In Bangladesh, cities are home to 65 million people (40% of the total population) and the urban population is estimated to reach 83 million by 2030. Existing urban health structures are largely inadequate to ensure universal access to health care for poor people. In urban areas, the role of Ministry of Health and Family Welfare (MOHFW) is limited to the provision of secondary and tertiary care. Primary health care (PHC) in urban areas is principally the responsibility of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC). Primary health care in urban areas is delivered through the City Corporations and Municipalities which run a few small to medium-sized hospitals and outpatient facilities in partnership with NGOs.

Urban areas are served by 184 public PHC service delivery points (maternity clinic and health center), while there are 5,680 PHC facilities at the upazilla level and below (Upazilla Health Complex, Maternal and Child Welfare Center, and Union Health and Family Welfare Center) in the rural areas, excluding more than 12,000 Community Clinics. In urban areas, a government PHC facility is available for nearly 0.3 million population, while there is a facility for every 18,000 rural population (Community Clinics not included). The Local Government Division (LGD) of the MOLGRDC is operating 113 primary health care centers and 25 maternity centers in 10 City Corporations and 4 Municipalities through its Urban Primary Health Care Services Delivery Project (UPHCSDP). The NGO Health Services Delivery Project (NHSDP) (previously the Smiling Sun Franchise Program) provides primary health care through 186 clinics in urban slums. Marie Stopes has a network of 132 static clinics and 9 maternity clinics, of which 3 are under the UPHCSDP.

Table 1: Public-sector PHC structure in urban and rural areas

Types of health facility	Urban	Rural
First-level hospital	Primary care hospital (Dhaka): 2 Maternity center: 32	UHC: 421
Sub-total	34	421
Primary health care centers	Primary health care center: 113 Urban dispensary: 35 Health center: 2	MCWC: 36 UHFWC (Health): 1,363 UHFWC (Family Planning): 3,860
Sub-total	150	5,259
Community health centers	No facility	Community Clinic: 12,779
Grand-total	**184**	**18,459**

Private-sector health care

The private for-profit health sector constitutes an important part of the urban healthcare delivery system. There are many urban clinics and diagnostic centers run by the private sector. Unfortunately, not all private-sector facilities maintain a good standard of service and management. Private facilities operating in and around the slums provide limited general clinical services including prescriptions. Nutrition and diagnostic services are largely absent in those service delivery points.

Inequity in utilization of health and family planning services

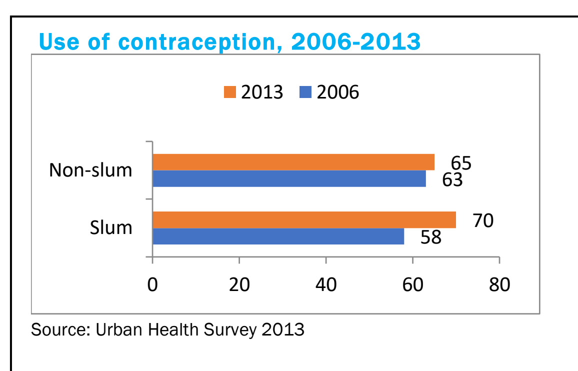
Despite the operation of two large NGO-based programs (UPHCSDP and NHSDP), significant needs of urban primary health care must be met. Yet, health indicators of slum populations are the worst, primarily because of limited access to affordable health services. Only 13 percent of slums have a government health facility within one kilometer.

Family planning

In urban areas, two-thirds of eligible couples use any method of contraception (higher than the national average of 62%) while among slum couples it is higher (70%). Most urban couples use short-acting methods of contraception (pills, condoms and injectables), which they mainly obtain from pharmacies. Overall, the private medical sector dominates the supply of family planning methods in urban areas (69% in slums, 82% in non-slums).

PRIVATE SECTOR CONTRIBUTION TO FP:
Slum: 69% • Non-slum: 82%

Conversely, the public sector supplies between 11 percent in non-slums and 16 percent in slums. The share of public sector is largely due to their contribution to long-acting and permanent methods (LAPMs). The public sector is the major source of LAPMs in both slums and non-slums (male sterilization: 72-77%, female sterilization: 53-66%, IUD: 57-70%, implants: 58-65%)



ANTENATAL CARE

In the use of four or more antenatal care (ANC) visits, there is a large disparity between slums and non-slums (29% and 58% respectively). Similarly, a large gap exists between slums and non-slums in seeking ANC from medically trained providers (54% and 83% respectively).

SLUMS USING UNQUALIFIED PROVIDERS FOR ANC 46%

The NGO sector is the prime source for ANC among women living in slums (42%) whereas the private sector is the main source of ANC among non-slum women (58%). A key concern is that almost half of the slum women do not receive ANC from qualified providers, which requires NGO clinics to be more proactive in ensuring regular and affordable services in slums.

DELIVERY CARE

Use of skilled birth attendants is much higher among women in non-slums (68%) than in slums (37%). Likewise, large inequalities exist between slums and non-slums in the use of facilities for delivery (non-slums: 65%, slums: 37%). Institutional delivery in slums (37%) is much lower than the national urban average at 57 percent.

LARGE INEQUALITY IN INSTITUTIONAL DELIVERY:
Slum: 37% • Non-slum: 65%
Urban overall: 57%

In slums, the share of both NGOs and the public sector for institutional deliveries is 13 percent while private facilities accounted for 11 percent.

SECTOR CONTRIBUTION TO INSTITUTIONAL DELIVERY:
Public: 13% • NGO: 13% • Private: 11%

POSTNATAL CARE

With a rate of 27 percent of postnatal care (PNC) for newborns, slums lag behind non-slums (49%). Large inequities also exist for PNC for women: one-third of women in slums (34%) receive PNC from a medically trained provider while the figure in non-slums is 60 percent. Women are less likely to seek PNC for newborns than for themselves (27% vs. 34%).

LARGE INEQUALITY IN SEEKING PNC FROM QUALIFIED PROVIDERS:
Slum: 34% • Non-slum: 60%

CHILD SURVIVAL

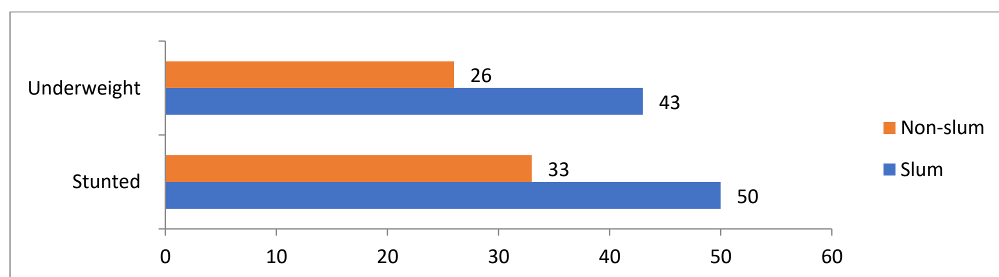
The current under-five mortality rate (U5MR) of 57 per 1,000 live births in slums is still above the national average of 46. Similarly, slums have a higher infant mortality rate than the national average (49 vs. 38). The higher rate of child deaths in urban slums exposes a lack of access to affordable services of a standardized quality.

LARGE INEQUALITY IN U5MR:
Slum: 57 • National average: 46

NUTRITIONAL STATUS OF CHILDREN

Malnutrition remains a major problem in urban areas especially for the poor living in informal settlements or urban slums. In slums, half of all U5 children are stunted (height-for-age), which is higher than in non-slums (33%). Likewise, underweight among U5 children in slums (43%) is considerably higher than in non-slums (26%).

Inequalities in child nutritional status



Non-communicable diseases

Non-communicable diseases (NCDs) (inclusive of injuries) account for 61 percent of the total disease burden in Bangladesh while 39 percent is from communicable diseases, maternal and child health, and nutrition, all combined. Three NCDs—cancer, cardiovascular diseases, and diabetes—have emerged as major health concerns in Bangladesh. A WHO study indicates an increasing trend in diabetes, especially in urban areas (11% in urban Dhaka).

NCD treatment comes mostly from the tertiary level. For first-line clinical care for NCDs, most people, including the poor, use private practitioners. Clinical treatment is also sought from the informal sector and through pharmacies, both licensed and unlicensed.

Gaps in service delivery

Lack of coordination between actors. There is a lack of coordination between MOLGRDC and MOHFW as well as among various providers. There is also an absence of a structured referral system between NGO clinics and government primary healthcare clinics on the one hand and government secondary or tertiary level hospitals on the other.

Use of unqualified or informal providers for healthcare. Non-communicable diseases (NCDs) treatment comes mostly from the tertiary hospitals located in large cities. For first-line clinical care for NCDs, most people, including the poor, use private practitioners. Private facilities operating in and around the slums provide limited general clinical services including prescriptions. Nutrition and diagnostic services are largely absent in those service delivery points. Slum dwellers prefer drug sellers as they provide low-cost treatments for a range of illnesses.