceptable. The government can provide support to the people by increasing supply through social safety net programmes. Truck sales are already taking place, the Family Card programme has been launched, and a reasonable social support system is already in place. Expanding the reach of these programmes even slightly would be beneficial. The government is reportedly planning to continue truck sales until March 12. If it is extended for another week, until March 19, and supply is increased in more locations, low-income households could experience some relief.

Price increases are already becoming a reality at the import stage. In such cases, monitoring is needed at the import and distributor or dealer levels, rather than only at the retail level, to protect consumer rights. It is also necessary to monitor whether goods are being hoarded or supplied in quantities below the usual levels in the market.

Can we use private healthcare to improve health literacy?

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When a diabetic patient walks out of a hospital without understanding how to manage their condition between visits, the cost of that failure is economic as much as it is medical. The patient may return sicker, require more expensive intervention, and quite possibly push their family deeper into debt. Multiply that by millions of patient interactions every year in a country where nearly 69 percent of health expenditure is paid directly out of pocket, and the picture becomes systemic.

Noncommunicable diseases (NCDs), also known as chronic diseases, are conditions that demand sustained management, early intervention, and informed patient behaviour. In Bangladesh, due to the absence of structured health literacy, NCDs account for around 67 percent of all deaths, with nearly one in five people between 30 and 70 years of age at the risk of dying, according to the World Health Organization (WHO).

Currently, public health communication in Bangladesh remains largely campaign-driven: seasonal dengue awareness, immunisation pushes, and periodic chronic disease messaging. These efforts reach millions but are episodic, centrally designed, and constrained by a system where public health spending stays below one percent of GDP. So, families often find themselves in a position where they have to decide on what symptoms to act upon, when to seek specialist consultation, how to manage hypertension between visits, whether to trust health advice circulating on social media, with almost no consistent, credible source of guidance. This is a gap that can be bridged through a collaboration between public and private healthcare.

The private healthcare sector, now responsible for over half of total healthcare demand, operates thousands of digital platforms, call centres, outreach programmes, and dedicated marketing teams that collectively reach millions daily. The communication infrastructure produces an array of promotional content on a regular basis: physician profiles, equipment announcements, service advertisements, and patient testimonials. However, it fails to ensure a proper health education for the general people.

This is not because hospitals are indifferent. It is because no policy connects private healthcare communication to public health objectives. There are no national standards defining what evidence-based health education from a private provider should look like. There is no incentive—through accreditation weighting, licensing consideration, or targeted tax benefits—that signals health literacy output carries institutional value. Without that signal, investing in health education remains commercially irrational. The gap is not one of intent but of policy.

Health education does not have to mean national campaigns or expensive programmes. Much of it can be embedded in what hospitals already do. For example, a cardiologist’s profile can include guidance on symptoms that warrant urgent evaluation. An endocrinology announcement can outline warning signs of uncontrolled diabetes. Discharge instructions can include standard follow-up messaging.

Similarly, a doctor who takes two minutes to explain why completing an antibiotic course matters is delivering health education, as is the nurse who teaches a new mother to recognise danger signs in her newborn. These might not be grand interventions and may cost almost nothing individually, but across millions of patient interactions every year, they reshape how a population relates to its own health. For that to happen, a systematic change must be brought forth.

Making it systematic means repositioning hospital communication teams to work alongside trained public health education and promotion specialists who can embed evidence-based guidance into routine outreach. This is not an additional burden on private providers. Hospitals that integrate health education into their communication build deeper community trust, attract patients earlier in their care journey, and differentiate themselves in an increasingly competitive market. The framework succeeds precisely because it aligns public health objectives with institutional self-interest and participation becomes commercially rational, not charitable.

But this shift requires a professional workforce that barely exists in Bangladesh’s private healthcare sector: public health education and promotion specialists trained in behavioural science, health communication, and programme evaluation. Currently, these professionals work mostly in government agencies, NGOs, and international organisations, not because they are irrelevant to private healthcare, but because there is currently no framework that generates demand for them there. Once the policy framework is created, the demand follows. And when the demand creates positions, it opens the door to measurable impact.

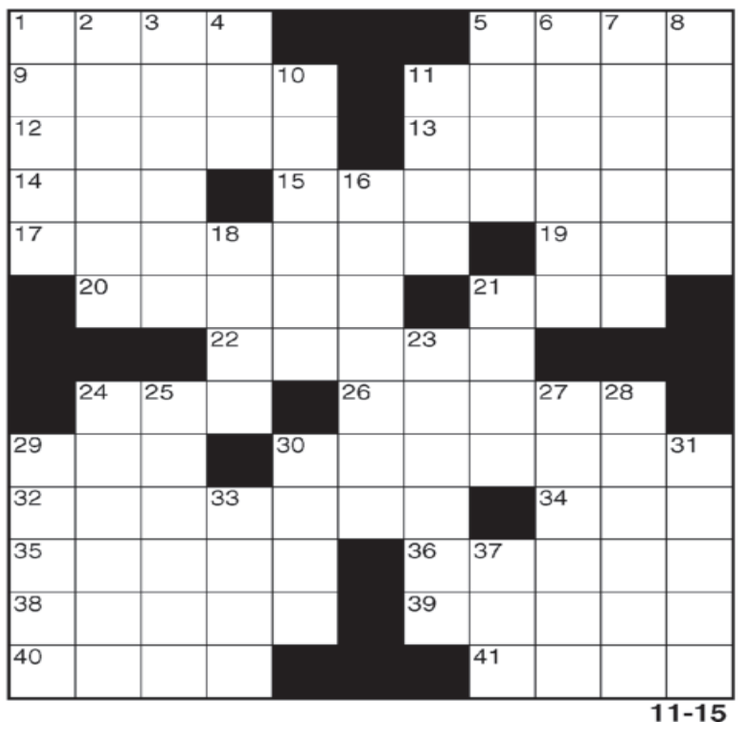
The government does not need new bureaucracies for this. The Bureau of Health Education under the Directorate General of Health Services already holds a nationwide mandate for health education, with resource centres across all 64 districts. Its scope, however, has never extended to the private sector. Expanding the bureau’s authority to set standards for private-sector health communication, staffed by public health education professionals—not administrative generalists—would give this framework an institutional home. Three mechanisms would make it operational: national content standards for private providers, incentive structures tied to health literacy output, and a public-private health communication compact enabling government messaging to flow through private networks during outbreaks and health emergencies.

If even a quarter of private healthcare communication incorporated structured health education, the effect on population health literacy would exceed what public spending increases alone could achieve. So, the question is not whether this would work. The question is what happens if the government does not act. The private sector will continue reaching millions daily, with content that does nothing to improve general health outcomes. Preventable complications will keep generating avoidable debt. And the country’s largest health communication infrastructure will remain commercially active but strategically wasted. The new government has pledged a stronger, more competitive Bangladesh. This would be a good place to start.

CROSSWORD
BY THOMAS JOSEPH

ACROSS
1 Singer Tori
5 Swift
9 Legitimate
11 Stately home
12 Tennis star Agassi
13 Boiling
14 Dine late
15 Goals
17 Ankle bones
19 Rent out
20 Director Malle
21 Suffered from
22 Wed in haste
24 Gum mass
26 Peruses
29 Part of a match
30 La Brea fossil preserve
32 Kilt patterns
34 Horse doctor
35 Chinese or Korean
36 Green hue
38 Enlists again
39 Frisco footballer
40 Shade trees
41 Ivy League school

DOWN
1 Sailor’s cry
2 Training book
3 Expert
4 Knight’s title
5 Viper feature
6 Lansbury of Broadway
7 Put into piles
8 Secret meeting
10 Fine point
11 Warring god
16 Campaign loser
18 Took to court
21 Whole bunch
23 Human being
24 Mink’s cousin
25 Skylit court
27 Heavenly
28 Director Spielberg
29 Fixed look
30 Earth tones
31 Somber
33 Spigots
37 Pert talk



11-15

TUESDAY’S ANSWERS

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