Why stakeholders matter in reimagining urban healthcare governance

Dr Noor Mohammad
is executive director at Population Services and Training Center (PSTC).

NOOR MOHAMMAD

Recent discussions surrounding the transfer of Bangladesh's Urban Primary Health Care Service Delivery Project (UPHCSDP) have largely focused on the distribution of administrative responsibilities between ministries. Of course, the issue extends far beyond institutional handover. The central question is not simply about who will manage the project, but about how uninterrupted, equitable, and sustainable healthcare services will continue for millions of vulnerable urban residents.

Since its inception in 1998, the UPHCSDP has evolved into one of Bangladesh's most significant public-private partnership (PPP) initiatives in the health sector. Developed with strong support from the Asian Development Bank (ADB) and other development partners, the programme emerged at a time when rapid urbanisation had exposed major gaps in healthcare access for low-income urban populations. Unlike rural areas, where government health structures had stronger operational networks, urban primary healthcare remained fragmented and underserved.

The project introduced an innovative PPP approach that combined government stewardship, donor financing, NGO-led implementation, and community engagement. Over time, this model became internationally recognised for its flexibility and effectiveness in delivering urban primary healthcare services in densely populated settings.

One of the most overlooked realities in current discussions is the central role NGOs have played in implementing the programme. For decades, NGOs have not merely supported the project; they have managed clinics, maintained outreach systems, recruited health workers, built community trust, and ensured service continuity under challenging urban conditions. Thousands of doctors, nurses, paramedics, outreach workers, counsellors, and support staff working under the project are employed through NGO systems rather than the government structure.

As a result, many of the programme's operational strengths including community linkages, accountability mechanisms, and service delivery efficiency have been built through NGO-led systems. Any transition process that excludes the implementing NGOs from meaningful consultation risks weakening the very foundation upon which the programme has operated successfully for nearly three decades.

Another major concern relates to infrastructure. A large number of UPHCSDP facilities operate from rented premises which are located strategically within underserved communities. Questions regarding lease continuation, operational expenses, utilities, maintenance, and uninterrupted service delivery remain insufficiently addressed. These are not minor administrative details. Temporary disruption of maternal care, immunisation services, reproductive health counselling, or treatment for chronic illnesses could directly affect the wellbeing of millions of urban residents.

The success of the UPHCSDP demonstrates that a PPP was not a temporary compromise, but rather a strategic strength. The model worked because it combined government legitimacy, development financing, NGO agility, and community responsiveness. Bangladesh's global achievements in family planning, immunisation, and community health have historically emerged out of collaborative partnerships rather than rigidly centralised systems. Urban healthcare challenges today, including climate-induced migration, overcrowding, adolescent vulnerability, non-communicable diseases, mental health concerns, and gender-based violence, require similarly coordinated and multi-sectoral responses.

For nearly three decades, Bangladesh's urban primary healthcare service has been vital in closing the gaps in healthcare access for low-income urban populations. FILE PHOTO: RASHED SHUMON

Transitions of this scale are most effective when stakeholders feel a sense of ownership over the process. In contrast, abrupt top-down decisions often generate uncertainty and even resistance at operational levels. There is growing concern that the current transition process risks becoming overly administrative rather than consultative. A programme developed over nearly 30 years cannot be sustainably transferred through procedural directives alone.

The transition process therefore requires transparency, phased planning, operational mapping, financial clarity, and human resource considerations. More importantly, it requires collective responsibility among all stakeholders. This is not about institutional control; it is about protecting essential healthcare services for millions of urban citizens.

Development partners must also remain part of the conversation. ADB's involvement in the programme has included not only financing (much of it through sovereign loans), but also technical guidance, monitoring systems, and policy support over several decades. Excluding development partners from substantive consultation would risk overlooking valuable institutional experience and lessons learned.

There is still time for constructive dialogue. A broader national consultation process involving government ministries, NGOs, development partners, urban local government representatives, health professionals, and community voices could help identify operational risks, clarify future partnership models, ensure service continuity, and strengthen financing mechanisms. Such engagement would enhance the credibility and sustainability of the transition, not delay it.

Bangladesh now stands at an important crossroads in terms of urban health governance. The challenge is not merely whether administrative ownership changes, but whether the country can preserve and strengthen the successful elements built over decades while adapting to emerging urban realities. The future framework must retain the strengths of partnership, protect institutional memory, ensure uninterrupted services, and prioritise people over procedures.

Urban health systems cannot be sustained through directives alone. They depend on trust, coordination, inclusion, and practical realism. Bangladesh has repeatedly demonstrated its ability to innovate through collaborative public health approaches. The transition of urban primary healthcare should become another example of that national wisdom grounded in inclusion, continuity, and long-term public interest.

The sachet trap: The hidden cost of mini packs

Farah Mahboob
is deputy manager at Social Innovation Lab in BRAC. She can be reached at fmahboobarc@gmail.com.

FARAH MAHBOOB

The global shift towards micro-packaging, particularly in the emerging markets of the Global South, represents one of the most significant transformations in fast-moving consumer goods (FMCG) distribution history. In Bangladesh, this phenomenon has coalesced into what experts identify as the "sachet economy," a system designed to maximise market penetration among low-income populations through the delivery of high-frequency, low-volume goods. Recently, for my work, I started visiting slums in different parts of Bangladesh. Something that started bothering me in every other place was the availability of "mini pack" of almost every item. From shampoo and detergent to biscuits and chips, every item imaginable has been shrunk down to a sachet. Furthermore, beside the regular brands, I found brands I've never seen in the upscale or retail chain shops like Shwapno, Agora, or Meena Bazar in Dhaka. To dig deep into it, I started looking at the roads and ground while walking in different slums in Dhaka, Khulna, and Barishal. And what was not surprising was the presence of empty sachets of these minipacks.

But why is there a mini pack for every item? And why in slums? I tried to look into the value chain to find the answers. The existence of the sachet is not a "cosmetic choice" by manufacturers but a response to the "daily liquidity cycle" prevalent in informal settlements. While a middle-class family in Dhaka would prefer to buy a reasonably large pack of detergent or a bottle of shampoo monthly, a family residing in a slum who lives on a daily liquidity cycle cannot commit probably Tk 300 to a bottle or regular-sized packet but can spare Tk 5 or Tk 10 on a need basis. On the surface, it is a solution. Under the hood, they are often paying a 20-30 percent premium per gram compared to the bulk buyer. This is the "poverty premium" and it is quite astonishing that over 95 percent of consumer goods in Bangladesh are sold through more than 20 lakh small, informal retailers, commonly known as *mudir dokan* (corner shops). For these *mudi dokandar* (shopkeepers), the sachet is a high-velocity item that minimises inventory risk and appeals directly to the cash-constrained consumer. We are essentially charging the poorest people the highest unit prices for the "convenience" of being unable to afford more. Data shows that as the volume of the package decreases, the unit cost increases exponentially, creating a structural barrier to wealth accumulation for the poor.

Also, these "invisible" brands, regional giants that bypass expensive marketing, have flooded the market with direct influence at the corner shops. They have perfected the art of the micro-transaction, engineering products with extra spice and high calories to fuel labour-intensive lives. But while they have mastered the distribution of the product, they have completely ignored the retrieval of the packaging, leading to significant environmental issues as the discarded materials accumulate in urban areas. Moreover, data shows that many products commonly consumed in slums fail to meet health benchmarks, contributing to the rising incidents of non-communicable diseases. Excessive consumption of these products is linked with hypertension, heart disease, and stroke—conditions that are now responsible for 70 percent of all deaths in Bangladesh. Children are particularly at risk, as surveys indicate they consume ultra-processed foods (UPFs) approximately 21 times per week. These regional players often operate below the radar of high-end retail chains, focusing on the dense networks of urban slums and rural hubs. Their competitive advantage lies in their ability to provide higher margins to local shopkeepers. These brands leverage strategic alliances to surmount obstacles related to infrastructure and promote innovation in product engineering, specifically tailoring flavours and calories to the needs of labourers, such as those in the RMG sector or rickshaw pullers.

The sachet economy is a brilliant business strategy for market penetration, but it is a catastrophic failure for disaster management and urban health. We are trading the long-term viability of our soil and drainage systems for short-term 'affordability.' Bangladesh demonstrates a clear pattern for addressing a plastic crisis. The soil here is physically choking on the remnants of a micro-transactional economy that failed to plan for its waste.

The environmental reality of the sachet economy is harsher; the flaw is visible in the soil of Dhaka, Barishal, and Khulna. These mini packs come in multi-layer plastic (MLP) packaging because it is cheap and indestructible. But because these sachets are small and contaminated, they hold zero resale value for the waste-pickers. Unlike a plastic bottle, a sachet is "worthless" to the circular economy. Therefore, they stay and become part of the soil.

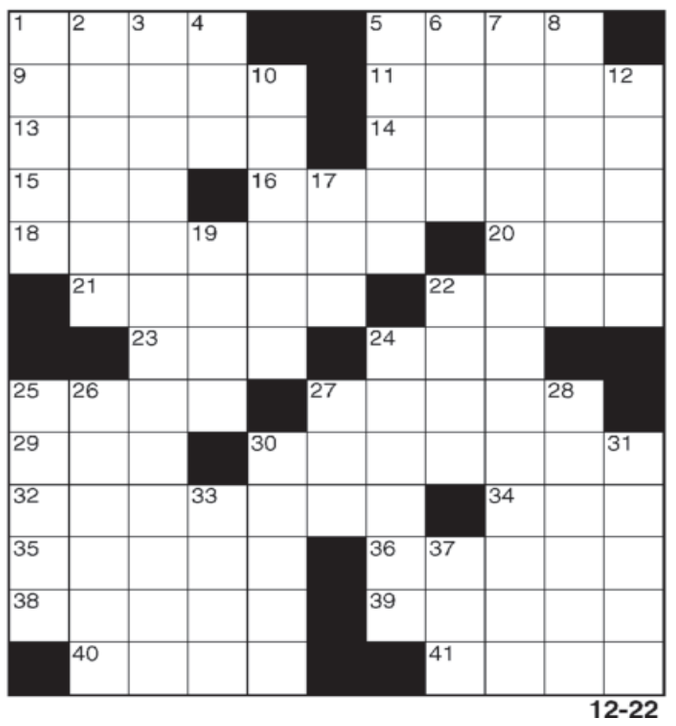
We often talk about "localisation" and "sustainability" as if they are separate from the market. However, the "veins" of the urban slum, the drains, cannot function properly when the very products designed to "serve" the slums choke them. This is true not only for the poor communities or localities but also for the cities as a whole. For example, in Barishal, the "death" of canals and ponds due to encroachment and plastic littering has led to a situation where water remains on the streets for three to four days after every heavy rainfall. The existing 30-kilometre drainage of the city is largely non-functional, with experts estimating that not even five percent of it is in optimal condition. When we allow a value chain to profit from the micro-transaction while externalising the macro-waste, we aren't innovating; we are extracting.

The sachet economy is a brilliant business strategy for market penetration, but it is a catastrophic failure for disaster management and urban health. We are trading the long-term viability of our soil and drainage systems for short-term "affordability." Bangladesh demonstrates a clear pattern for addressing a plastic crisis. The soil here is physically choking on the remnants of a micro-transactional economy that failed to plan for its waste. The move towards refillable, sustainable, and equitable systems is the only viable path forward for the country's future. If we want efficiency and equity in our urban environments, we have to shift the model from "disposable sachets" to "refillable systems" that respect local liquidity without destroying local ecology. At the end of the day, we must realise that the soil doesn't lie.

CROSSWORD
BY THOMAS JOSEPH

ACROSS
1 Bar bills
5 Makes suits
9 Brass, for one
11 City on the Po
13 Genetic copy
14 Give an address
15 Young fox
16 Relevant
18 Liberate
20 Place
21 Goddess of the hunt
22 Is the right size
23 Greek consonants
24 Hr. part
25 Leo or Libra
27 Avoid
29 Band blaster
30 Billing option
32 Cornered
34 Simile words
35 Crime outing
36 Short putt
38 Justice Kagan
39 Like a sports car
40 Pretentious
41 Goes astray

DOWN
1 Bulletin board items
2 In cahoots
3 Old aid for pen users
4 Heir, often
5 Emporium
6 Mark's replacement
7 Present surroundings
8 Abstain
10 Longs
12 High homes
17 Casserole bit
19 Satyr's kin
22 Rover's pal
24 Some sacred music
25 Pasta topper
26 Gazelle's cousin
27 Word on a bill
28 Less complex
30 Lineup
31 GIs overseas
33 Pitched shelter
37 Hoppy brew



12-22

YESTERDAY'S ANSWERS

A	C	R	E			G	L	O	S	S
T	H	U	M	B		R	A	N	T	O
L	E	N	T	O		I	T	S	O	N
A	R	I		W	I	N	S	T	O	N
W	I	N	T	E	R			A	P	E
			I	D	E	A		G	E	T
	M	I	N	T		N	E	E	D	
T	A	R		O	T	T	O			
O	N	O			W	I	N	D	O	W
W	I	N	S	L	O	W		I	C	E
E	L	A	T	E		A	L	O	H	A
L	O	G	O	N		R	I	D	E	R
S	W	E	P	T			V	E	R	Y