POLICY BRIEF

Strengthening Urban Health Resilience through Climate Finance

BANGLADESH URBAN HEALTH NETWORK

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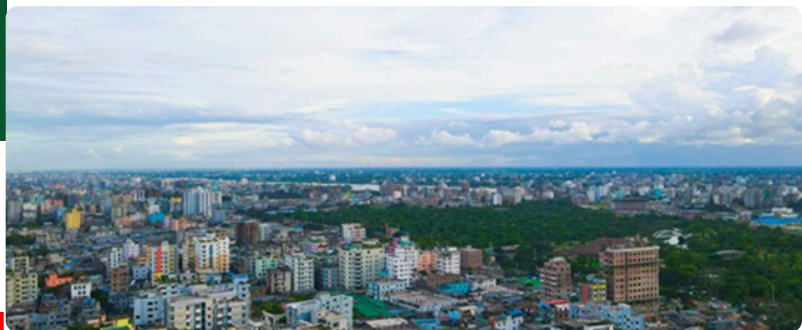
INTRODUCTION AND RATIONALE

Bangladesh's rapid urban transition, concentrated in Dhaka, Chattogram, Khulna, Rajshahi and secondary cities, has concentrated both economic growth and climate exposure. Urban residents, especially Dhaka's four million-plus slum dwellers, face climate-sensitive health threats rural disaster systems weren't designed for: extreme heat from lost green cover, monsoon waterlogging that breeds disease vectors and contaminates water, cyclone-driven displacement, and heat/rainfall-linked surges in dengue, diarrhoeal disease, and respiratory illness.

The urban health system is itself fragmented: MoHFW sets standards and runs secondary/tertiary care, while urban primary/preventive care is devolved to City Corporations and municipalities under MoLGRD&Co, often via NGO contracts. Climate and disaster governance sits with MoEFCC and MoDMR; climate finance is coordinated by ERD and Finance Division. No single institution owns the intersection of urban health, DRR, and climate finance — why health falls through the cracks of climate budgeting despite Bangladesh's elaborate climate-policy architecture.

Structure

- Section 1 reviews the literature with laws/ policies/ strategies against this nexus
- Section 2 covers financing gaps with SWOT analysis
- Section 3 sets out recommendations



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Section 01

LITERATURE REVIEW AND MAPPING LAWS/ POLICIES/ STRATEGIES

2.1 — RISK ON THE GROUND

Climate-Sensitive Urban Health Risks

Dhaka land-surface heat elevation — 60%+ built-up area

- **Urban Heat Island (UHI):** Heat-vulnerability mapping (2022–2025) shows risk concentrated in dense, low-income, informal neighbourhoods with minimal green cover.
- **Korail slum fieldwork (2024–25):** residents rely on informal coping — makeshift shading, shifted work hours — not structural adaptation.
- **Gendered & age-differentiated burden:** women carry a double load of household + income work under heat stress; older residents face mobility barriers to shade/cooling.
- **Rajshahi:** rising extreme-heat days since 1980 — literature calls for green infrastructure, planning reform, targeted protection.
- **Dengue & vector-borne disease:** satellite land-surface-temperature and land-cover data are statistically linked to dengue prevalence in Dhaka — consistent with Aedes aegypti's temperature sensitivity.
- **Post-pandemic dengue surge:** clinical literature calls for climate-driven early-warning systems coupling forecasting, vector control, and health-system readiness.
- Dhaka's heatwave early-warning is cited as a partial global model — but very few cities anywhere, Bangladesh's included, have dedicated, adequately financed climate-health adaptation strategies.

2.2 — A FRACTURED DELIVERY SYSTEM

Urban Health Governance & Fragmentation

MoHFW — standards · curative care

MoLGRD&Co / LGIs — preventive · primary care

1998 UPHCP → 2005 UPHCP-II → 2012 UPHCSDP → 2018–23 UPHCSDP-II

- Since 1998, urban primary health care (UPHC) has run through successive donor-financed, NGO-contracted projects delivered with City Corporations & municipalities.
- The MoHFW / MoLGRD&Co split creates **persistent coordination failures**; limited LGI technical capacity undermines sustainability and absorption into the national system.
- Impact evaluations (2006–2012, propensity-score matched) **do** find measurable gains in maternal & child health utilisation and equity from contracted UPHC.
- But Dhaka service-quality studies report persistently **low patient satisfaction** and weak monitoring linkages across MoHFW, NGOs, and MoLGRD&Co.
- None of this literature was designed around climate resilience — the UPHC model has **no dedicated DRR or climate-adaptation financing line**.
- Climate-health integration must therefore be **retrofitted** onto an already strained delivery architecture, not built fresh.

2.3 — THE FINANCING GAP

Climate Finance & the Health Gap

BCCTF projects reaching Health Services Division

3 of 877 projects (<1%) — to 2024

2.74% (FY21–22) → 1.97% (FY25–26)

~2.5% → ~1.5% (Health share, nat'l climate budget '21–22 → same, '25–26)

- Domestic architecture is mature — Climate Change Trust Act (2010) → BCCTF/BCCRF; Climate Fiscal Framework (2014, rev. 2020) — but funding concentrates in infrastructure, water, agriculture & forestry.
- Health is a marginal recipient despite BCCSAP (2009) formally naming it a priority theme (Food Security, Social Protection & Health).
- **>60% of health-relevant climate spending is short-term/project-based** — surveillance, emergency preparedness, workforce development and research remain chronically underfunded.
- Coastal women's health research links salinity intrusion, water scarcity & poor sanitation to menstrual and maternal-health complications — the human cost of the financing gap.
- Bangladesh needs an estimated **USD 500+ billion** to implement its full climate-plan suite (NAP, Delta Plan, MCPP, NDC).
- Literature calls for institutional coordination, blended instruments (resilience bonds, catastrophe insurance, carbon markets, debt-for-climate swaps) and stronger project-preparation — none yet systematically aimed at urban health.

Instrument (Year)	Relevance to Urban Health–DRR–Climate Finance Nexus
Constitution of Bangladesh, Arts. 15 & 18	Constitutional anchor for treating health protection, including from climate hazards, as a state duty rather than a discretionary programme.
National Health Policy (2008)	Predates climate mainstreaming; has not been substantively updated to embed climate-health risk, a recognised gap.
BCCSAP – Bangladesh Climate Change Strategy and Action Plan (2009)	First national instrument to formally name health as a climate priority; foundational reference for the BCCTF.
Climate Change Trust Act (2010) / BCCTF & BCCRF	Principal domestic climate-finance channel; per recent tracking, has funded only 3 of 877 projects through HSD
Disaster Management Act (2012)	Provides for health representation in local disaster coordination but does not create a dedicated urban health-DRR financing mechanism.
Standing Orders on Disaster / SOD (1997; revised 2010, 2019)	Assigns health-sector duties in disaster response but is response-oriented; urban long-term health-system resilience is only implicitly covered.
8th Five Year Plan (2020–2025)	The mechanism through which health's declining climate-budget share (2.5%→1.5%) has been made visible; also the natural instrument for a dedicated urban-health-climate budget line.

Instrument (Year)	Relevance to Urban Health–DRR–Climate Finance Nexus
Health, Population and Nutrition Sector Development Programme / HNPSIP (2016–2021, successor programmes ongoing)	Vehicle through which climate-resilient health-system investment could be systematically budgeted if climate criteria were embedded in the next sector programme.
National Plan for Disaster Management / NPDM (2016–2020; 2021–2025)	Recognises urban-climate-disaster linkage at plan level; implementation depends on ministries' own annual work plans, where health uptake has been weak.
Health-National Adaptation Plan / HNAP (drafted 2018; updated 2024)	The single most directly relevant instrument — a ready-made technical roadmap for climate-resilient health systems that remains under-resourced and under-implemented, especially in urban settings.
Nationally Determined Contribution / NDC (2021, updated; NDC 3.0 in preparation)	Signals international climate commitments that donors use to calibrate support; health/urban adaptation remains a minor component relative to energy and agriculture.
Bangladesh Delta Plan 2100	Provides the spatial-planning backbone into which climate-resilient urban health infrastructure siting should be integrated but is not yet systematically linked to health facility planning.
National Adaptation Plan / NAP (2023–2050)	Establishes multilevel, locally-led adaptation governance; health's cross-cutting (rather than sectoral) status risks continued marginal prioritisation and financing.
Sendai Framework for Disaster Risk Reduction 2015–2030 (international, domesticated via SOD/NPDM)	International benchmark against which Bangladesh's urban health-DRR integration can be measured, particularly Priority 3 (investing in resilience, incl. health facilities).

Section 02

FINANCING GAPS WITH SWOT ANALYSIS

BCCTF Projects via Health Services Division

3 projects
(<1% of 877 total)

Static / Minimal

Health Services Division Climate-Relevant Budget Share

2.74% → 1.97%
FY2021-22 → FY2025-26

Declining

Health's Share of the National Climate Budget

~2.5% → ~1.5%

Declining

Share of Health-Relevant Climate Expenditure that is Project-Based
(vs. Recurrent/Systemic)

>60%

Fragmented

Estimated Total Financing Needed to Implement Bangladesh's Climate Plans (NAP, Delta Plan, MCPP, NDC)

≈ USD 533.7 billion

Large, Growing Need

International Climate Finance to Bangladesh (Annually)

≈ USD 1.2 billion
~60% to Adaptation

Insufficient Relative to Need

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- Strong policy framework (DM Act, NAP, HNAP, MCPP, BCCSAP)
- Health sector roadmap aligned with WHO (HNAP)
- Proven disaster preparedness with effective early warning systems
- Existing urban PHC platform adaptable for climate resilience
- Established climate finance mechanisms (BCCTF, GCF, Climate Fiscal Framework)
- Growing evidence & advocacy network (ICCCAD, CPRD, BUHN, academia)

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- Fragmented governance across health, urban, climate & disaster sectors
- Health underfunded in climate finance (<1% BCCTF; declining budget share)
- Project-driven financing (>60% short-term; weak system investment)
- Outdated health policies lacking climate/DRR integration
- Limited climate finance readiness for GCF & adaptation funds
- Weak urban PHC capacity and monitoring systems
- Informal settlements underserved, hindering climate-health action

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- Rapid urbanisation is outpacing health capacity and climate planning.
- Rising climate risks are straining health systems and financing.
- LDC graduation (2026) may limit concessional climate finance access.
- Fiscal pressures threaten investment in health resilience.
- Finance competition demands stronger evidence and investable solutions.
- Governance gaps may affect equitable climate fund allocation.
- Climate migration could overwhelm urban health systems.

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- MCPP & NDC 3.0 enable urban health–climate investment
- Climate budget tagging can create a dedicated health budget line
- Emerging climate finance (GCF, bonds, insurance, blended finance)
- Delta Plan 2100 supports climate-smart health infrastructure
- Private-sector co-financing for resilient health facilities
- Global loss & damage funding creates new financing opportunities
- Scalable early-warning systems for heat and disease response



Section 03

RECOMMENDATIONS

SHORT-TERM (0–18 MONTHS)

- Create a dedicated urban health–climate budget line.
- Establish an inter-ministerial urban health–climate coordination mechanism.
- Operationalise the Health National Adaptation Plan (HNAP) for urban areas.
- Scale up heat and disease early-warning systems across all City Corporations.
- Conduct climate vulnerability assessments of urban health facilities.

MEDIUM-TERM (18 MONTHS–5 YEARS)

- Update the National Urban Health Strategy and National Health Policy to integrate climate resilience.
- Develop a bankable urban health–climate finance pipeline.
- Mainstream climate-resilient design into urban health infrastructure.
- Expand social health protection for climate-vulnerable urban populations.
- Build climate-health workforce capacity and strengthen interagency data sharing.

LONG-TERM (5+ YEARS)

- Institutionalise climate-resilient urban health financing in national planning.
- Integrate informal settlements into climate and health planning.
- Diversify climate-health financing (bonds, blended finance, green sukuk, etc.).
- Prepare urban health systems for climate-induced migration.
- Strengthen monitoring, research, and accountability for climate-health investments.

CROSS-CUTTING PRIORITIES

- Ensure gender- and age-responsive urban health planning.
- Increase recurrent funding for surveillance, workforce, and research.
- Strengthen BUHN's convening role for cross-sector collaboration.
- Use the evidence base to inform advocacy, budgeting, and climate-finance proposals.

WHO ARE WE?

Established in 2009, the **Bangladesh Urban Health Network (BUHN)** is a civil society network dedicated to advancing health equity in urban areas. Secretarial support for Social Development is provided by Eminence Associates, facilitating the network's operations. BUHN serves as a platform that unites diverse stakeholders in the urban health sector, fostering effective collaboration. Moreover, it collaborates with other organizations to host conferences aimed at addressing challenges within the urban health sector and seeking potential solutions.

Affiliated with the International Society for Urban Health (ISUH), BUHN has its well-developed website. The site serves as a comprehensive repository featuring resources, articles, and insights, facilitating information sharing within the community. Additionally, the website includes blogs and monthly e-newsletters to enhance communication and knowledge dissemination among its members.

BUHN Thematic Areas

The following thematic focus areas are included for the activities of BUHN, but it will not be limited to these, and can extend beyond the following:

For further information, Please contract:

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