BANGLADESH URBAN HEALTH NETWORK

NATIONAL POLICY DIALOGUE

URBAN HEALTH AND PRIVATE SECTOR ENGAGEMENT

22 SEPTEMBER, 2025

Why It Matters?

Urban health in Bangladesh presents significant challenges, with 41% of the population residing in urban areas[1] where primary healthcare (PHC) delivery remains fragmented and complex. This complexity stems from overlapping jurisdictions of the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Local Government, Rural Development, and Cooperatives (MoLGRD&C)[2-3], creating gaps in coordination and service quality. Despite efforts like the Urban Primary Health Care Service Delivery Project (UPHCSDP)[4] and the Bangladesh Smiling Sun Franchise Program[5], urban healthcare remains underfunded, heavily reliant on external support, and unsustainable without robust reforms.[6]The private sector plays a dominant role in healthcare delivery in Bangladesh, operating approximately 60% of the healthcare system[7], with 16,979 facilities and providing twice the number of hospital beds compared to government hospitals[8]. However, weak regulatory oversight has led to high out-of-pocket costs, which constitute 73% of total health expenditures, pushing millions into poverty each year[9]. Public-Private Partnerships (PPP) hold potential to bridge these gaps, as seen in neighboring countries like India, where innovative PPP models in states like Kerala have strengthened healthcare access and affordability[10]. These activities Dialogue and roundtable discussion aim to enhance urban PHC services by integrating the private health sector within the health system framework, seeking to establish a sustainable urban healthcare model, aligning with the principles of Universal Health Coverage (UHC) and ensuring access to quality healthcare for all.

Themes of the Dialogue

The Policy Dialogue on Urban Health and Private Sector Engagement will focus on three interrelated themes that are central to strengthening urban health governance and service delivery in Bangladesh:

Private Sector Engagement in Primary Healthcare Delivery

Recognizing the dominant role of private providers in urban healthcare, this theme will explore how the private sector can be more effectively engaged in delivering primary healthcare.

Equitable Access to Essential Drugs in Urban Health Systems

The barriers to equitable access to essential medicines, including issues of affordability, availability, and rational use with a particular focus on the most vulnerable groups.

Objectives of the Dialogue

1. **Explore strategies for engaging the private sector** in primary healthcare delivery, including models for collaboration, regulation, and innovation to improve coverage and service quality.
2. **Identify policy options to ensure equitable access to essential drugs**, particularly for underserved and vulnerable urban populations, by addressing issues of affordability, availability, and rational use.
3. **Generate actionable recommendations** for government, private sector, and development partners to foster sustainable partnerships in urban health service delivery.

TIME AND PLACE

On Monday, September 22, 2025, the Bangladesh Urban Health Network (BUHN) convened a National Policy Dialogue titled "Urban Health and Private Sector Engagement" at the Dr. Cecep Effendi Conference Hall, CIRDAP, Chameli House, 17 Topkhana Road, Dhaka-1000, Bangladesh. Held from 10:30 AM to 1:00 PM (BDT, GMT +6), the session was skillfully moderated by Dr. Kazi Saifuddin Bennoor, Senior Consultant at United Hospital, Dhaka.

DAILOGUE DESCRIPTION:

Welcome Speech

Dr. Margub Aref Jahangir, Health Specialist (Urban), Health Section, UNICEF Bangladesh

Dr. Margub Aref Jahangir, Health Specialist (Urban), Health Section, UNICEF Bangladesh, welcomed attendees by highlighting Bangladesh's rapid urbanization, noting that over one-third of the population lived in urban areas, presenting both opportunities and challenges for accessible, affordable, and equitable healthcare. He emphasized that healthcare was a fundamental right, not a privilege, pointing out that the private sector delivered 60% of services while underserved groups like the urban poor, slum dwellers, and migrants faced significant barriers. He cited the Aalo Clinic, a public-private partnership, as a model of effective collaboration and stressed the need for transparent, accountable partnerships to strengthen primary healthcare systems, ensuring no child, mother, or family was left behind.

Keynote Speech - 01

Presentation on Private Sector Engagement in Primary Healthcare Delivery

Dr. Md. Shamim Hayder Talukder, CEO of Eminence Associates for Social Development and Member Secretary of BUHN

In his keynote address, Dr. Md. Shamim Hayder Talukder, CEO of Eminence Associates for Social Development and Member Secretary of BUHN, underscored the critical role of the private sector in enhancing accessibility, timely care, and digital innovation in Bangladesh's urban healthcare, given the limitations of government services. He highlighted stark disparities, noting that only 66% of urban children received healthcare compared to 95% in rural areas, 22% of urban children were vaccinated versus 93% in rural areas, and just 39% had access to family planning services compared to 83% in rural areas, drawing on successful models from India, Kenya, and Thailand. Dr. He also called for result-based financing, formal recognition of private providers, robust digital data systems, and targeted support for low-income groups, emphasizing that sustainable urban healthcare demanded strong coordination between the government and private sector to address fragmented services, weak monitoring, and quality concerns.

Keynote Speech – 02

Presentation on Access to medicine: current status and gaps in urban settings of Bangladesh

Dr. Ahmed Ehsanur Rahman, Scientist at icddr,b and member of the Health Sector Reform Commission

In his keynote speech, Dr. Ahmed Ehsanur Rahman, Scientist at icddr,b and member of the Health Sector Reform Commission, highlighted the dire health conditions in urban slums, noting that 34 percent of children under five in these areas were stunted, compared to 22 percent in rural areas, according to the latest national survey. He also revealed critical gaps in medicine availability, stating that 27 percent of district hospitals lacked oxytocin, a vital drug for maternal health, and only 39 percent of urban hospitals had amoxicillin for childhood pneumonia, compared to 95 percent of rural health centers, as per the latest health facility survey. Dr. Rahman emphasized the urgent need for health sector reforms to address these disparities and improve urban healthcare access.

Speech by Special Guests

Dr. Ziauddin Hyder, an advisor to the BNP chairperson and former World Bank nutrition expert

Dr. Ziauddin Hyder, an advisor to the BNP chairperson and former World Bank nutrition expert, stated that the BNP considered introducing a universal health card with an integrated patient management system for all citizens, covering both public and private sectors. He emphasized the critical role of primary healthcare in Bangladesh's health system, calling for major reforms, including a medical negligence act, improved emergency medical services, regulation of Caesarian section deliveries, and bringing urban health under the Ministry of Health. Additionally, he advocated for a structured framework for primary, secondary, and tertiary hospitals, enhanced medical waste disposal systems, and strategic purchasing to strengthen the healthcare system.

Prof. Dr. Sayeba Akhter, a member of the Health Sector Reform Commission and President of the Bangladesh Medical Research Council

Prof. Dr. Sayeba Akhter, a member of the Health Sector Reform Commission and President of the Bangladesh Medical Research Council, stated that while Bangladesh's health sector was structurally strong, it was functionally weak and required positive political commitment to address its challenges. She demanded an increased budget for the health sector and emphasized the need for more research focused on urban areas and populations. Expressing disappointment, she described the lack of implementation of the health sector reform commission's recommendations as unfortunate.

Speech by the Chief Guest

Dr. Hossain Zillur Rahman, Executive Chairman; Power and Participation Research Centre - PPRC

Renowned economist Dr. Hossain Zillur Rahman, Executive Chairman; Power and Participation Research Centre - PPRC, citing a recent study, stated that 52% of households in the country have patients with chronic diseases, requiring long-term medication purchases. He recommended introducing social programs to protect these families from the financial burden of medicine costs, emphasizing the need for a healthcare safety net similar to other social security programs to ensure access to affordable medicines. The former advisor to the caretaker government noted that there is a noticeable lack of momentum in implementing reforms across nearly all sectors of the country. He observed that while the country is progressing, it is doing so at a slow pace, which he described as a luxury the current times cannot afford, as the demand is for rapid progress. He further pointed out that filling the 40% vacant positions in the healthcare sector would significantly accelerate progress without requiring any reforms.

Speech by the Session Chair

Dr. Mohammad Zahirul Islam, Senior Programme Officer and Health Advisor in the Development Cooperation Section of the Embassy of Sweden

Dr. Mohammad Zahirul Islam, Senior Programme Officer and Health Advisor in the Development Cooperation Section of the Embassy of Sweden, highlighted the poorly regulated formal and informal private health sectors in Bangladesh, which have led to haphazard growth of pharmacies and diagnostic centers alongside escalating health expenditures. He advocated for achieving Universal Health Coverage through integrated engagement of public, private, and community sectors, with the government defining service provision and procurement from private entities, alongside mandatory accreditation for both sectors and reforms to health administration, primary healthcare & public health, and the Directorate General of Clinical Services. He underscored the government's pivotal role in driving these comprehensive changes.

Session Moderator

Dr. Kazi Saifuddin Bennoor, Convener, Sushasther Bangadesh & Senior Consultant at United Hospital, Dhaka

Dr. Kazi Saifuddin Bennoor served as the session moderator, skillfully guiding discussions on urban healthcare challenges. His expertise facilitated impactful dialogue, fostering collaboration to address critical issues like health sector reforms and equitable service delivery.

Speakers During Open Discussion

Dr. Zeba Mahmud, Director of the Micronutrient Initiative Bangladesh

Dr. Zeba Mahmud commended Bangladesh's strong health infrastructure, highlighting its potential to support equitable healthcare delivery. She urged prioritizing preventive medicine in urban areas to align with rural advancements, emphasizing the critical role of educating women and communities on preventive health measures. By fostering awareness and proactive health practices, she believed urban populations could achieve improved health outcomes, reducing disparities and strengthening the overall healthcare system, though implementation challenges remain a concern.

Prof. Dr. Farhana Dewan, Member of the Obstetrical and Gynaecological Society of Bangladesh (OGSB)

Prof. Dr. Farhana Dewan emphasized that the inconsistent availability and distribution of prescribed medicines significantly hinder effective healthcare delivery in Bangladesh. She advocated for stricter regulations, enhanced oversight, and comprehensive training programs for general practitioners and doctors to improve prescription practices. By implementing these measures, she believes the healthcare system can ensure more accurate, safe, and accessible medication distribution, ultimately enhancing patient outcomes and addressing critical gaps in urban healthcare services.

Prof. Dr. Shakhawat Hossain Sayantha, an Associate Professor at Bangladesh Medical University

Prof. Dr. Shakhawat Hossain Sayantha praised the formulation of robust health policies in Bangladesh, noting their potential to significantly enhance the health sector if effectively implemented. However, he expressed concern over persistent challenges, including poor governance and corruption, which created a significant gap between policy creation and execution. He emphasized that even partial implementation could have yielded substantial improvements, but the ongoing disconnect between policy promises and actual outcomes remained a critical barrier to progress.

Dr. Nizam Uddin Ahmed, Chair of the GAVI CSO Steering Committee

Dr. Nizam Uddin Ahmed highlighted the chaotic state of Bangladesh's urban health sector, advocating for the Ministry of Health to take full control to ensure cohesive service delivery. He called for strong political leadership to bridge the divide between the Ministry of Health and Local Government, urging swift implementation of the health reform commission's recommendations. He also condemned pharmaceutical companies'

unchecked promotional spending, which inflates medicine costs by influencing doctors' prescriptions.

Dr. Arif Mahmud, Director of Medical Services at Evercare Hospital Bangladesh

Dr. Arif Mahmud highlighted the well-established infrastructure in the country but noted the severe shortage of human resources, with only 1 lakh nurses available against a need for 3 lakhs, and similar deficits in doctors and other staff. He stressed the incomplete implementation of the PPP model, the need for clear principles and roles for each sector, a proper digital health record system, health insurance facilities, and an improved referral system.

Dr. Fazle Rabbi, General Manager of United Hospital Limited

He underscored the importance of proactively strengthen the health sector to prevent overburdening tertiary care facilities, ensuring sustainable healthcare delivery. By enhancing understanding of primary, secondary, and tertiary healthcare levels, he advocated for optimized resource distribution to alleviate pressure on advanced care centers. This approach would improve access to timely care, strengthen primary and secondary services, and address inefficiencies, ultimately creating a more balanced and resilient healthcare system for all communities.

Prof. Syed Abdul Hamid of the Institute of Health Economics at Dhaka University

He stated that providing healthcare in urban areas was not feasible without involving the Local Government Ministry, advocating for a single national health authority for both urban and rural areas to manage strategic purchasing or public-private partnerships (PPPs). He highlighted the potential to utilize existing Primary Healthcare Centers and, where absent, collaborate with the private sector using models like the Aalo Clinic, while emphasizing the importance of needs assessment in the healthcare sector.

Shishir Moral, Special Correspondent for Prothom Alo

He acknowledged the productive discussions that highlighted the urgent need for a unified healthcare system under the Ministry of Health to streamline urban healthcare services and improve access for underserved communities. However, he expressed disappointment that these talks failed to establish the Ministry of Health as the sole authority over urban healthcare, despite the evident necessity for such a transformative change to address ongoing fragmentation and inefficiencies.

Dr. Fida Mehran, Health Systems Specialist at UNICEF Bangladesh

Dr. Fida Mehran highlighted the significant divide between bureaucracy and the reform commission, stressing that urban health encompasses not only primary healthcare but also environmental health and climate change, which must be addressed. He also emphasized the importance of resource mobilization and the People Act to foster effective public-private partnerships (PPPs) in urban areas of Bangladesh.

Prof. Dr. Syed Md Akram Hussain, Professor of Clinical Oncology at BMU

Dr. Syed Md Akram Hussain highlighted the persistent lack of action despite numerous discussions on improving Bangladesh's health sector, emphasizing the critical need to implement the health reform commission's recommendations to address systemic inefficiencies. He advocated for enacting an ordinance to legally empower the commission, ensuring robust reforms to strengthen healthcare delivery, enhance accountability, and improve access, particularly for underserved urban populations, to achieve equitable and sustainable health outcomes.

Dr. Sharmin Mizan, a Public Health Specialist with the World Bank and LGD, MoLGRD&C

Dr. Sharmin Mizan noted that a memorandum of understanding was signed between DNCC, DSCC, and partner NGOs, incorporating a cost-sharing strategy to sustain primary healthcare (PHC) services in urban areas. She emphasized the need for collaborative efforts to ensure cost-effective primary, secondary, and tertiary healthcare coverage in every urban ward.

Prof. Dr. Saria Tasnim, Member of the Obstetrical and Gynaecological Society of Bangladesh (OGSB)

She emphasized the need for better coordination between the health sector and health education, highlighting the importance of clarifying the government's expectations from the private sector and addressing the proliferation of pharmacies around government hospitals. She advocated for a shift in mindset to prioritize health promotion and prevention over treatment, particularly to reduce the rising rates of cesarean deliveries, and stressed the need to develop policies to address these issues.

Ms. Masuda Begum, Director (Health and Nutrition) of Nari Maitree

She emphasized that political commitment was essential for the health sector ahead of the upcoming election. She requested that policymakers establish a treatment time schedule for urban communities, considering the unique characteristics of urban populations, and conduct an analysis on how strategic purchasing should be implemented.

Brig Gen (Retd.) Dr. Md. Saidur Rahman, Team Leader of the Aalo Clinics project at Partners in Health and Development (PHD)

Dr. Md. Saidur Rahman emphasized that ensuring primary healthcare in urban areas through strategic purchasing and public-private partnerships, such as Aalo Clinic, Surjer Hashi Clinic, or the UPHSDP project, should be our primary target. He also advocated for an ordinance to establish legal bindings for primary healthcare to strengthen its implementation.

Ms. Khondker Rebaka Sun Yat, Member Secretary and Executive Director of the Coalition for Urban Poor (CUP)

Khondker Rebaka Sun Yat, Member Secretary and Executive Director of the Coalition for Urban Poor (CUP), emphasized the significant challenges in securing consistent funding disbursement for urban healthcare in both public and private sectors, which hinders service delivery to the urban poor. She highlighted the transformative potential of Corporate Social Responsibility (CSR) initiatives, advocating for their strategic use to mobilize resources and support sustainable healthcare solutions for underserved urban communities in Bangladesh.

Dr. Md. Mahbubul Alam, Head of Programs at PSTC

He highlighted the critical need for sustainable financing to address the declining funding for Surjer Hashi Clinic and UPHSDP, emphasizing that securing long-term resources and enhancing coordination among stakeholders beyond 2025 were vital steps. These measures, he stressed, would strengthen urban health services, bridge existing gaps, and ensure equitable access to quality care for underserved urban populations in Bangladesh.

RECOMMENDAIONS

1. Establish a sustainable financing framework by integrating result-based financing models, such as public-private partnerships (PPPs), with Corporate Social Responsibility (CSR) initiatives and strategic purchasing agreements, ensuring cost-sharing strategies between government, private sectors, and NGOs to secure long-term funding for primary healthcare services, particularly for underserved urban populations, while leveraging digital health systems to enhance transparency and accountability in fund allocation and utilization.
2. Introduce mandatory accreditation and stricter regulations for pharmacies and diagnostic centers to curb haphazard growth, control pharmaceutical companies' promotional practices, and ensure quality and affordability of medicines in urban areas.
3. Tackle shortages in nurses, doctors, and staff by filling 40% vacant positions, improving training for ethical prescription practices, and curbing pharmaceutical companies' promotional influences to lower medicine costs and improve quality.
4. Introduce universal health cards, integrated digital health records, improved referral systems, and health insurance schemes, coupled with result-based financing and CSR mobilization, to bridge urban-rural gaps and ensure affordable care for low-income groups.
5. Increase health sector budget allocations, conduct needs-based assessments for urban-specific research, and foster political commitment ahead of elections to sustain funding beyond 2025 and integrate environmental health and climate resilience into urban strategies.

ANNEXURE

Annex 1:


URBAN HEALTH
Welcome to today's Policy Dialogue
Sverige
Funding Support
eminence
Secretarial Support
unicef
for every child
Technical Support


URBAN HEALTH
National Policy Dialogue
Urban Health and Private Sector Engagement
22 September, 2022
10.30 AM - 1.00PM (Bangladesh Time, GMT +6)
Dr. Cecep Effendi Conference Hall,
CIRDAP
Chameli House, 17 Topkhana Road, Dhaka-1000, Bangladesh
Sverige
eminence
unicef
Availability of medicines


National Policy Dialogue
Urban Health and Private Sector Engagement


National Policy Dialogue
Urban Health and Private Sector Engagement

Annex 2:

Private Sector Engagement in Primary Healthcare Delivery

Presented by
Dr. Md Shamim Hayder Talukder
CEO and Founder | Eminence Associates for Social Development
Member Secretary | Bangladesh Urban Health Network (BUHN)

"Medical science has made such tremendous progress that there is hardly a healthy human left."

- Aldous Huxley (English writer and philosopher, 1894)

Global Context

The private sector provides up to **40%** of all healthcare services in the PAHO, AFRO, and WPRO regions

42% of outpatient care is sought in the formal private sector

The private sector provides **57%** of all healthcare services in the SEARO region

27% of inpatient care is sought in the formal private sector

The private sector provides **62%** of all healthcare services in the EMRO region

33% of the poorest population (by wealth quintile) seek care in the private sector

Successful Examples

- **India** – PPPs in diagnostics & telemedicine (e.g. Ayushman Bharat);
- **Kenya** – Franchised PHC (e.g. PS Kenya, Marie Stopes);
- **Thailand** – Strategic purchasing from accredited private providers under UHC.

WHO (2018): calls for "whole-of-society" approaches to PHC, explicitly including private actors in UHC roadmaps.

Bangladesh

THE WHO HEALTH SYSTEM FRAMEWORK

Urbanization is accelerating →

Over **41% of Bangladesh's population now lives in cities**, growing at ~3% annually.

Service availability at health facilities:

Child curative care:
66% urban vs **95% rural**

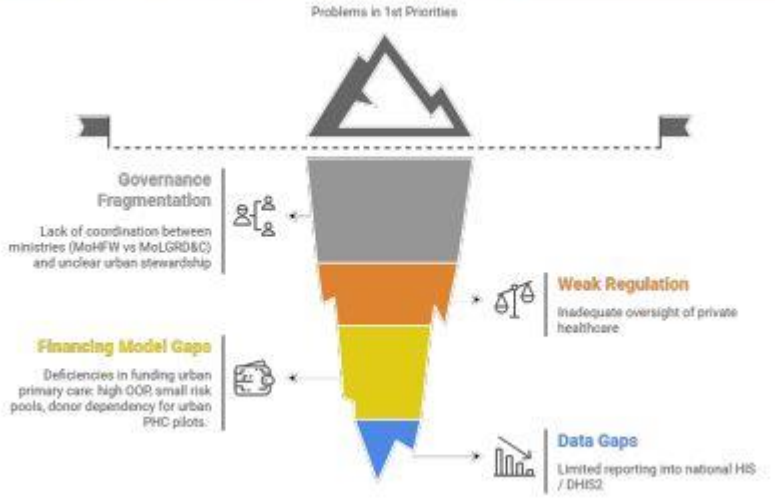
Child vaccination:
22% urban vs **93% rural**

Family planning:
39% urban vs **83% rural**

Antenatal care:
79% urban but **normal delivery only 11%**

Government spending remains **below 1% of GDP** for two decades

What Are the Challenges ?



Why Private Sector ?

Local pharmaceutical companies manufacture and distribute most of the targeted products, and the majority of Bangladeshis usually obtain their drugs from the private sector.

No. of Pvt. Health Facilities	2000	2021
Hospitals	1,125	4,452
Clinics	633	2,236
Diagnostic centers	1,778	16,979

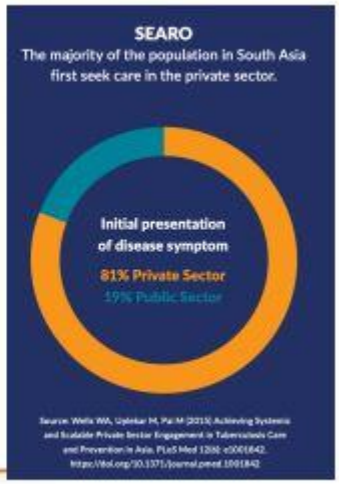
Pharmacies and informal providers are the **main drug source** even for the poor

16,444 registered private hospitals, clinics, diagnostic centers, and blood banks, as of 2020

BHFS 2022

91,537 private hospital beds nationwide- two-thirds of all beds in Bangladesh

BHFS 2022



Potential Private Sector Facilities

Private Hospitals & Clinics

Major Hospitals: United Hospital, Square Hospital, Evercare Hospital, Bangladesh Specialized Hospital, Green Life Hospital, etc.

Specialized Clinics: Labaid Specialized Hospital, Popular Diagnostic & Clinic, etc.

Urban areas: majority of inpatient care and specialist services accessed through private hospitals

Diagnostic Centers & Laboratories

Major Chains: LabAid, Popular Diagnostics, Square Diagnostic, Apollo Hospitals Lab

Specialized Labs: United Diagnostics, BioLab, Renata Diagnostic Center

Corporate/NGO Labs: BRAC Health Labs, ICDDR,B Lab Services

Private Hospital Labs: Evercare, United Hospital, Square Hospital

Pharmacies & Drug Shops

Well-Known Pharmacy Chains: Lazz Pharma; Popular Pharma Pharmacy; Shwapno & Agora Pharmacies; Square, etc.

- **118,000 retail drug shops** nationwide (formal & informal)

NGO-Run Clinics & Hospitals

Major NGO Health Networks

BRAC Health Program; Gonoshasthaya Kendra (GK); Population Services and Training Center (PSTC); Surjer Hashi Network (SHN)

Specialized NGO Hospitals

Ad-din Foundation Hospitals; UTTARAN & Sajida Foundation Clinics, etc.

Corporate & Employer-Supported Services

Large Corporations & Business Groups

Square Group, Apollo/Bashundhara collaboration, Incepta Pharmaceuticals, AK Khan Group, etc.

Export-Oriented Industries such as BGMEA & BKMEA runs Garment Workers Hospitals/Clinics.

Banking & Insurance Sector

Prime Bank Ltd, Eastern Bank Ltd, Standard Chartered, etc. has Corporate health packages & insurance coverage

Evidence from Bangladesh

GO–NGO contracting (UPHCP / UPHCSDP):
government + donor funded; model scaled to multiple city corporations / municipalities; extensive satellite centers (UPHCP/UPHCSDP project documentation).

Private-led pilots: Aalo Clinics:
Donor-financed pilot offering free, comprehensive PHC to urban areas (~5–6k households per clinic in pilot areas); strong monitoring & digitalization in pilot design.

Community-based insurance / microinsurance:
localized pilots (Gonoshasthaya Kendra), small scale, promising for financial protection if pooled and digitally scaled.

Community Clinics
Govt-funded PHC model with community involvement.~13,800 clinics, each serving ~6,000 people nationwide. Provide basic PHC (MCH, FP, nutrition, NCDs).Strengths: Wide coverage, community ownership.

https://uphcsdp.gov.bd/ https://r4d.org/wp-content/uploads/SMHS-SCS-UPHCP2-Bangladesh-FINAL.pdf , https://dashboard.dghs.gov.bd/pages/dashboard_alo_clinic.php ,
https://doi.org/10.3390/healthcare9080950

Recommendations

Governance & Financing towards UHC

Governance & Stewardship

- ✓ Urban Health Stewardship Compact→ MoHFW + MoLGRD&C + City Corporations
- ✓ Health PPP SOPs → contracts, equity clauses, dispute resolution
- ✓ Urban Health Monitoring & Regulation Authority (UHMRA) for all urban providers

Financing & Strategic Purchasing

- ✓ Strategic purchasing for NGOs/for-profits tied to quality & equity indicators
- ✓ Capacity building and introduce health insurance for ensuring UHC
- ✓ Introduce Urban Primary Care Benefit Package (UPCBP) for slum populations
- ✓ Use bundled tariffs & reference pricing to contain costs

Integration & Equity towards UHC

Integrating For-Profit Sector

- ✓ Fast-track accreditation with standardized rates & "green list" providers
- ✓ Contract pharmacies for NCD drugs with e-prescriptions, price ceilings
- ✓ Enforce equity clauses → cross-subsidized slots for poor patients

Equity for Slums

- ✓ Targeted vouchers/e-cards for RMNCH, FP, TB, NCDs
- ✓ Community health connectors for slum enrollment & adherence
- ✓ Mobile/extended-hours clinics in dense settlements

Service, Digital, Workforce

Service Model Upgrade

- ✓ Integrated PHC package: communicable + NCD + nutrition + mental health
- ✓ Specialized COPD/asthma + heat-health packages
- ✓ HTN–DM bidirectional screening + surge packages for vector-borne diseases

Data, Digital & Accountability

- ✓ DHIS2-compatible reporting by all providers
- ✓ Real-time dashboards & outcome-linked payments
- ✓ Toll-free lines, chatbots, digital doctor directory

Workforce & Supply Chain

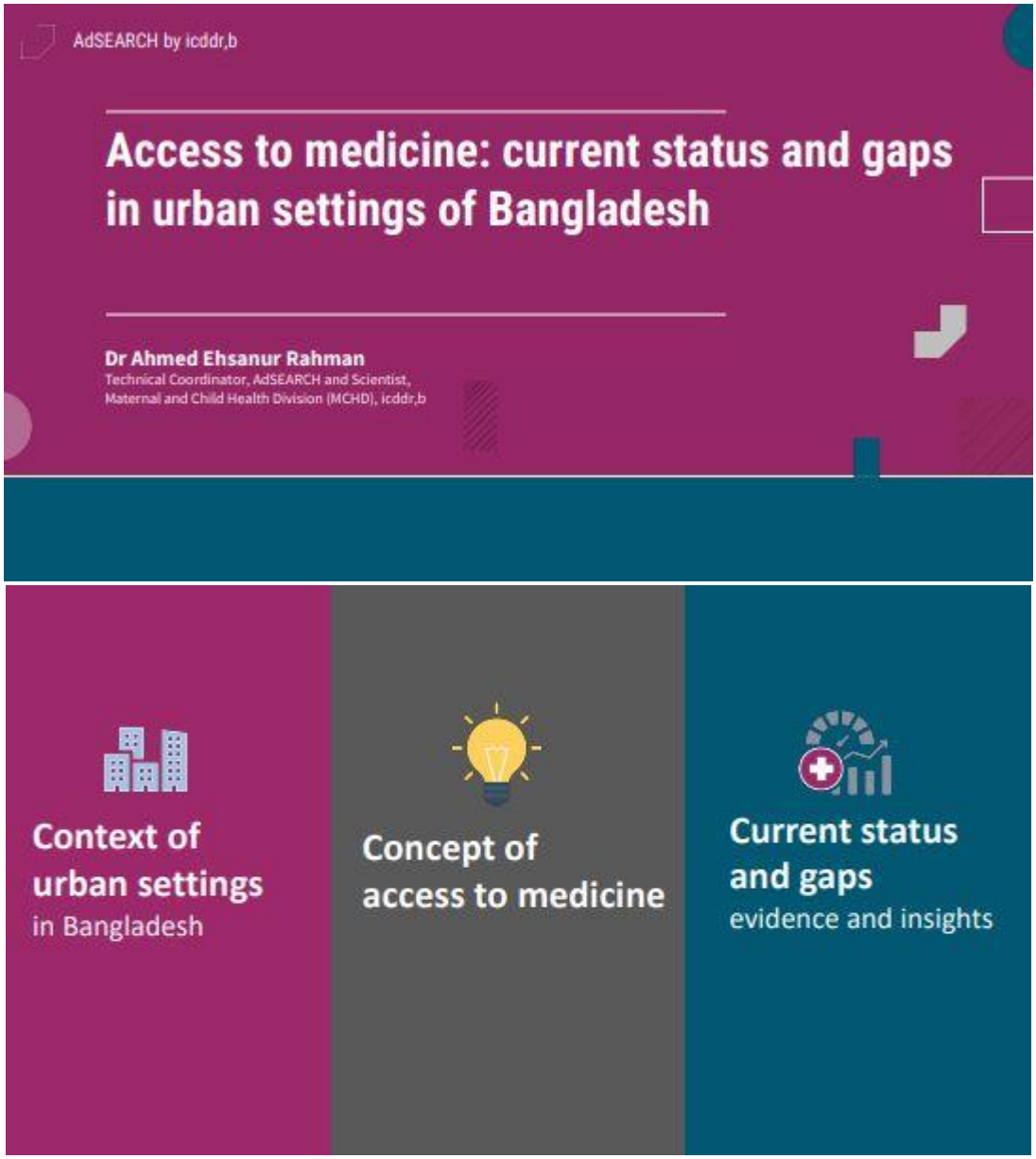
- ✓ Short courses: contracting, costing, HMIS
- ✓ HR distribution based on population mapping
- ✓ E-LMIS integration, stockout penalties

BANGLADESH URBAN HEALTH NETWORK

THANKS FOR YOUR TIME !

Sweden Sverige · eminence associates for social development · unicef for every child

Annex 3:


AdSEARCH by icddr,b
Access to medicine: current status and gaps in urban settings of Bangladesh
Dr Ahmed Ehsanur Rahman
Technical Coordinator, AdSEARCH and Scientist,
Maternal and Child Health Division (MCHD), icddr,b
Context of urban settings in Bangladesh
Concept of access to medicine
Current status and gaps evidence and insights

Context of urban settings
in Bangladesh

Definition of Urban Area

Bangladesh Bureau of Statistics defined an Urban area

"An urban area is defined as a region characterized by high population density, a majority of the population engaged in non-agricultural occupations, and the availability of amenities such as paved roads, electricity, gas, water supply, and sanitation."

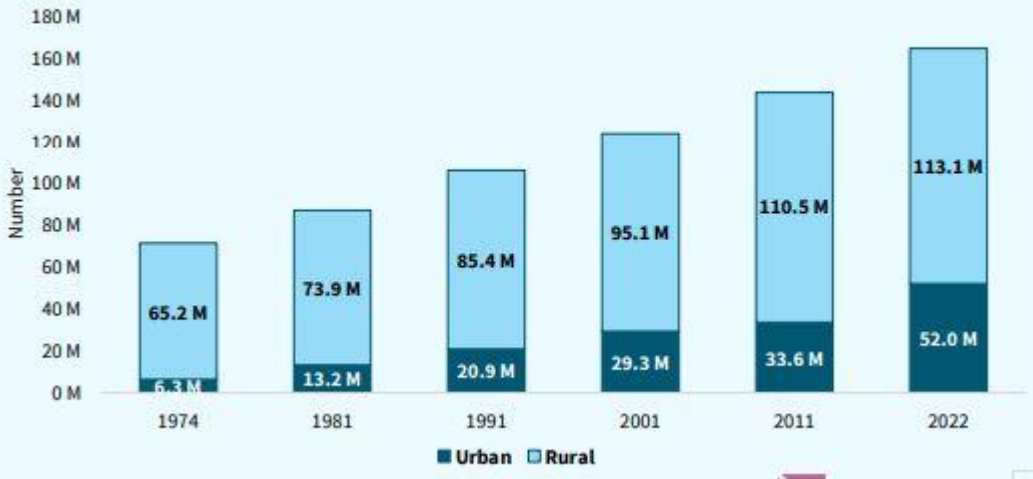
Types of Urban Area

City corporation → 13

Municipality → 330

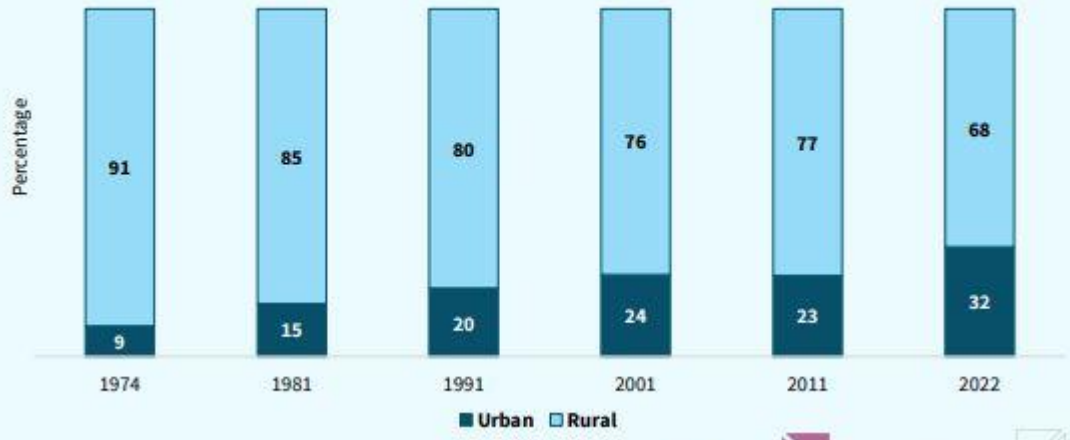
Population over time by place of residence

Source
Population and Housing Census



Percentage of population over time by place of residence

Source
Population and Housing Census



What is the health status of urban populations?

What is the health status of urban populations?

Health impact

Source: BDHS 2022 & Urban health survey 2021

		Rural	Urban	Slum	Non-slum
Life	**Life expectancy at birth** *(in years) SVRS 2023*	71.9	74.6	N/A	N/A

Health impact

Source: BDHS 2022 & Urban health survey 2021

		Rural	Urban	Slum	Non-slum
Life	**Life expectancy at birth** *(in years) SVRS 2023*	71.9	74.6	N/A	N/A
Death	**Maternal Mortality Ratio** *(per 100,000 live births), BMMS 2016*	217	138	N/A	N/A
	Under-5 Mortality Rate *(per 1,000 live births), BDHS 2022*	33	31	41	35
	Neonatal Mortality Rate *(per 1,000 live births), BDHS 2022*	22	22	27	20

Health impact

Source: BDHS 2022 & Urban health survey 2021

		Rural	Urban	Slum	Non-slum
Life	**Life expectancy at birth** *(in years) SVRS 2023*	71.9	74.6	N/A	N/A
Death	**Maternal Mortality Ratio** *(per 100,000 live births), BMMS 2016*	217	138	N/A	N/A
	Under-5 Mortality Rate *(per 1,000 live births), BDHS 2022*	33	31	41	35
	Neonatal Mortality Rate *(per 1,000 live births), BDHS 2022*	22	22	27	20
Nutritional status	**Stunting** *(percentage), BDHS 2022*	24	22	34	27

What is the health status of urban populations?

Health service coverage

Source: BDHS 2022 & Urban health survey 2021

	Rural	Urban	Slum	Non-slum
ANC (4 or more) *(percentage)*	35	57	40	53
Quality ANC *(percentage)*	17	33	N/A	N/A

Health service coverage

Source: BDHS 2022 & Urban health survey 2021

	Rural	Urban	Slum	Non-slum
ANC (4 or more) *(percentage)*	35	57	40	53
Quality ANC *(percentage)*	17	33	N/A	N/A
Facility Delivery *(percentage)*	61	71	54	77
C-section *(percentage)*	42	56	31	59

What is the health status of urban populations?

Health behavior

Source: BDHS 2022 & Urban health survey 2021

	Rural	Urban	Slum	Non-slum
Care seeking for ARI *(percentage)*	84	85	82	87
Care seeking for diarrhoea *(percentage)*	65	68	N/A	N/A
Care seeking for fever *(percentage)*	76	73	N/A	N/A
CPR (any method) *(percentage)*	55	56	N/A	N/A

Context of urban settings
in Bangladesh

Concept of access to medicine

Current status and gaps
evidence and insights

Concept of access to medicine

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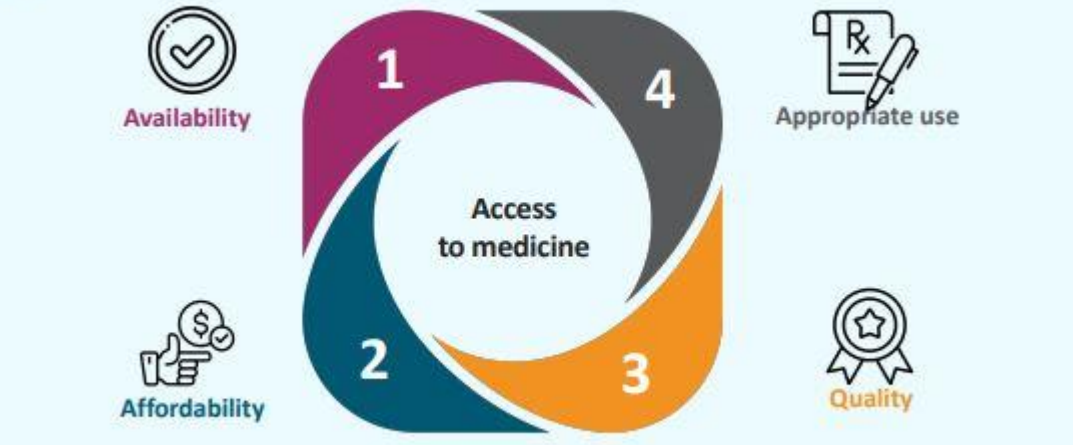

Context of urban settings
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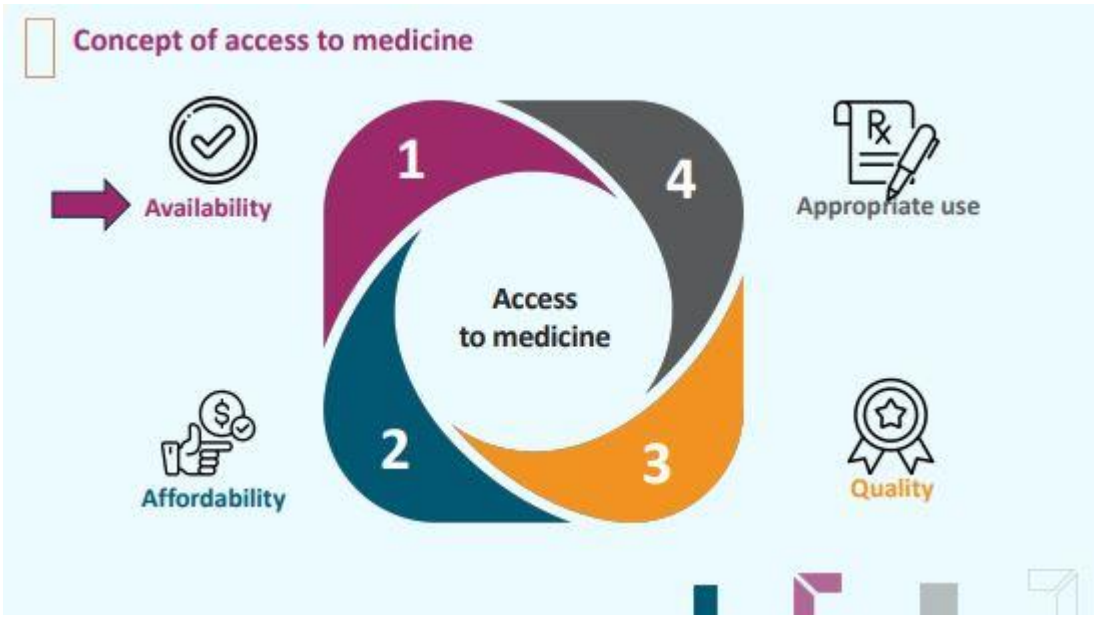
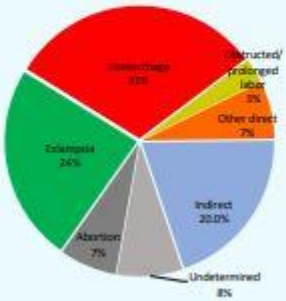
Current status and gaps
evidence and insights



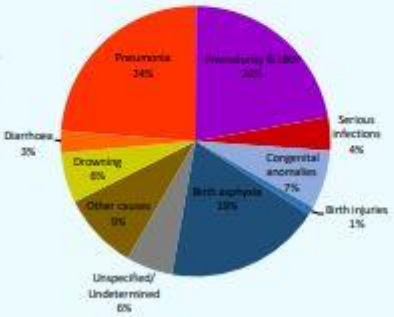
Causes of death

Source
BDHS 2022,
BMMS 2016 &
Excess mortality survey, icddr,b, 2022-23

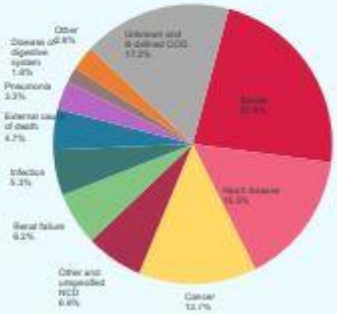
Maternal cause of death
(percentage distribution)



Under-5 child cause of death
(percentage distribution)



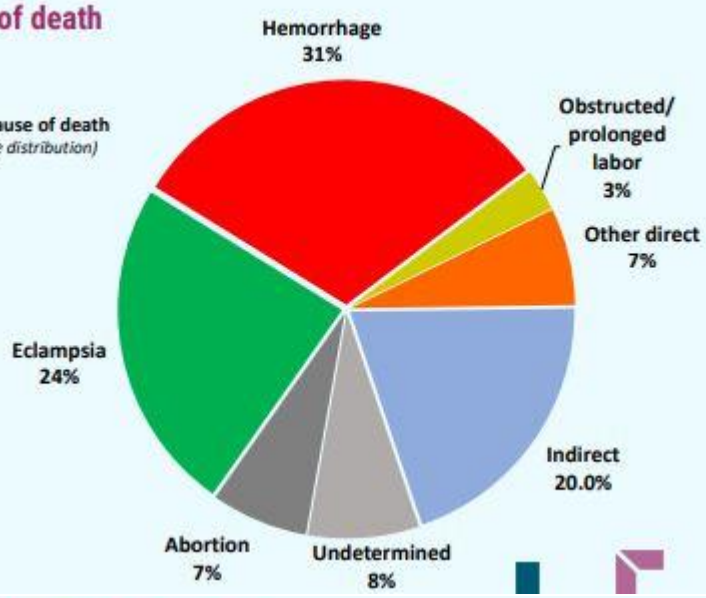
Adult cause of death
(percentage distribution)



Causes of death

Source
BDHS 2022,
BMMS 2016 &
Excess mortality survey, icddr,b, 2022-23

Maternal cause of death
(percentage distribution)



Availability of medicines

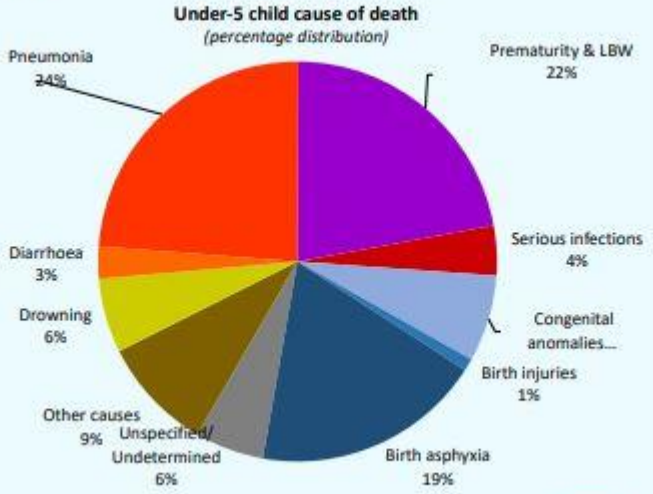
Maternal health

Source
Bangladesh health facility survey 2022

		Rural	Urban	DH	UHC
Hemorrhage	Oxytocin (percentage)	6	53	73	85
	Ergometrine (percentage)	<1	9	2	3
Eclampsia/ Pre-eclampsia	Magnesium sulfate (percentage)	1	32	37	26

Causes of death

Source
BDHS 2022,
BMMS 2016 &
Excess mortality survey, icddr,b, 2022-23



Availability of medicines

Child health

Source: Bangladesh health facility survey 2022

		Rural	Urban	DH	UHC
Pneumonia	Amoxicillin (percentage)	95	39	68	89
	Amoxiclav (percentage)	2	22	24	10

Availability of medicines

Child health

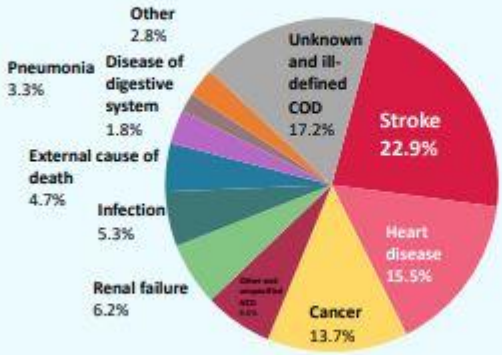
Source: Bangladesh health facility survey 2022

		Rural	Urban	DH	UHC
Pneumonia	Amoxicillin (percentage)	95	39	68	89
	Amoxiclav (percentage)	2	22	24	10
Prematurity & LBW ⇩ Sepsis	Ampicilin (percentage)	2	11	11	48
	Gentamicin (percentage)	5	42	58	81
	Ampicilin+Gentamicin (percentage)	1	8	10	42

Causes of death

Source
BDHS 2022, BMMS 2016 & *Excess mortality survey, icddr,b, 2022-23*

Adult cause of death
(percentage distribution)



Availability of medicines

Non-communicable disease

Source
Bangladesh health facility survey 2022

		Rural	Urban	DH	UHC
Hypertension	Amlodipine/ Nifedipine (percentage)	3	57	65	73
	Losartan (percentage)	4	57	89	90

Availability of medicines

Non-communicable disease

Source
Bangladesh health facility survey 2022

		Rural	Urban	DH	UHC
Hypertension	Amlodipine/ Nifedipine (percentage)	3	57	65	73
	Losartan (percentage)	4	57	89	90
Diabetes	Metformin (percentage)	3	36	81	88

National Essential Medicine

Source
National Essential Medicine List 2016, BHFS 2022

National Essential Medicine List 2016

285

73

National Essential Medicine

Source
National Essential Medicine List 2016, BHFS 2022

National Essential Medicine List 2016

285

73

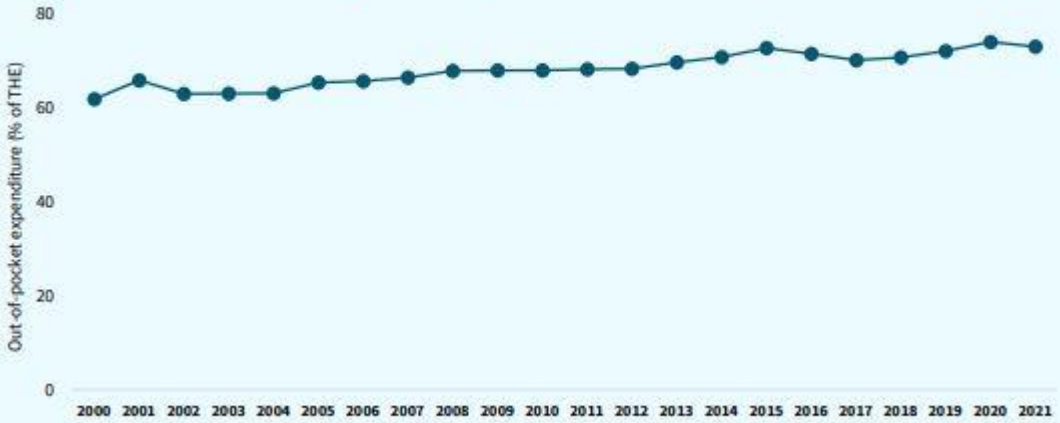
Availability of essential medicines
(Average score out of 73 medicines)

Rural	Urban	DH	UHC
13	18	29	34

Concept of access to medicine

Trend of out-of-pocket expenditure (% of total health expenditure)

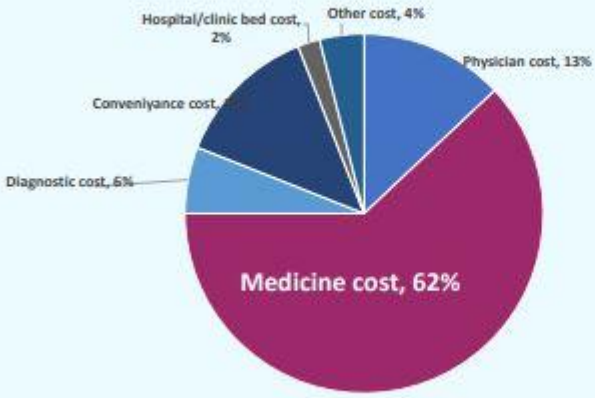
Source
WB, WHO, BNHA



OOP healthcare expenditure: National

Source
HIES 2010

Mahumud et al. (2017) examined the distribution and determinants of out-of-pocket healthcare expenditures in Bangladesh https://doi.org/10.3961/jpmph.16.089



OOP healthcare expenditure: urban-rural

Source
HIES 2010

Mahumud et al. (2017) examined the distribution and determinants of out-of-pocket healthcare expenditures in Bangladesh https://doi.org/10.3961/jpmph.16.089

Urban area

62% out-of-pocket expenditure on medicine

Rural area

60% out-of-pocket expenditure on medicine

Concept of access to medicine

Appropriate Use of Drugs

Urban residents typically follow a pattern of:

Self-medication
over **40% of adults** in Bangladesh

Purchase without prescriptions
65% of drug shop clients arrived without prescriptions

Consultation with Informal drug sellers
49% salespersons have no formal training in dispensing drugs

Antibiotic resistance
63% of antibiotics are prescribed by unqualified health care providers
68.8% antibiotic resistance due to non-compliance

Source

1. Roy et al. (2024) https://doi.org/10.3390/epidemiologia5020010
2. Access to Medicine in Urban Settings: A Comprehensive Analysis of Bangladesh
3. S. M. Ahmed et al. (2017); doi: 10.1186/S40545-017-0108-8
4. Bonna et al. (2022); https://doi.org/10.1016/j.ijso.2022.100581

Thank you

PARTICIPANT LIST (Without Supporting Staffs)

BANGLADESH URBAN HEALTH NETWORK

National Policy Dialogue
Urban Health and Private Sector Engagement

Venue: Dr. Cecep Effendi Conference Hall,
Centre on Integrated Rural Development for Asia and the Pacific (CIRDAP), Chameli House, 17 Topkhana Road, Dhaka-1000, Bangladesh
Date: 22 September, 2025 **Time:** 10.30 AM - 1.00PM (Bangladesh Time, GMT +6)

Attendance Sheet

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1.	Dr. Nazia Rahman	PHD	Program Coordinator CQI	nazia@phd-bd.org	01727105105	[signature]
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15.	Saiful	1. khaua 2			01610564112	[signature]
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25.	Fariuin shultana	Eminence	Senior officer			[signature]
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27.	Robiul Islam	Eminence	Finence officer		01747159931	[signature]

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11.	[illegible]	SP [illegible]	Sr.	[illegible]	01712-41624	
12.	Syed Sohel Kamo	S. Repuke	Senior	The Daily Nayadiganta	01712227272	
13.	Ahmed Ehsanur Rahman	icddr,b	Scientist	ehsanur@icddrb.org	01727010050	
14.	[illegible]	Ever care	Research officer		01921548079	
15.	[illegible]	[illegible]	officer		01712055035	
16.	[illegible]	IPH	officer		0332092[illegible]	
17.	MD IDRIS	ICDDRB	Health officer		01818427[illegible]	

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11.	Dr. Shamim Talukder	CEO Eminence	CEO	ceo@eminence-bd.org	01713066602	
12.	Sanjay Mallick	[illegible]			01712063820	
13.	Prof. M. A Hye	S/E-varsity	F/member		0171-666-3196	
14.	Akir Chowdhury	Eminence	IT officer		—	
15.	Mostafizur Rahman	PG	Prof. Dr. Akram		01626192767	
16.	Akir Chowdhuri	Eminence	It officer		01632259612	
17.						