POLICY BRIEFS

ADVANCING URBAN HEALTH SYSTEMS THROUGH EVIDENCE

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At a Glance

Community-Led Responsive and Effective Urban Health Systems (CHORUS) is a Research Programme Consortium (2020-26) funded by Foreign, Commonwealth & Development Office, UK (FCDO) that brings together health researchers from Africa, South Asia and the UK. CHORUS works with communities, health professionals and city level decision makers to develop and test ways to improve the health of the poorest urban residents.

Bangladesh (Dhaka)	Nepal (Pokhara)	Ghana (Ashaiman)	Nigeria (Enugu)	United Kingdom (Leeds, York)

Urban Health System Challenges

As rapid and uncontrolled urbanisation continues across low- and middle-income countries, health systems are struggling to keep up, and the needs of poor urban communities are often not met. This is especially true for those experiencing exclusion due to intersections with gender, caste, ethnicity, religion and disability. Many of the challenges to good health among urban residents are created by the wider urban environment such as inadequate water and sanitation provision, air pollution, urban design that favours vehicles and the influential role of commercial organisations and easy access to unhealthy diets, tobacco and substance abuse.

Chorus Response

The CHORUS vision is to address these multi-sectoral challenges and help build resilience in urban health systems. A demand-led approach was applied working closely with poor communities to understand their health needs and design and evaluate interventions that will drive the improvement of the urban health system. Enaggement with urban policymakers and providers ensures that the interventions co-designed are consistent with policy objectives and are feasible and sustainable.

Linking Plurality of Providers | **Multisectora Collaboration** | **Responding to CDs & NCDs** | **Engaging the Urban Poor**

1. Linking Plurality of Providers: Focuses on improving coordination between formal and informal healthcare providers to enhance service delivery and coverage, especially in complex urban systems.
2. Multisectoral Collaboration: Promotes collaboration across sectors beyond health (e.g., water, transport, environment, climate change, economic development, education) to address wider determinants of health in urban settings.
3. Responding to Communicable and Non-Communicable Diseases (CDs & NCDs): Emphasizes addressing the dual burden of diseases of both infectious and chronic conditions by strengthening prevention, management, and service delivery system in urban settings.
4. Engaging the Urban Poor: Ensures that vulnerable and marginalized populations are actively engaged in identifying problems and shaping solutions, improving inclusiveness and equity.

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Urban Health in National Policies of Bangladesh: Five Decades of Reform and Persistent Gaps

Baby Naznin, Swaksar Adhikary, Zahidul Quayyum

The policy challenge

Bangladesh has achieved significant health gains in the 50 years since independence, yet urban health remained an afterthought in national policies. Despite rapid urbanization, successive Five-Year Plans (FYPs) and sector programmes primarily focused on developing healthcare infrastructure for rural settings. This resulted in limited public provision of healthcare in urban areas, particularly for the urban poor. Urban service delivery is dominated by the private sector, which provides nearly 80% of care often with weak regulation contributing to high out-of-pocket expenditure (around 73%). PHC in cities has largely depended on short-term projects and NGO-led initiatives, creating inequities in access, quality, and affordability.

This review systematically analyzed national policy documents to examine how urban health has been framed, identify persistent policy gaps, and assess whether recent reforms signal a shift toward a more coherent and equitable urban health system.

KEY URBAN HEALTH FACTS

39% of Bangladesh's population now urban

2.5% urban population growth rate (almost double of national rate -1.4%)

35% of all urban residents live in Dhaka alone

>70% health expenditure is out-of-pocket - globally among the highest

METHODS

- Initially, retrospective document review of 26 national policy documents (1972–2022).
- Developments from 2023 to 2025 were treated as an emerging policy context and discussed separately
- Document sources: MoHFW, DGHS, DGFP, LGD, development partners
- Relevant literature review (PubMed, Google Scholar)
- Thematic analysis

Five decades of urban health policy — what changed?

1973–1990: Rural focus by design — urban health invisible

The 1st, 2nd, and 3rd Five-Year Plans (FYPs) explicitly focused on building rural healthcare infrastructure. The 1977 Paurashava Ordinance delegated PHC to municipalities without required funding or capacity to provide services.

1990s–2003: Acknowledgements of urban health, yet no dedicated plans

The 5th FYP (1997) first recognised rapid urban migration and the need to improve urban healthcare delivery. However, the HPSP (1998–2003) and the first national health policy (NHP 2000) focused exclusively on rural PHC through the Essential Service Package and Community Clinics, with no structured urban equivalent. During this period, MoLGRDC relied on contracted NGOs to deliver limited urban services, later formalised under the Urban Primary Health Care Services Delivery Project (UPHCSDP), which implemented NGO-managed PHC in selected urban areas.

2003–2011: Structural reforms attempted, urban PHC outsourced to NGOs

HNPSP (2003–2011) introduced the purchaser-provider split and demand-side financing. The City Corporation Act & Paurashava Act (2009) gave LGIs a formal PHC mandate but with no adequate resource transfer from MOHFW. Urban PHC continued to be largely delivered through NGO-contracted arrangements under MoLGRDC, reinforcing a fragmented and externally managed service delivery model.

2014: First-ever National Urban Health Strategy (UHS)

The 2014 UHS marked the first dedicated urban health policy 43 years after independence. It set eight strategic goals, including advancing universal health coverage (UHC) with a pro-poor focus, and was the first national policy to explicitly recognise urban slum dwellers, floating populations, and garment workers as distinct groups requiring tailored service delivery approaches.

2020 onwards: Updated strategy, procurement reforms, and a new policy window

The 2020 UHS updated priorities with a stronger focus on equity, system integration and UHC in urban settings. The 2024 governance transition and the Public Procurement Ordinance/Rules (PPO/PPR) 2025 amendments introduced a legal basis for outcome-based health service contracting. The Health Sector Reform Commission (2025) marked an ambitious escalation of the reform agenda indicating a potential shift toward more coordinated and accountable urban health system.

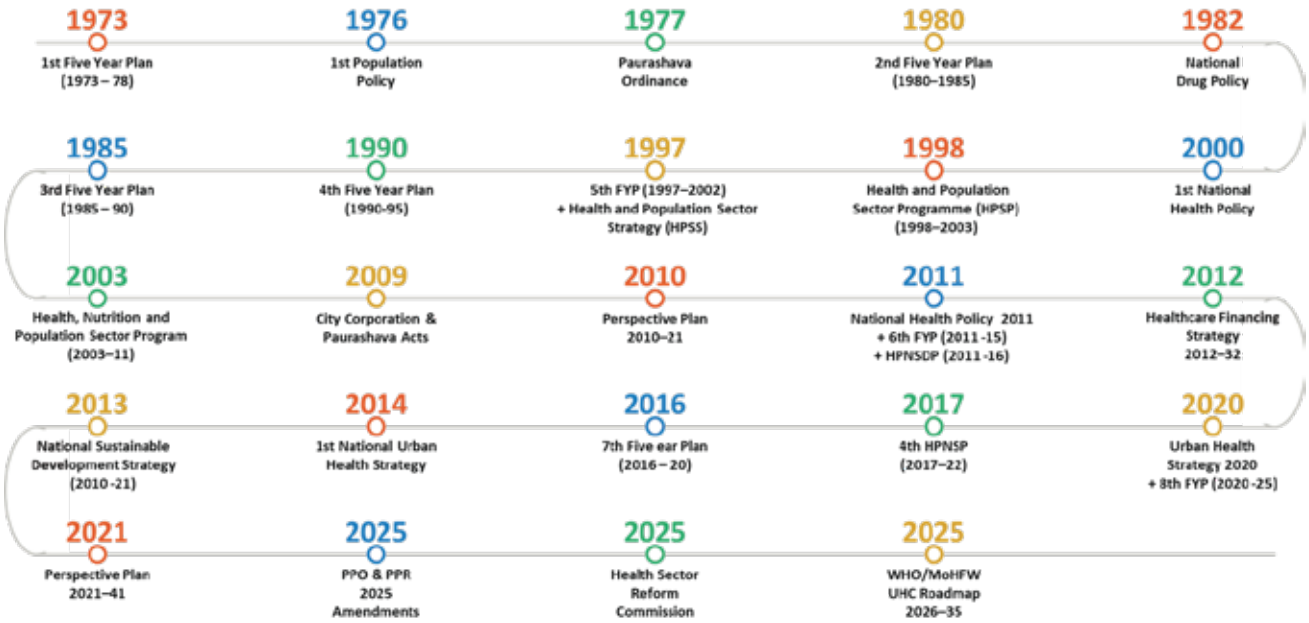
Three eras of policy evolution

Rural-focused era (1973–1996)
Urban health missing in all planning documents; municipalities mandated to provide PHC but underfunded.

Transition era (1997–2013)
Urban PHC acknowledged; NGO contracting introduced and expanded; LGIs given legal mandate for PHC provision but with limited resources.

Urban focus era (2014–2025)
First urban-specific strategy; emphasis on Public-private partnership; PPO/PPR reform; Reform Commission calling for constitutional change; Several policy discourse on Strategic Purchasing.

Chronological timeline of Bangladesh Health Policies



Note: FYPs and sector programmes (HPSP, HNPSP, HPNSDP, HPNSP) are shown in the timeline because they are the primary national planning documents and most urban health commitments were embedded within them, not in stand-alone policies. Showing them alongside urban-specific milestones reflects that urban health was long treated as a secondary issue within rural-focused planning. The 2025 Health Reform Commission Report and PPO/PPR amendments are included as they represent the most significant shifts in the policy and legal environment since the 2014 Urban Health Strategy.

Persistent gaps identified that are unresolved across 50 years

Interministerial Coordination: MoHFW vs MoLGRDC

Since 2009, CCs legally mandated for urban PHC delivery, but responsibilities between the MoHFW and the MoLGRDC remain fragmented, with weak coordination, unclear accountability, and no unified authority for planning, financing, and oversight.

No urban-specific needs assessment mechanism

No policy has prioritized systematic urban health needs assessment disaggregated by slum type, occupation, or mobility status. The 2020 Strategy recommends population mapping, but this remains aspirational, with no implementation mechanism established so far.

Inadequate dedicated health budget for City Corporations

City Corporations have no separate health budget line. They depend on central transfers and donor projects. No minimum allocation standard or domestic financing mechanism has been established in 50 years of planning.

Fragmented health information systems, purchasing without data

HMIS is not integrated across public, NGO, and private sectors. Available data tracks inputs and processes, not quality and outcomes making evidence-based purchasing structurally difficult.

Physical access without utilization

The 2020 Urban Health Strategy indicated that 95% of slum communities had a facility within 2 km, yet reliance on public facilities remains very low, with continued dominance of private providers, pharmacies, and informal practitioners reflecting persistent weak trust in public services.

Absent referral system flagged since the 4th FYP (1990)

The 2020 Strategy again recommended structured urban referral protocols, yet no standardised guidelines exist. Patients bypass PHC facilities directly for tertiary care, creating bottlenecks and catastrophic out-of-pocket expenditure.

Private sector dominates but remains unregulated

The Medical Practice and Private Clinics Ordinance (1982) is still in force, unchanged. No independent hospital accreditation body exists, despite recommendations in the 4th HPNSP. Private providers deliver majority of the urban healthcare with no mandatory quality monitoring.

Social determinants and community engagement largely absent

The 2020 Strategy acknowledges that poor sanitation, water, and nutrition in informal settlements undermine any health system intervention, but no policy includes enforceable cross-sectoral accountability for wider determinants of health.

Health Sector Reform Commission Report 2025

Urban Health Propositions

- Recommended the establishment of ward-based urban PHC centres, aligned with city corporation administrative units
- Proposed 170 Urban Primary Health and Nutrition Centres (“City Health Centres”) for 2025-2028, targeting major urban areas
- Suggested adaptation of the rural union sub-centre model for urban PHC service delivery
- Planned extended service hours (two shifts) to improve accessibility for working urban populations
- Identified governance fragmentation between the MoHFW and MoLGRDC as a key structural constraint
- Recommended establishing a health service commission and prioritized Health in All Policies (HiAP) framework to enable cross-sectoral coordination highlighting social determinants of health, including housing, environment, and urban planning
- Recommended decentralisation of service delivery, including specialised care at the district level and advanced tertiary care at the divisional level to reduce patient concentration in Dhaka-based facilities and improve geographic equity in access

Looking ahead – WHO/MoHFW UHC Roadmap 2026 - 2035: In November 2025, WHO convened a high-level consultation to present the draft Bangladesh UHC Roadmap 2026–2035, developed with MoHFW. The roadmap emphasized alignment with the Health Sector Reform Commission and its translation into Bangla to support inclusion in 2026 election manifestos. For urban health, it highlighted financial protection, prioritization of low-income and informal urban populations, and progressive expansion of PHC. It represented a significant opportunity to embed urban PHC governance reform within a nationally owned and politically visible framework.

Emerging priorities for strengthening urban health

Legislate a Joint Urban PHC Authority with a Dedicated Budget Line

- Establish a joint MoHFW-MoLGRDC Urban PHC Coordination Authority with legal mandate, dedicated budget, and quarterly accountability reporting.
- Clearly delineate functions, e.g., MoHFW to set clinical standards and guidelines, and LGIs to act as service commissioners with mandatory technical and capacity support.

Replace the 1982 Private Sector Ordinance and Mandate Provider Reporting

- Enact a comprehensive Private Healthcare Act to replace the earlier Ordinance.
- Establish an autonomous National Accreditation Body.
- Mandate NGO and private providers to report into a DHIS2-linked urban HMIS to enable performance monitoring and evidence-based purchasing

Mandate Urban Health Needs Assessment Disaggregated by Population Sub-type

- Require bi-annual urban health needs assessments disaggregated by slum type, occupation, and mobility status.
- Introduce entitlement cards for the urban poor enabling free PHC at government and city corporation facilities as proposed in the 2020 Strategy.

Establish a Structured Urban Referral System

MoHFW must issue standardised urban referral protocols, assign catchment areas to designated PHC centres, and restrict secondary/tertiary facilities to referred cases as first proposed in the 4th FYP (1990) and re-proposed in every Urban Health Strategy since.

Frame Urban PHC as a Constitutional Entitlement

Adopt the Reform Commission's recommendation to mandate free PHC as a constitutional right. This shifts LGI budget obligations, minimum service standards, and accountability mechanisms from policy preference to legal obligation, as this kind of framing often has produced durable change in comparable LMIC health systems.

Urban health entered Bangladesh's policy agenda relatively late, but rapid and accelerating urbanization has now made it a central health system priority. This review shows that while policies increasingly recognize urban health needs, progress has largely remained at the level of intent, with long-standing structural gaps persisting.

With recent reforms and evolving policy momentum, there is now a critical opportunity to translate existing commitments into action. Aligning and implementing current policies, particularly around governance, financing including public-private partnership and strategic purchasing, accountability, and reaching the underserved population (properly identifying the poor and vulnerable population in small urban areas) will be essential to ensure an equitable, responsive, and sustainable urban health system.

Technical Efficiency of Sub-District Hospitals in Bangladesh: Evidence for Policy Action

Md. Zahid Hasan, Edward JD Webb, Silviya Nikolova, Khadija Islam Tisha, Zahidul Quayyum & Tim Ensor

Background

The public healthcare system in Bangladesh is structed into a hierarchical framework, includes primary, secondary, tertiary level healthcare facilities across the country. At the primary level, the public sector provider operates a total of 15,910 facilities in eight divisions of the country, including sub-district level hospitals (SDH), Union sub-centres, Union health and family welfare centres, and community clinics. Sub district hospitals (SDHs), known as Upazila Health Complexes (UHCs) are the first referral point in both rural and municipal corporation areas, using a significant share of public health expenditure, play a crucial role in achieving Universal Health Coverage (UHC).

Ensuring the efficient use of available resources (Technical efficiency) is imperative to build a sustainable healthcare system, and for this SDH needs through maximizing outputs from given inputs, and enabling improve service delivery, expanding coverage.

Knowledge Gap

A significant gap exists about the knowledge on how efficiently the SDHs are operating with regards to their capacity to transform given inputs into optimal service outputs, so that they can meet the growing healthcare demands of the population.

Methods

This study assessed the technical efficiency of public sub-district hospitals, the UHCs, in Bangladesh to generate evidence for health sector decision-makers.

The methods framework is given below (Figure 1) suggest that inputs used as decision making units (DMU, i.e. hospitals) are transformed into outputs through the production function.

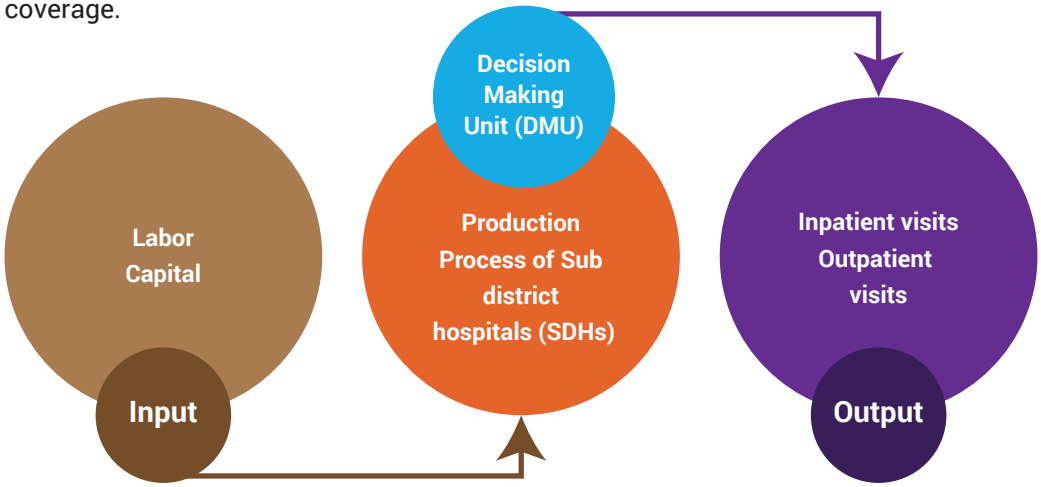


Figure1: Framework of Health outcome production process

This study analyzed a secondary cross-sectional dataset of 423 Sub-District Hospitals (SDHs) extracted from the Bangladesh Local Health Bulletin 2017 and external data sources including Bangladesh Sample Vital Statistics from Bangladesh Bureau of Statistics. An econometric analysis was conducted in two stages, estimate technical efficiency score and identify key associated factors using Data Envelopment Analysis (DEA)[1] and Stochastic Frontier Analysis (SFA)[2].

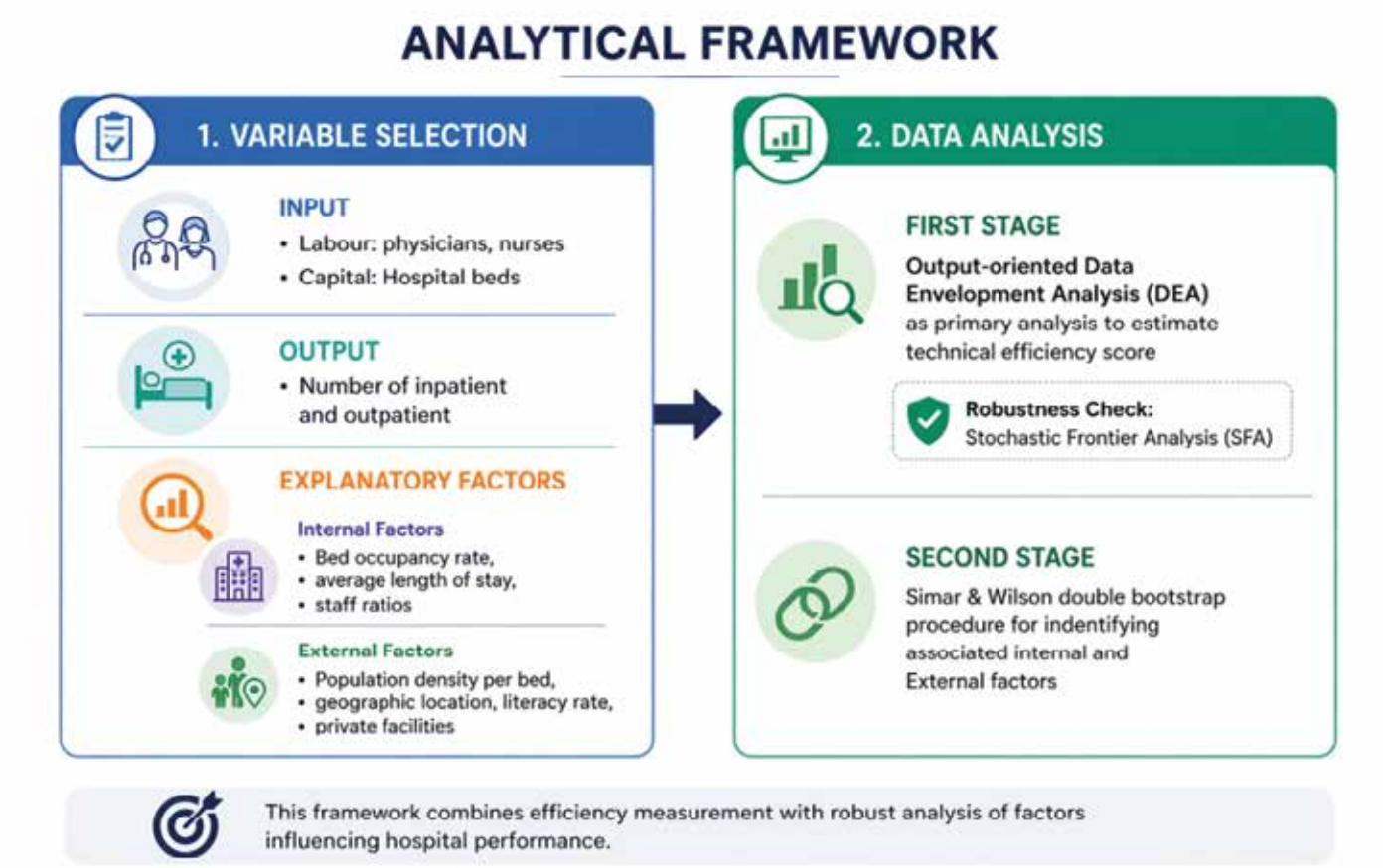


Figure 2: Analytical Framework for Assessing Technical Efficiency of Subdistrict Hospitals (SDHs) in Bangladesh

Key Findings

Overall Efficiency Performance	
Subdistrict hospitals (SDHs) operate below their full potential. Of the 423 SDHs, only 15 (3.5%) and 30 (7.1%) facilities were accounted to be technically efficient, depending on the approach used and 60 (14.2%) SDHs were optimal in size based on different assumptions. The SDHs experience inefficiencies due to managerial issues and input-output imbalance.	**Average technical efficiency score:** 53.3% in terms of Constant Returns to Scale (CRS) 58.8% in terms of Variable Returns to Scale (VRS) 90.7% in terms of scale efficiency **SDHs could increase output by about 42% using existing inputs.**

[1]DEA is a method for measuring how efficiently organizations use resources by comparing them to the best performers.
[2]SFA measures efficiency by estimating the best possible performance and separating inefficiency from random variation.

Regional Disparities

Significant regional disparities in efficiency are observed among subdistrict hospitals (SDHs) across Bangladesh.

Barishal Division records lower efficiency (43%–46%), whereas Sylhet Division demonstrates comparatively higher performance (69%–74%).
The relatively low efficiency in Barishal may be attributed with location as it is a riverine region with limited transport and communication infrastructure, which can constrain access to services and. This lower efficiency of SDHs could further be associated with reduced utilization of services, partly due to limited readiness in delivering healthcare

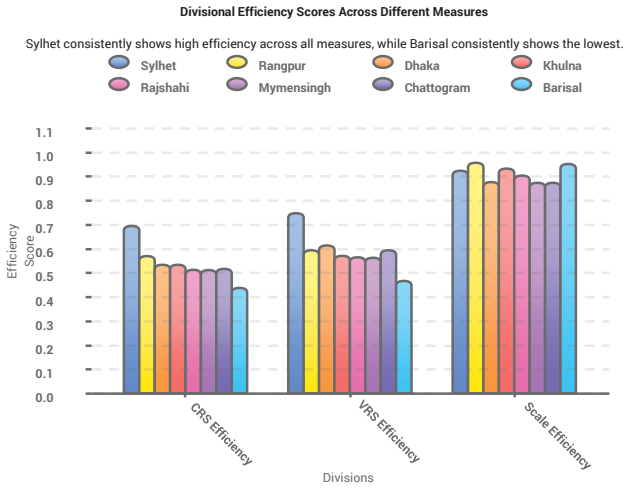


Figure 3: Efficiency Score of the SDHs across different division under different assumptions

Key Factors Associated with Efficiency

Several internal factors including the bed occupancy ratio, bed-to-physician ratio, and physician-to-nurse ratio are significantly and positively associated with efficiency. On average, one unit increase in ratio of beds to physicians, results in a 0.158 unit increase in the technical efficiency score.

The average length of stay and ratio of beds to nurses has a significant negative association with the efficiency score, meaning that a one-unit change in these factors will reduce the efficiency by 0.067 and 0.042, respectively.

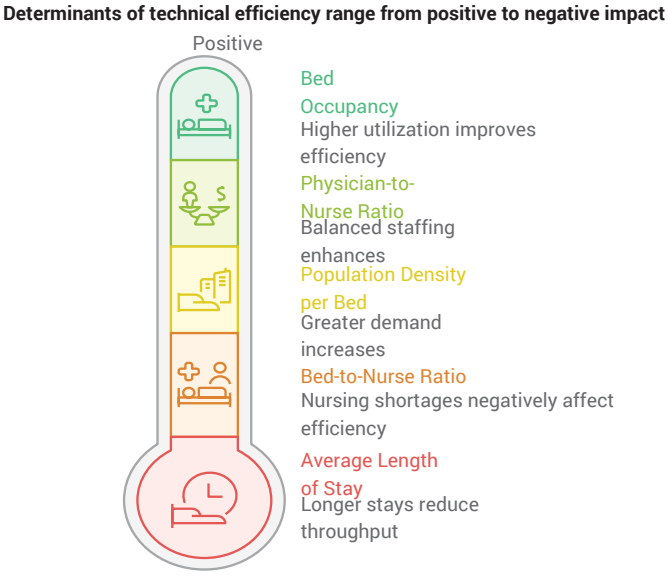


Figure 4: Key associated Factors with Efficiency

Research To Policy

Necessary actions that may be considered to improve overall efficiency of SDHs-

- The Ministry of Health and Family Welfare (MOHFW) should systematically use its existing datasets to generate technical efficiency scores and incorporate in resource allocation decisions
- Promote a formal benchmark mechanism where inefficient SDHs learn from high-performing (efficient) facilities and policymaker can utilize the study for benchmarking.
- Adopt a performance-based financing system by aligning payment mechanisms with both the quantity and quality of care provided, thereby creating incentives for efficient operations and the delivery of high-quality health services.

This research findings would support equitable resource distribution and identify key determinants that influence facility performance, enabling targeted policy interventions and optimizing the use of limited healthcare resources.

Can Bangladesh Shift to Strategic Purchasing for Urban Primary Health Care? Stakeholders Perspectives on Feasibility and Reform Pathways

Baby Naznin, Fatema Kashfi, Amatul Haque Chaahat, Syeda Tahmina Ahmed, Swaksar Adhikary, Jannatun Tajree, Bryony Dawkins, Baassey Ebenso, Noemia Siqueira, Tim Ensor, Helen Elsey, Rumana Huque, Zahidul Quayyum

The challenge: from spending more to spending smarter

Across health systems globally, the central question in health financing is shifting. It is no longer only how much is spent on health, but how effectively those resources are translated into accessible, high-quality services for those who need them most. In Bangladesh, inefficiencies in health spending remain a critical concern. Out-of-pocket payments account for over 70% of total health expenditure, placing a substantial financial burden on households rather than pooling risk across the system. Despite decades of investment in urban primary health care (PHC), financing mechanisms remain largely passive with funds are allocated based on historical budgets and administrative processes, rather than population needs, provider performance, or health outcomes.

Urban PHC has long depended on externally financed, project-based programmes, most notably the Urban Primary Health Care Service Delivery Project (UPHCSDP). While these initiatives have expanded access, they have not resulted in a sustainable, domestically financed system. When projects end, service continuity is often at risk. The recurring question, what happens after funding stops, remains unresolved after nearly three decades. At its core, this reflects a structural limitation. The government has primarily functioned as a provider of services rather than a strategic purchaser. It manages facilities, personnel, and inputs, but does not systematically determine which services should be purchased, from whom, at what price, and with what quality standards.

What is strategic purchasing — and why does it matter?

Strategic purchasing refers to the deliberate allocation of pooled health resources to providers based on population needs, service quality, and performance. Instead of passively disbursing funds, governments (or designated purchasing entities) actively decide which services to buy, from whom, at what cost, and under what conditions.

For Bangladesh, adopting strategic purchasing offers an opportunity to transform urban PHC from a fragmented, project-dependent system into one that is equitable, accountable, and financially sustainable. The key question is not whether this shift is desirable, but how it can be achieved and what barriers must be addressed.

About this study

This two-phase qualitative study examines stakeholder perspectives on the feasibility, barriers, and reform pathways for strategic purchasing in Bangladesh's urban health system. The research was conducted in Dhaka between 2023 and 2025, spanning a period of political transition and significant procurement reform.

Component	Details
Phase 1: Key Informant Interviews (KIIs)	32 key informant interviews (July–December 2023) with policymakers, development partners, NGO programme managers, and academia
Phase 2: Stakeholder Workshops	Two consultation workshops (September–October 2025) involving 87 participants to validate and contextualise findings
Analytical Framework	Strategic Health Purchasing Progress Tracking Framework (SPARC), applied prospectively to assess readiness for reform

The study was guided by the Strategic Health Purchasing Progress Tracking Framework, developed by the Strategic Purchasing Africa Resource Center (SPARC) in 2018. The framework conceptualises strategic health purchasing as a set of interrelated functions through which pooled health resources are translated into service delivery within a broader governance and health system context.

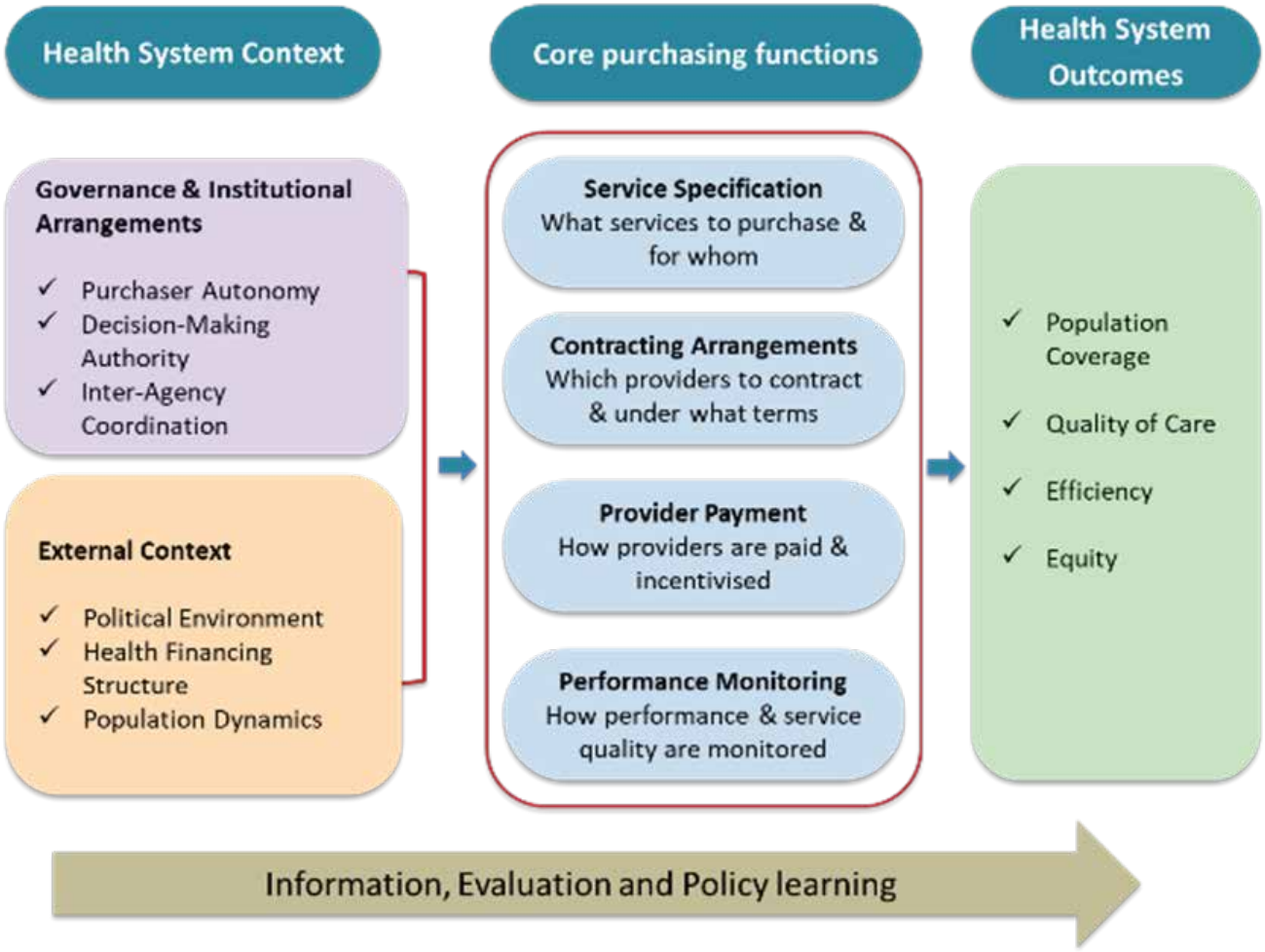


Figure 1: Strategic Health Purchasing Progress Tracking Framework

Key findings

Enabling conditions: what is already in place

Bangladesh is not starting from scratch. Several features of the current health system provide a foundation for strategic purchasing:

Established Experience in NGO Contracting
Nearly three decades of contracting NGOs under UPHCSDP have built practical experience in tendering, contract management, and reporting. Notably, some municipalities continued service provision through locally negotiated contracts after external financing ended in 2025, indicating emerging institutional capacity.

A Diverse, Pluralistic Provider Landscape
Urban health services are delivered through a diverse mix of public facilities, NGOs, private providers, pharmacies, and informal practitioners. Strategic purchasing can leverage this diversity by directing public funds toward providers that deliver quality care to underserved populations.

Recent Legal and Procurement Reforms
Revisions to the Public Procurement Ordinance (2025) and Rules (2025) introduce "physical services" as a procurement category, enabling

performance-based contracting for health services. This creates a critical legal foundation for strategic purchasing.

Emerging Political Commitment
The 2024 political transition has opened a potential reform window. The establishment of a Health Reform Commission and the recommended purchasing reform suggest growing political ownership.

Systemic barriers: what is holding progress back

Despite these promising foundations, critical structural and institutional barriers remain between the current system and a functioning strategic purchasing model that require deliberate policy attention.

Absence of a Dedicated Purchasing Authority
No institution (e.g., MoHFW, MoLGRDC) currently holds a clear mandate to perform purchasing functions independently. Ministries simultaneously act as providers and purchasers, creating conflicts of interest and weakening accountability.

Institutional Fragmentation
Responsibility for urban PHC is assigned to local government institutions (LGIs), yet legal and financial frameworks restrict resource flows and technical authority. This misalignment hampers effective governance and implementation.

Fragmented Health Information Systems
Health Information systems remain siloed across sectors, with limited interoperability. Private providers are not required to report data, and existing systems focus on inputs rather than outcomes. The absence of unique patient identifiers further limits continuity of care tracking.

> *"We make purchasing decisions with almost no information about what is being purchased, how well it is being delivered, or whether it is reaching the people who need it most. You cannot be a strategic purchaser without data."* — KII Participant

Input-Based Financing Models
Existing contracts reimburse NGOs for operational costs (e.g., salaries, medicines, equipment) rather than rewarding service quality or coverage outcomes. This provides no financial incentive for improvement. Combined with reliance on donor-funded projects, this perpetuates inefficiencies and undermines sustainability.

Urban Population Heterogeneity
Urban populations are highly heterogeneous, including slum communities, geographically scattered informal settlements, migrant and floating populations, informal sector workers, and other marginalised groups. Existing service packages do not adequately reflect evolving needs, particularly the growing burden of non-communicable diseases (NCDs).

> *"Even within slums, there are differences. Karail and Kunipara have established social networks, but informal settlements in wealthier parts of the city have a completely different dynamic. The simple dichotomy of slum versus non-slum doesn't work for service planning."* — KII Participant

Implementation priorities: the way forward

Stakeholders identified several interrelated priorities for advancing strategic purchasing for urban PHC:

Establish a Dedicated Purchasing Authority
Designate a specific authority, whether a unit within MoHFW, a formal MoHFW-LGI arrangement, or a national purchasing body similar to Thailand's National Health Security Office (NHSO) with a clear, legally grounded mandate to carry out core purchasing functions independently of service provision. This should be supported by an appropriate legal instrument (e.g., executive order, revised operational plan, or legislation). While the PPO 2025 provides the procurement framework, a complementary policy mandate is required.

Build Institutionally Embedded, Multidisciplinary Purchasing Capacity

Strategic purchasing requires sustained institutional capacity, not short-term training. Multidisciplinary teams (legal, economic, public health, IT) should be embedded within government structures and linked to defined positions. Strengthening LGI-level capacity is a priority, alongside establishing career pathways in health management to retain skilled personnel.

Design a Contextually Appropriate, Urban-Specific Service Package

The current Essential Service Package does not adequately reflect urban needs. A revised package should include preventive and promotive care; maternal, child, and adolescent health; NCD management (e.g., hypertension, diabetes, mental health); communicable diseases (e.g., dengue, tuberculosis); and basic emergency care. Medicines and diagnostics should be integral. Design should be informed by up-to-date, urban-specific needs assessments.

Adopt Multi-Modal Service Delivery to Reach All Urban Populations

A single delivery model cannot reach diverse urban populations. A multi-modal approach is needed, combining fixed facilities, mobile units for underserved groups, and community health workers for household-level care. Payment mechanisms should incentivize outreach to hard-to-reach populations, not just high-volume areas.

Reform Contracting for Performance-Based Accountability

Contracts should shift from input-based to output- and outcome-based approaches. Procurement must prioritise quality alongside cost to avoid underpricing. Large contracts may be divided into smaller, geographically defined areas. Contracts should include clear performance indicators, improvement periods, sanctions, and exit provisions. Standard Tender Documents under PPO/PPR 2025 can support implementation.

Build an Integrated Health Information System

An integrated platform linking public, NGO, and private providers should feed into DHIS2 for system-wide monitoring. Unique patient identifiers are important for tracking continuity of care. Community feedback mechanisms should be included. Data must be directly linked to payment and contracting decisions.

The equity imperative for strategic purchasing

Strategic purchasing must not improve efficiency for some while deepening inequality for others. Bangladesh's continued reliance on out-of-pocket spending already places a disproportionate burden on the urban poor and informal sector workers, many of whom lack financial protection.

Equity Safeguards that Must be Embedded in Purchasing Design

- **Differentiated Financing:** Full public financing for services in low-income and informal settlements; partial cost-sharing considered in better-off urban areas
- **Protection Against Exclusion:** Risk-adjusted payments, mandatory service obligations for marginalised groups, and monitoring systems to detect and prevent selective exclusion
- **Equity-Linked Performance Indicators:** Contracts should measure coverage of disadvantaged populations, not only overall service volumes
- Medicines and diagnostics must be treated as core entitlements. As medicines and diagnostics are the major drivers of out-of-pocket spending and catastrophic expenditure, they should be included in all purchased service packages.

Community Preferences for Urban Primary Health Care Services in Bangladesh: A Discrete Choice Experiment

M M Fardeen Kabir, Zahidul Quayyum, Zahid Hassan, Farzana Sehrin, Baby Naznin, Fatema Kashfi, Jinat Jahan Khan, Bryony Dawkins, Rumana Huque, Helen Elsey, Tim Ensor

Why a Discrete Choice Experiment?

Urban low-income populations in Bangladesh face persistent barriers to accessing quality primary healthcare (PHC) services driven by high population density, inadequate living conditions, and financial constraints. In cities like Dhaka, home to some of the world's most densely populated informal settlements, health systems often struggle to respond effectively to the needs and priorities of underserved communities. Despite ongoing investments in urban health, service design and delivery remain largely supply-driven, with limited empirical evidence on what users themselves value when choosing healthcare. There are very few studies in Bangladesh that have systematically examined PHC preferences among urban poor populations. This evidence gap constrains policymakers' ability to design responsive service packages aligned with community needs.

To address this, the study applies a Discrete Choice Experiment (DCE), a robust, theory-based method for eliciting preferences and understanding trade-offs in decision-making. Unlike traditional satisfaction surveys, DCEs simulate real-world choices by asking respondents to select between hypothetical service options with varying characteristics. This approach enables estimation of the relative importance of different service attributes, and the trade-offs individuals are willing to make, including willingness to pay or accept changes in service quality. Recommended by the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) as a gold-standard approach, DCEs generate actionable, policy-relevant evidence for designing people-centred health systems.

Study Objectives

This study aims to quantify preferences for primary healthcare attributes among urban low-income residents. Specific Objectives are:

- Identify which PHC service attributes matter most to urban low-income populations
- Understand the trade-offs residents make when choosing healthcare facilities
- Explore heterogeneity in preferences across population sub-groups
- Generate evidence to inform demand-responsive PHC service design and strategic purchasing

Methods

Study Design: A sequential mixed-methods approach was used. Qualitative research (24 in-depth interviews and 4 focus group discussions) informed the development of DCE attributes. The study adhered to ISPOR Good Research Practice guidelines for conjoint analysis. Latent Class Analysis (LCA) was applied to identify distinct preference groups.

Study Setting: A densely populated informal settlement in Mirpur, Dhaka, one of the largest urban slum areas in Bangladesh.

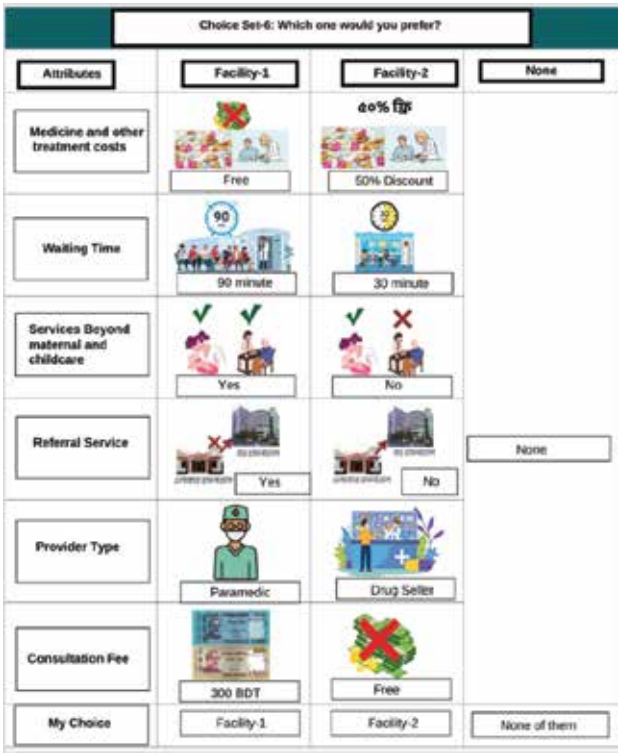
Sample: A total of 288 adult residents (aged ≥18 years) was recruited using systematic random sampling across 10 blocks, with a sampling interval of four households.

Attribute Development: A four-stage process was followed:

- **Qualitative exploration:** Initially developed 17 attributes based on community perspectives
- **Expert review:** Reduced to 12 attributes aligned with the WHO AAAQ framework (Availability, Accessibility, Acceptability, Quality).
- **Community validation:** Prioritized attributes based on lived experiences with community people through two ranking exercise workshops.
- **Pilot testing:** Refined attributes and levels for clarity and comprehension.

Final DCE Attributes and Levels:

Attribute	Levels
Provider Type	MBBS Doctor, Paramedic, Drug Seller
Consultation Fee	Free, 100 BDT, 200 BDT, 300 BDT
Medicine & Other Treatment Costs	Free, Half Payment, Full Payment
Waiting Time	30 minutes, 60 minutes, 90 minutes
Services Beyond MCH	Yes, No
Referral System	Yes, No



Experimental Design: A Bayesian D-efficient design (generated using Ngene software) was used to construct choice sets. Each respondent completed eight choice tasks, each presenting two hypothetical healthcare facilities with varying attribute combinations, along with an opt-out option.

Data Collection: Data were collected through face-to-face interviews using visual Q-cards (laminated A4 sheets with illustrations) to facilitate understanding among respondents with limited literacy. Trained research assistants conducted interviews following a three-day intensive training programme.

Key Findings

Sample Characteristics

Gender	Male	40%
	Female	60%
Literacy Level	Cannot Read and Write	8.07%
	Sign Only	25.61%
	Read Only	0.35%
	Can Read & Write	67%

Overall Preferences: Mixed-Logit Regression

Urban poor populations strongly value comprehensive services and qualified providers, even above immediate cost considerations. The Mixed-Logit regression results show:

- **Service comprehensiveness** (beyond maternal and child health) is the most highly valued attribute (Coefficient: +2.22, $p<0.001$).
- **Referral system availability** is nearly as important (Coefficient: +1.88, $p<0.001$).
- **Qualified providers** (MBBS doctors) are strongly preferred over paramedics (Coeff: −2.03, $p<0.001$) or drug sellers (Coeff: −2.09, $p<0.001$).
- **Shorter waiting times** significantly increase facility preference.

Cost-Related Findings

- Full payment for medicine has negative and highly significant coefficient
- Half-payment **is preferred to fully free medicine** (likely reflects trust/quality signaling)
- Respondents are **not strictly fee-averse** – they accept some consultation fee for better care

Heterogeneity in Preferences: Latent Class Analysis

A three-class Latent Class Analysis revealed meaningful heterogeneity in preferences across the sample. Understanding these segments is critical for designing differentiated, people-centred PHC interventions.

Preference Class	Share	Key Characteristics
Class 1 — Quality and Value Seekers	37.1%	Strong preferences for MBBS doctors, comprehensive services, and referral availability; relatively lower sensitivity to medicine costs.
Class 2 — Cost-Averse, Waiting-Tolerant	18.2%	Strong aversion to medicine payments, positive valuation of longer waiting times, and limited preference for service scope beyond reproductive health.
Class 3 — Price-Sensitive Comprehensive Care Advocates	44.7%	Strong preferences for MBBS doctors, short waiting times, comprehensive services, and referral, alongside marked fee aversion.

From Evidence to Policy Action

The findings highlight clear priorities for designing more responsive and effective urban PHC services:

- Expand urban PHC packages beyond maternal and child health (MCH) to include NCDs and mental health
- Establish functional, well-communicated referral pathways linking primary to higher-level care
- Prioritise deployment and retention of MBBS doctors in urban PHC through strategic purchasing and contracting
- Introducing appointment systems, triage, and digital patient flow management to reduce delays
- Apply segmented financing approaches - targeted subsidies, quality-linked cost-sharing, and convenience-focused service models
- Pair subsidies with visible quality assurance, standards, and accountability mechanisms

Urban PHC systems should incorporate people-centred design rather than relying solely on supply-driven models. Aligning services with community preferences can enhance utilization, trust, and health outcomes; however, certain decisions should continue to be guided by normative considerations.

Tackling Heat Exposure in Dhaka

Anisur Rahman Bayazid, Riaz Hossain Khan, Zahidul Quayyum

Dhaka faces multiple challenges, with extreme heat exposure as one of the significant ones. To address this, BRAC James P Grant School of Public Health, BRAC University monitored and analyzed city-wide temperature exposure to bridge knowledge gaps and inform policy action.

A temperature monitoring campaign was held in July-September 2023 where in-situ near surface air temperature (3 to 6 meters above ground) has been measured from 8 fixed (continuous 60 days) and 61 rotating (continuous 72 hours) sites comprising 5 land use categories. The land use categories are:

a. Built-up area
b. Roadspace area
c. Green and Blue space area
d. Suburban area
e. Industrial area

This monitoring data has been used to identify areas with the maximum heat exposure and people residing or working in these areas has been interviewed through 9 Focus Group Discussions (FGDs). Additionally, 10 Key Informant Interviews (KIIs) were also conducted with relevant stakeholders from government departments/ agencies, non-government organizations, and academia. This study is developing a pilot scale heatwave vulnerability index (HVI) with relevant and available secondary data.

Results and Policy Recommendations

Scorching Heat

During the study period, the average temperature recorded by Bangladesh Meteorological Department (BMD) was 29.7°C, closely aligning with this study's average of 29.9°C. But the maximum temperature recorded by BMD was 37.0°C, while field data showed a significantly higher peak of 44.0°C.

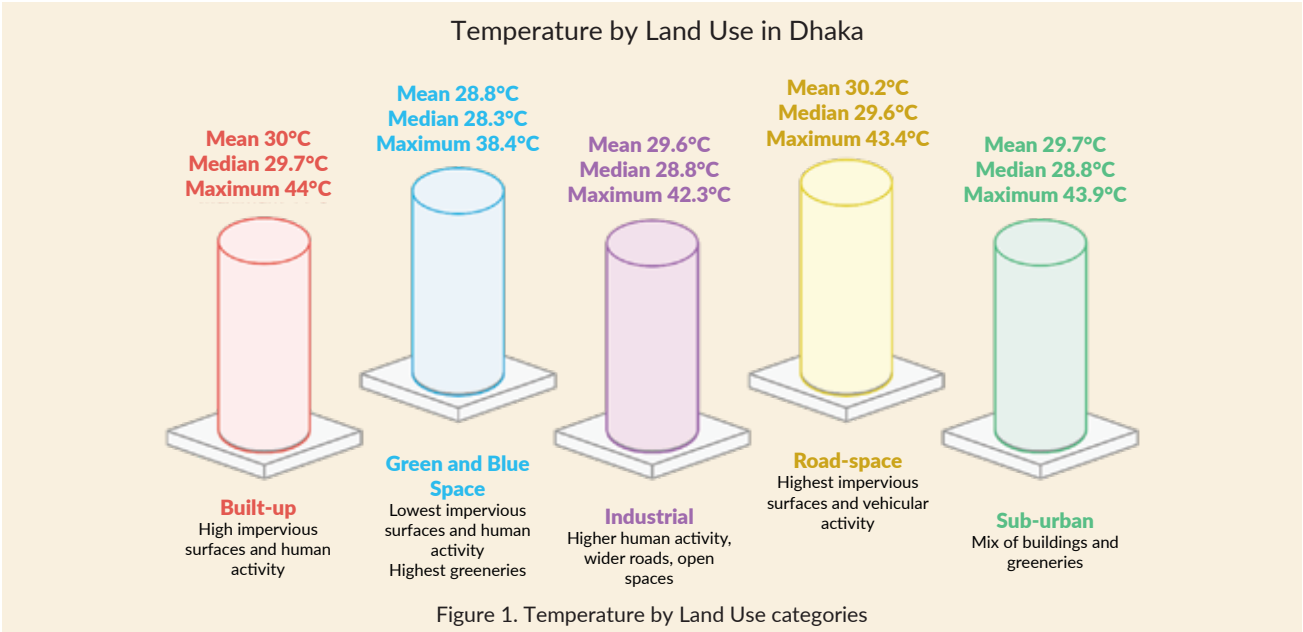


Figure 1. Temperature by Land Use categories

- Temperature distribution varied across different land use types, as shown in Figure 1. The data shows that Green and Blue space areas of the city stays comparatively cooler, more during heat extremes (e.g. heat waves). To address the scorching heat faced by people of different parts of the city, this study recommends installing networks of monitoring stations for the city.

  √ Networks of monitoring stations covering all land use types is necessary for Dhaka. Currently BMD has a single monitoring station at Dhaka, which only captures city-wide averages useful for climate modelling and weather forecasting. Along with BMD, city corporations (local government), RAJUK, health ministry, and organizations working on climate and health, can setup monitoring stations for monitoring, research, planning, and management.

  √ A broader network will help to identify heat hotspots, vulnerable communities, and localized drivers of extreme heat.

Partially Burned

- Green and blue spaces are 0.8°C to 1.4°C cooler than other areas. In Dhaka, none of these areas are completely linear, rather green and blue features (trees, waterbodies) are dominant with the presence of other land uses.
- If the city can adopt sufficient green and blue spaces, the city temperature can be reduced by approximately 1°C.
- A minimum of 0.5°C can be reduced if sub-urban characteristics, like a mix of greeneries and infrastructures can be adopted.

  √ Outdoor temperature in industrial areas are comparatively less hot, probably due to more open spaces, wider roads, and scattered greeneries. The heat condition of these areas can be improved much easily with proper management and policy. The policies should increase the number of open areas and impervious surfaces in industrial sites, along with ensuring the protection and care of existing and new trees.

Intra-Urban Heat Islands - IUHI (Hottest Neighborhoods of the City)

Four neighborhoods of Dhaka has been identified with the highest heat exposure, both for mean and maximum temperatures. These areas cover diverse land use characteristics and are among the major Central Business Districts (CBDs) of the city.

- **Uttara-Airport-Bashundhara:** This is the largest IUHI in the city. Major characteristics of this area include wider roads, airport, and comparatively well-maintained residential areas. The impervious surface area is higher in these neighborhoods.
- **Farmgate:** This is an important transportation junction in the city, having wider roads. The area is characterized by dense traffic, numerous commercial establishments, and limited green cover.
- **Gulistan-Shahbagh:** These areas are also important transportation junctions. The dense urban fabric, coupled with high pedestrian and vehicular traffic, leads to substantial heat retention. In these areas. Although there are several parks in and around these areas, they cannot reduce the heat mostly due to anthropogenic heat generation.
- **Shyampur:** This is an industrial area. This area can be characterized by extensive built-up area with minimal vegetation cover. This is a key entry point for the city, and faces high vehicular movement all the time.

  √ IUHI areas need urgent area-specific mitigations. Need comprehensive and separate plans for each IUHI. Respective authorities, including city corporations, Roads and Bridges authority, and ministry of industry can play significant roles for these areas.

Dhaka's Hottest Neighborhoods

Uttara-Airport-Bashundhar
Largest IUHI with wider roads, planned residential areas, and airport. Impervious surface area is higher in these neighborhoods.

Farmgate-Tejgaon
Important transport junction with dense traffic, government and commercial establishments. The area has limited green cover

Gulistan-Shahbagh
Dense urban fabric with high traffic and human volume. Parks offer limited cooling effect.

Shyampur-Postogola
Industrial area with minimal vegetation cover. Key entry point of the city with high vehicular movement.

Figure 2. IUHIs of Dhaka and their characteristics

The Discrimination

Heat exposure is not uniform across the city, so is the vulnerability. When Informal settlements temperature (LST) is compared to non-informal areas temperature, a significant temperature difference has been observed (Figure 3). People living in informal settlements are exposed to more heat than other areas, 1.4°C precisely.

- √ Informal settlement areas need assistance during heat waves to combat the heat. Access to clean drinking water, access to medical facilities, and shades for outdoor markets and walkways are inadequate in these areas. City corporations, WASA, LGD, and health ministry need to work together to combat heat for vulnerable population.

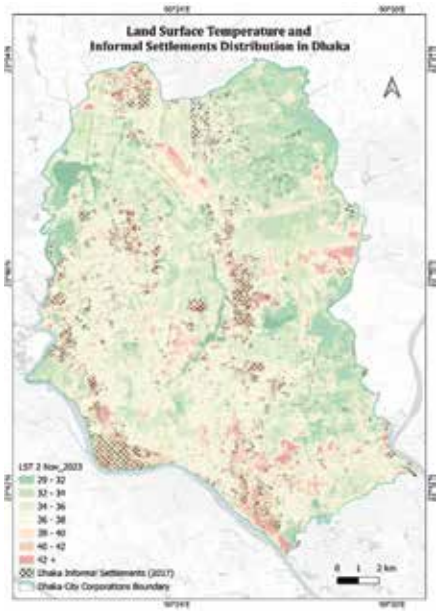


Figure 3. Temperature variability in informal settlements

Health Implications

Due to insufficient data on heat related health problems, direct correlation between exposure to high temperatures and specific health burdens could not be established. Lived experience of the people residing in the heat hotspots of each land use category and interviews with key stakeholders identified some of the health problems that intensifies during heat waves.

- √ Heat exhaustion, heat stress, unconsciousness, fever, cold, diarrhea, headache, skin diseases, anger issues, mood swings, and heat strokes are reported as the health burdens.
- √ A robust health data collection is a necessity to prioritize health expenditures and combat outbreaks. This robust health data should contain in-detail patient records including precise residence location and geospatial data to analyze for present and future use.

Hidden Spatial Inequality and Heat Vulnerability in Dhaka

Anisur Rahman Bayazid, Riaz Hossain Khan, Zahidul Quayyum, Baby Naznin, Amatul Haque Chaahat

Introduction

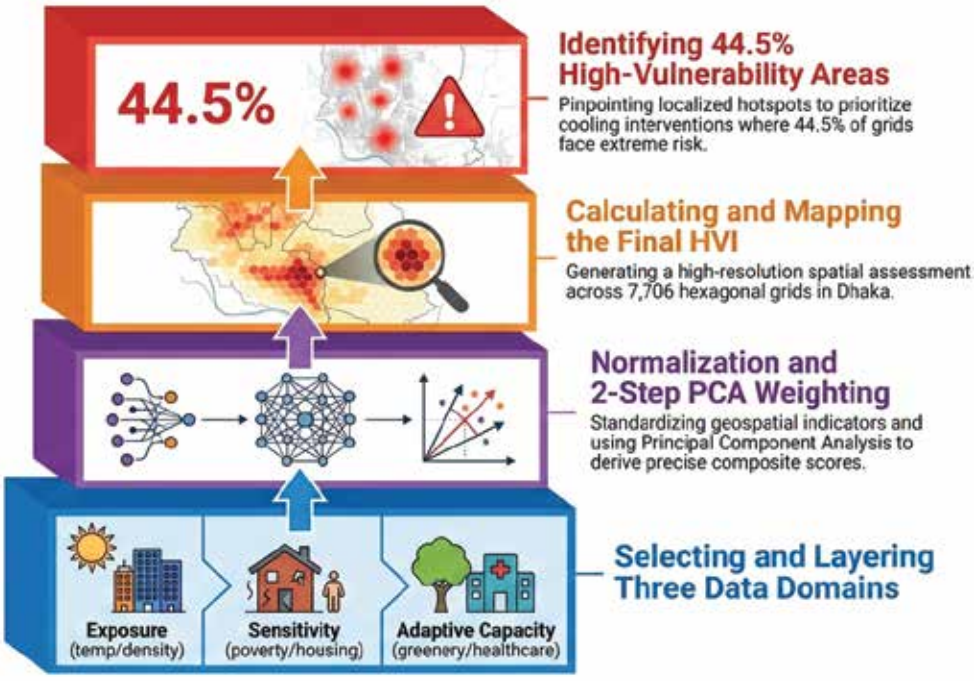
Extreme heat is an increasingly urgent public health challenge for rapidly growing cities. Climate change is increasing the frequency, intensity, and duration of hot days, while urbanization amplifies heat through the urban heat island (UHI) effect. In densely populated cities like Dhaka, concrete surfaces, traffic congestion, limited vegetation, and high population concentration trap heat and reduce nighttime cooling. These conditions place residents at greater risk of dehydration, heat exhaustion, cardiovascular stress, reduced productivity, and heat-related mortality.

Problem Statement

The burden of extreme heat in Dhaka is not shared equally. While the entire city faces rising temperatures, a profound intra-urban inequality exists. Current urban planning often relies on broad administrative data that overlooks "hyper-local" hotspots. Without high-resolution spatial data, municipal authorities cannot effectively identify which neighborhoods and which specific populations are at the highest risk of heat-related morbidity and mortality, and cannot prioritize where and how to intervene.

Work at BRAC JPGSPH

BRAC James P Grant School of Public Health has conducted a research study on the small-area heat vulnerability in Dhaka. The objective was to move beyond broad citywide statistics and identify small-area patterns of heat vulnerability across both Dhaka North City Corporation (DNCC) and Dhaka South City Corporation (DSCC). Using open source data and geostatistical methods, a spatial assessment across DNCC and DSCC was conducted, analyzing vulnerability at both a 250-meter hexagonal grid level (n=7,706) and the administrative ward (n=134) level. Geospatial indicators were resampled to a 30-meter resolution across three domains, Exposure, Sensitivity, and Adaptive Capacity. We used a



two-step Principal Component Analysis (PCA) to derive composite domain scores and a final HVI. Vulnerability was then classified into five categories from lowest to highest.

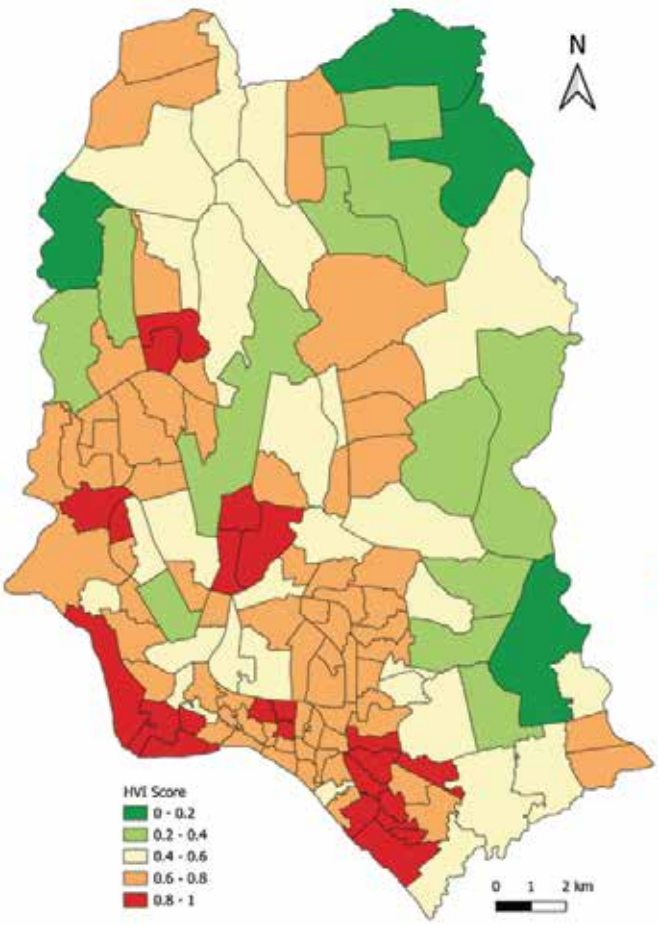
Our analysis revealed confounding intra-urban inequality. In 2023, LST fluctuated by nearly 20°C across the city (22.2°C to 42.1°C), where higher values were spatially clustered in densely built, and high-road-density areas, particularly in central and southern Dhaka. Population density reached extremes of nearly 200,000 persons/km². Alarmingly, 44.5% of the analyzed grids fell into the highest vulnerability category, while only 0.2% were classified as low vulnerability. These low-risk pockets were limited to the northern and eastern fringes characterized by large green, blue, and open spaces.

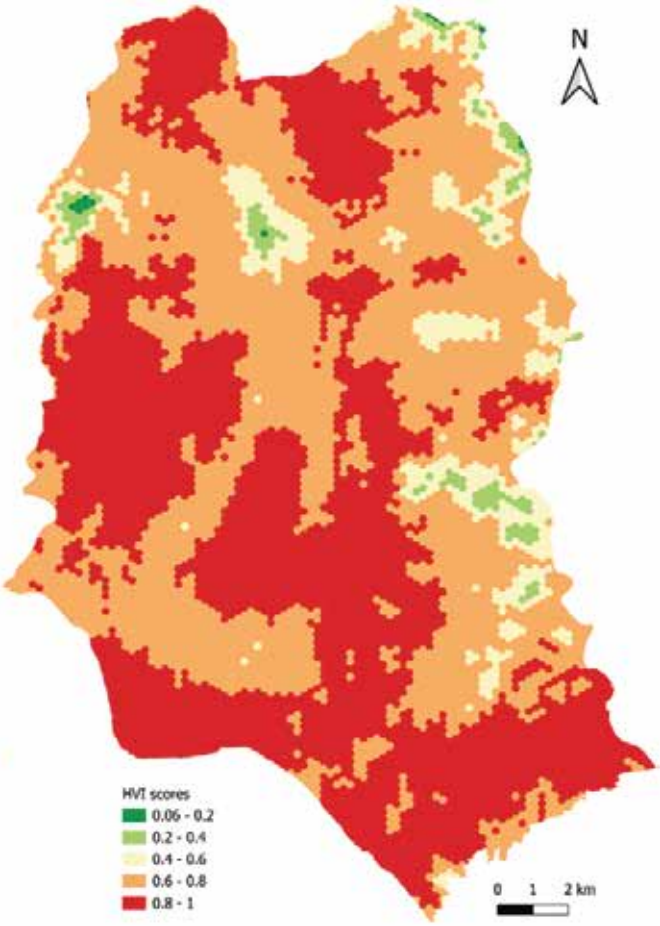
At the administrative level, the highest vulnerability (1st quartile) was concentrated in 25 DSCC and 10 DNCC wards. DSCC wards 34, 35, and 52, with high vulnerability, completely lack healthcare facilities, while several other high-risk wards, like DNCC 03, 05, 25, 26, 30, and DSCC 48, 50, 51, 53, 55, 57 have no government-run health centres. Grid-level analysis further revealed substantial within-ward heterogeneity, indicating that administrative averages may mask localized hotspots.

Exposure Indicators:
Land surface temperature (LST), Population density, Road density, Industrial activity, Sky view factor (SVF)

Sensitivity Indicators:
Poverty, Building density, Informal settlements, NDBI

Adaptive Capacity Indicators:
Green spaces, Blue spaces, Healthcare access, Night-time lights





Research to Policy

The following policy takeaways can be suggested to address heat vulnerability in Dhaka:

- **Institutionalize Vulnerability Index:** The Heat Vulnerability Index should be integrated into city planning, disaster management, and health policy. Regular updates using new satellite and administrative data would help track progress and emerging hotspots.
- **Implement Hyper-Local Targeting for Interventions:** Administrative ward-level averages can mask significant "localized hotspots" within the city. Policy efforts should utilize the study's neighborhood-level analysis to identify and prioritize specific high-risk pockets for cooling interventions rather than relying solely on ward-level data
- **Prioritize Nature-Based Solutions in High-Density Areas:** The study found that low-risk areas were almost exclusively those with large green, blue (water), and open spaces. Urban planning should focus on increasing green and blue spaces in these vulnerable, high-road-density sectors to mitigate the extreme fluctuations in Land Surface Temperature (LST) by:

    - **Preservation:** Legally protect the remaining green and blue spaces in the northern and eastern fringes, as these are the only areas currently providing a "low-vulnerability" buffer.
    - **Urban Greening:** Incentivize vertical gardening and neighborhood-scale parks in dense southern clusters to increase the Sky View Factor (SVF) and reduce LST.

- **Address Spatial Inequities in Healthcare Access:** There is a critical gap in adaptive capacity, with some high-vulnerability wards completely lacking healthcare facilities, and many others lacking government-run centers. The government should prioritize the establishment of heat-health emergency centers in these specific underserved wards to improve residents' ability to cope with heat-related illnesses.
- **Integrate Poverty Reduction with Urban Planning:** Because vulnerability is driven by sensitivity factors like poverty and informal settlements, heat mitigation cannot be solved through environmental policy alone. Policy should integrate urban heat planning with social safety nets and housing improvements for residents in informal settlements to reduce their inherent sensitivity to temperature extremes. For the heat wave period, satellite clinics , access to water, community cooling spaces, and worker protections need to be ensured targeting informal settlements.

Heat in Dhaka is not only an environmental issue, it is a spatial inequality issue. Fine-scale evidence now makes it possible to target solutions where they are needed most.

Embedding Capacity Strengthening in Research Consortia: Lessons from the CHORUS Urban Health Programme

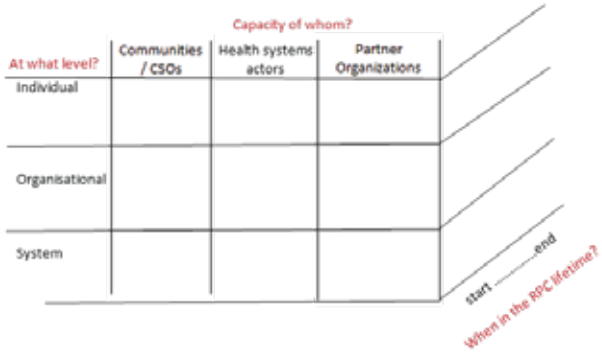
Baby Naznin, Zahidul Quayyum, Chinyere Mbachu, Shreeman Sharma, Nabila Binth Jahan, Delali Kumapley, Obinna Onwujekwe, Genevieve Aryeetey, Rumana Huque, Sushil Baral, Bassey Ebenso, Helen Elsey, Irene Agyepong, Tolib Mirzoev

Context

Capacity, in the health systems context, refers to the combination of knowledge, skills, attitudes, and systemic enablers that allow individuals, organisations, and health systems to perform their functions effectively, equitably, and sustainably. Research consortia in low and middle-income countries (LMICs) often include capacity strengthening (CS) as a stand-alone activity, typically a series of training events disconnected from core research.

CHORUS programme adopted a different approach. Since the inception, CS was designed as a cross-cutting, systems-oriented function embedded within all aspects of the research process, rather than an add-on. CHORUS adopted a comprehensive CS framework to guide its work across partner countries. The framework conceptualises CS along three interconnected levels – individual, organisational, and system – and across three groups of actors: health system actors (including health service providers, m[1.1]anagers, and policymakers), communities and civil society organisations, and CHORUS partner organisations. A defining principle of the framework is an asset-based orientation: rather than beginning with capacity needs, it explicitly maps and leverages pre-existing strengths, competencies, and institutional assets as the foundation for CS activities.

BRAC James P Grant School of Public Health (JPGSPH) led the CS workstream for South Asia, covering Bangladesh and Nepal, two contexts where urban health systems face rapid population growth, fragmented service delivery, and persistent inequities.



How Capacity Strengthening Worked Within the CHORUS Consortium

Four interconnected mechanisms shaped the design and delivery of CS within CHORUS:

Evidence-driven planning: Baseline capacity assessments, using surveys, document reviews, and structured interviews were conducted across partner institutions. These findings directly informed the design of interventions, ensuring that activities addressed real, context-specific gaps rather than assumed needs.

Layered delivery approaches of CS Interventions: CS combined broad-reach webinars (for wide engagement), intensive training, writing and data analysis workshops (for skill-building), and Action Learning Groups or ALGs (for peer exchange and collaborative problem-solving across countries).

Country ownership and peer learning: CS activities were led by country partners rather than centrally imposed. Regional workshops and ALG structures facilitated South–South and cross-regional knowledge exchange.

Continuous learning and adaptation: Period assessments (e.g., midline researchers capacity

survey) tracked progress and adjusted priorities. Quarterly reporting mechanisms ensured that learning was systematically fed back into programme design and implementation.

15+ Training Courses	25+ Webinars	4 Writing & Data Analysis Workshops	6 Action Learning Groups

Key Outcomes and Impacts

The CS workstream generated outcomes at multiple levels:

- Researchers' capacity assessments informed designing targeted CS activities, while organizational assessments enabled partners to reflect on internal capacities, identify gaps, and take tailored actions aligned with their institutional needs
- Researchers across Bangladesh and Nepal developed demonstrable skills in implementation research, health economics, GIS, qualitative and quantitative methods, and scientific writing enabling them to independently lead applied urban health research.
- Health system actors, including local government officials, policymakers, and service providers, gained knowledge and tools to engage meaningfully with evidence and to co-design health system interventions.
- A cross-country research community emerged from regional workshops and ALGs, a network that continues to generate collaborative outputs beyond the project period.
- A completed systematic review on public–private partnership (PPP) models in urban health systems in LMICs produced critical, policy-relevant evidence for health system reform in Bangladesh and comparable settings.

What the Evidence Shows: Findings from the Midline Assessment

- Writing workshops and structured training sessions were consistently rated the most effective interventions by participants.
- Webinars successfully reached large audiences but were less effective for deeper skill development, highlighting the need to organize more focused, hands-on training.
- Action Learning Groups facilitated practical, context-specific problem-solving that formal training alone could not achieve.
- Organisational assessments encouraged institutions to address structural constraints, not just individual skill

Policy and Programme Implications

The CHORUS CS experience generates lessons for funders, policymakers and program implementers:

- Capacity assessments should precede training design and be repeated to track progress and refine approaches.
- Webinars are valuable for broad engagement, but sustained capacity gains require intensive, participatory formats such as trainings courses, workshops and ALGs.
- Embedding CS within research activities rather than treating it as separate, creates reinforcing and sustained impact.
- Institutional systems (e.g., governance, ethics, data management) must develop alongside individual competencies.
- South-South and cross-regional collaboration should be formally resourced as a core component of consortia.
- Peer learning, shared tools, and co-produced outputs should be built to sustain consortia CS efforts.

Capacity strengthening is most effective when it is evidence-based, contextually grounded, and fully integrated into research systems. The CHORUS experience demonstrates that structured, multi-level CS approaches can generate impacts that extend beyond individual skills—strengthening institutions, fostering collaborative networks, and supporting long-term research ecosystems.

Urban Health in the Shadows

Why Bangladesh and Nepal's Media Must Move Beyond the Crisis Cycle

Policy Commentary | Based on the study: From Evidence to Influence: Media's Role in Informing Urban Health Policies in Bangladesh and Nepal

Sabrina Mustabin Jaigirdar, Sulata Karki, Shreeman Sharma, Rumpa Akter, Sabina Marasini, Rumana Haque, Sushil Baral, Helen Elsey, Zahidul Quayyum

Where is Health in Media Coverage

In both Bangladesh and Nepal, urban health sits at the intersection of two converging crises: a deepening public health burden driven by rapid, unplanned urbanization, and a media landscape structurally ill-equipped to give it sustained attention. The media is the stepping stone linking research to policy. Unplanned rapid urbanization has contributed to a triple disease burden, noncommunicable diseases, infectious outbreaks, and social vulnerability, with a substantial proportion of the urban poor living in informal settlements where access to health services is fragmented and unreliable. A large segment of the urban poor (slum and floating population) remained invisible to formal health systems, excluded due to unstable housing and absent from government records.

Yet despite this reality, our qualitative research involving 30 key informants, journalists (n=17), health policymakers (n=10), and public health advocates (n=3) across both countries reveals that urban health consistently ranks lower in the media priority lists.

> *"Urban health is typically ranked lower in priority — perhaps around seventh or eighth. Issues such as recruitment, transfers, and corruption dominate the discourse in Bangladeshi health content."* — Journalist, Bangladesh

Why Urban Health Gets Left Behind

Evidence access is constrained and politically influenced

Stakeholders (health policymakers, public health advocates and journalists) in both countries relied primarily on government data but faced bureaucratic barriers, data concealment, and political pressure. Government-acknowledged data was treated as more usable for policy advocacy, even when incomplete or biased. Journalists said they supplemented formal sources with expert opinions, field visits, and informal networks, but policymakers and public health advocates frequently questioned media credibility. Peer-reviewed research publication was valued but underutilized due to its technical language and limited accessibility.

Media influence on policy is indirect, episodic, and crisis-driven

Despite limited formal inclusion in policy processes, media coverage generated public pressure that accelerated government response during emergencies. COVID-19 reporting contributed to expanded ICU capacity and oxygen availability in Bangladesh; reporting on pesticide uses in Nepal prompted market monitoring. Outside of crises, media-policy engagement was sporadic and relationship-dependent rather than formal and institutionalized. Issue-focused and investigative reporting, the forms most likely to shape policy, were infrequent.

The Affluence Misconception
In Nepal, a damaging assumption persists that city residents are generally wealthy and health-literate, meaning intra-urban inequities receive almost no coverage. Urban poor populations often face worse health outcomes than their rural counterparts, a finding that demands journalistic investigation, not silence.

No Dedicated Beat, No Continuity
Journalists in both Bangladesh and Nepal mentioned urban health reporting as important yet consistently under-prioritized within the media landscape. It was even rarely treated as a primary reporting area within the health beat.

> *"There is no dedicated urban health beat where reporters consistently focus on just this area. If someone reports it today, they might move on to another topic tomorrow."* — Journalist, Nepal

Structural and Financial Constraints
Journalists in both countries cited low salaries, scarce fellowship programs and training opportunities, dependence on advertising or funding, and restricted data access as key constraints in contributing to continuous coverage and specialization for investigative urban health reporting.

What Needs to Change

Open government health data
City governments and ministries should release timely, disaggregated urban health information via public portals and appoint media contacts to decrease bureaucratic barriers to access.

Institutionalize journalist, policymaker, public health advocates dialogue
Create institutionalized multi-stakeholder processes with health journalists at the early stages of policy formulation and not only during post-decision briefings.

Invest in health journalism
Governments, development partners, and media organizations should work together to fund fellowships and training programs in health journalism so that urban health becomes a formal reporting beat.

Translate research for media audiences
Researchers should develop journalist-friendly outputs such as policy briefs, data summaries, and community-oriented stories to help journalists grasp different issues and use them in their reporting.

Protect media independence
The regulatory bodies should protect journalists against political and commercial pressures, and policymakers should officially acknowledge responsible urban health reporting to motivate continued quality coverage.

Unmasking urban affluence myth
Urban affluence is often assumed, masking intra-urban health inequities. Strengthening journalists' capacity for equity-focused, evidence-based reporting is key to revealing these disparities.

Conclusion

Urban health in Bangladesh and Nepal remains systematically under-reported due to financial constraints, a crisis-driven editorial culture, absent dedicated beats, and restricted data access. The consequences are direct: poor urban communities' health risks stay invisible in the media and deprioritized in policy. Where media influence exists, it is episodic and crisis-driven — insufficient to sustain evidence-informed policymaking. Closing this gap requires three specific actions: institutionalizing open access to disaggregated urban health data, establishing urban health as a dedicated editorial beat, and creating structured, recurring journalist, policymaker, public health advocates engagement beyond ad hoc press briefings.

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Research Outputs from the Project

All the BRAC JPGSPH studies are part of the CHORUS research grant that has been funded by FCDO from the UK government (grant reference number: 301132). However, the views expressed do not necessarily reflect the UK government's official policies.

Peer Reviewed Journal Articles

The Role of the Private Sector in the COVID-19 Pandemic: Experiences from Four Health Systems

Authors: Lauren J. Wallace; Irene Agyepong; Sushil Baral; Deepa Barua; Mahua Das; Rumana Huque; Deepak Joshi; Chinyere Mbachu; Baby Naznin; Justice Nonvignon; Anthony Ofosu; Obinna Onwujekwe; Shreeman Sharma; Zahidul Quayyum; Tim Ensor; Helen Elsey
Journal: Frontiers in public health
Date of Publication: 27 May 2022

Assessment of Public-Private Partnership (PPP) Models in Health Systems in Least Developed, Low Income and Lower-Middle-Income Countries and Territories: A Protocol for a Systematic Review

Authors: Baby Naznin; Zahidul Quayyum; Jannatun Tajree; Deepa Barua; Maisha Ahsan; Faisal Kabir; Deepak Joshi; Sampurna Kakchapati; Florence Sibeudu; Juliana Onuh et al.
Journal: Health Care: Current Reviews
Date of Publication: 29 September 2022

Factors affecting out-of-pocket expenditures for chronic and acute illnesses in Bangladesh

Authors: Jinat Jahan Khan, Farzana Sehrin, Zahidul Quayyum, Abdur Razzaque Sarker, Mohammad Shafiqur Rahman
Journal: PLOS One
Date of Publication: 9 April 2025

Study protocol for developing an urban deprivation index in Nepal: Data review, measurement, visualization and real-world application in urban poverty alleviation

Authors: Sampurna Kakchapati, Sitashma Mainali, Noemia Teixeira de Siqueira-Filha, Helen Elsey, Joseph Paul Hicks, Andrew Clark, Farzana Sehrin, Zahidul Quayyum, Bassey Ebenso, Sushil Chandra Baral
Journal: PLOS One
Date of Publication: 11 June 2025

Designing a strategic purchasing framework for urban primary healthcare services in Bangladesh: a protocol for a mixed-method study with a discrete choice experiment

Authors: Baby Naznin; Fatema Kashfi; Farzana Sehrin; Bryony Dawkins; Garrett Wallace Brown; Timothy Ensor; Rumana Huque; Zahidul Quayyum; Helen Elsey
Journal: BMJ Open
Date of Publication: 23 September 2025

Public–Private Mix (PPM) for Tuberculosis (TB) in Urban Health Systems in Least Developed, Low Income and Lower-Middle-Income Countries and Territories – A Systematic Review

Authors: Aishwarya Lakshmi Vidyasagaran; Noemia Teixeira de Siqueira Filha; Sampurna Kakchapati; Thomas Falconer Hall; Baby Naznin; Jannatun Tajree; Zahidul Quayyum; Deepak Joshi; Florence Tochukwu Sibeudu; Pamela Adaobi Ogbozor et al.
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Date of Publication: 15 December 2025

Technical efficiency of sub-district level hospitals in Bangladesh: a comparative frontier analysis

Authors: Md. Zahid Hasan, Edward JD Webb, Silviya Nikolova, Khadija Islam Tisha, Zahidul Quayyum & Tim Ensor
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Date of Publication: 09 March 2026

Choice of primary healthcare providers among population in urban areas of low- and middle-income countries—a protocol for systematic review of literature
Authors: Md. Zahid Hasan, Edward JD Webb, Zahidul Quayyum & Tim Ensor
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