# 19 PROJECTS – 1 QUESTION: HOW CAN CITIES ADDRESS URBAN HEALTH INEQUITY?

Insights from CHORUS Projects in Nepal, Bangladesh, Nigeria & Ghana

**Wednesday 22 April 2026 10.00 - 12.00 UTC**

**10.00 – 11.00: How can different sectors work together to address the upstream causes of urban health**

**11.00 –12.00: What barriers to good health do low-income urban residents face and how can city services be accountable to all**

ISUH Urban Health Systems Working Group Launch

# 19 Projects, 1 Challenge: How Can Cities Address Urban Health Inequity?

INTERNATIONAL SOCIETY FOR URBAN HEALTH

CHORUS RESEARCH ON URBAN HEALTH

Webinar Opening:
Giselle Sebag, Executive Director, ISUH

Webinar Chair:
Badruddin Saify, ARK Foundation

Session 1: How can difference sectors work together for improved urban health services and health equity

Panel Session Moderator:
Professor Shafiq Rahman, University of Dhaka

Session 2: What barriers to good health do low-income urban residents face and how can city services be accountable to all

Panel Session Moderator:
Professor Prof. Zahidul Quayyum BRAC James P Grant School of Public Health

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# CHORUS Innovation Fund

**2 Application Rounds. 17 Awarded Projects, from 35 Applications (Externally Reviewed),**

**Project Budgets from £20,000 - £50,000**

**Led by Early to Mid-Career Researchers, from across 4 Countries**

**2 Funded PhD awards (University of York & University of Leeds)**


**Each Innovation Fund Project aimed to:**

- **Extend knowledge in relation to the 4 CHORUS Research Pillars**
- **Explore pillars in relation to groups of urban poor residents facing marginalisation or exclusion**
- **Explore a context relevant urban issue, identified by communities and stakeholders**
- **Is supported by mentors who are expert in the field**

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# Session 1:
# Multisectoral Collaboration - How can different sectors work together to address the upstream causes of urban health, with a focus on actions at city & local government level

# Protecting Urban School Children (PUSH)

**Prince Agwu**
**Health Policy Research Group (HPRG), University of Nigeria, Nsukka**

# PUSH (Protecting Urban School Children) Project

- Informal care practices dominate care for school-aged children, with patronage of PMVs, faith-based organisations (prayer houses), and home management of illnesses the most common.
  - There is evidence that these are more obtainable in poor neighbourhoods like the urban slums, but a diminishing economy and constraints in accessing formal healthcare have made these practices increasingly generic across urban areas.

- Since school-aged children are present for 9 of 12 months in schools, evidence showed that effective school health services are the best start to correct anomalies involving health-seeking and health rights that concern them.

- Stakeholders were brought together and saw the need to update the 2006 School Health Policy for the first time, using PUSH evidence and other sources from development partners.
  - Big change is the combination of school-based and school-linked health services
  - Ongoing nudge for validation of the updates before the push for approval at the Council

# Exploring Multisectoral Collaboration for Population Health Improvement in Ashaiman, Greater Accra, Ghana

**Patience Ami Mamattah**
**Municipal Director of Health Services, Ningo-Prampram, Greater Accra**
**School of Public Health, University of Ghana**

## Background

Rapid-uncontrolled urbanisation is a challenge for most LMICs with WHO estimating ***70%*** of the global population ***will be urbanized by 2050*** (WHO, 2025).

-The phenomenon comes with a lot of challenges to population health and ***multisectoral collaboration holds key*** to its solutions (WHO, 2022; Trowbridge et al., 2022 Olufemi et al., 2025).

-Multisectoral collaboration through ***HiAP promotes*** population health improvement on scale (Ollila, 2011a; Salunke *et al*, 2017).

## Methods

- Exploratory descriptive case study, within Ashaiman Municipality, Greater Accra
- Study Population: CSOs, NGOs, Assembly Members, Community Members, Traditional Authorities, Clergy
- Document Review / KIIs, Stakeholder Workshops

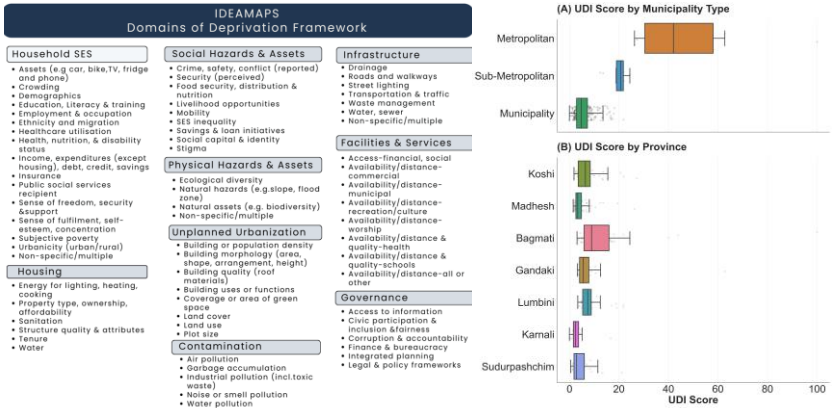
## Key Messages

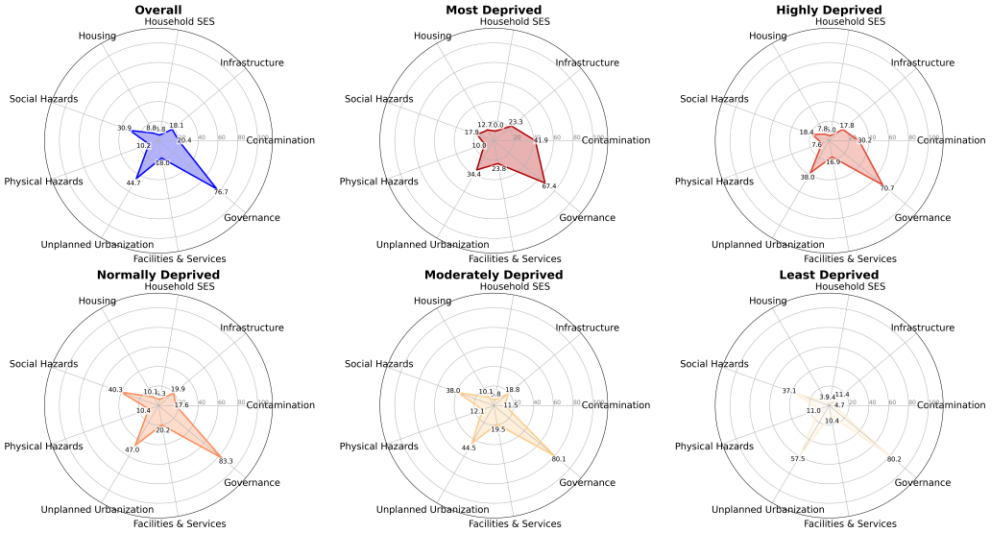
- Inadequate understanding of multisectoral collaboration and required approach for population health improvement on scale.
- Politicisation and political party interference in programming for population health improvement.
- Perceived corruption due to lack of transparency among stakeholders.
- Disjointed, parallel and non-harmonized policing and programming.
- Lack of essential technical capacity in terms of knowledge on multisectoral collaboration.
- Lack of resources including funds to advance multisectoral collaboration.
- Transformational leadership holds key for the success of multisectoral collaboration.
- Available accountability measures in the study setting albeit not aligned to Health-in-All Policies and population health improvement.

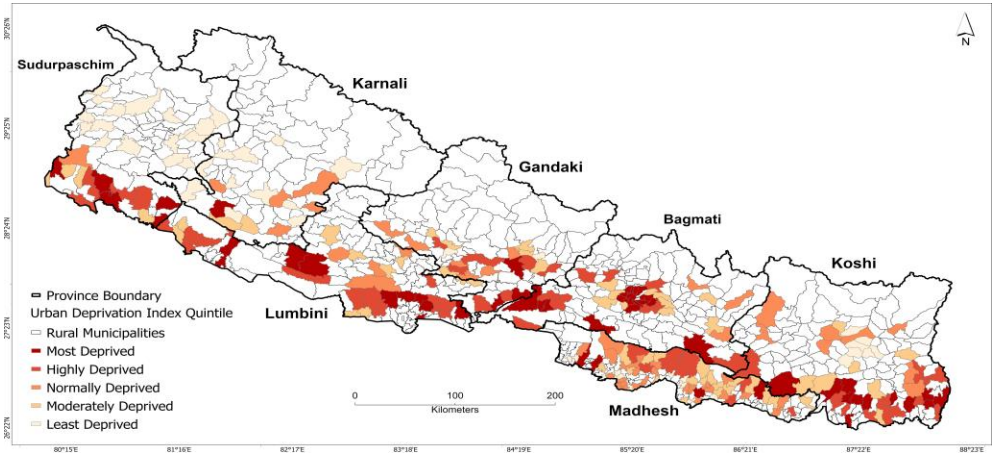
# Developing an Urban Deprivation Index in Nepal: A Multidimensional Approach to Measuring and Addressing Urban Inequalities

**Sampurna Kakchapati**
**HERD International, Nepal**

- Nepal rapidly urbanizing (66.8% urban population)
- Unplanned growth → inequalities
- Income-based poverty measures are insufficient
- Develop a multidimensional UDI using national routine data
- Methods: 293 municipalities, 309 indicators, 9 domains
- Principal Component Analysis → Index (5 deprivation levels)




## Key Messages

- Urban deprivation in Nepal is multidimensional, not income-based
- Highest deprivation occurs in dense urban and metropolitan areas
- Governance is the strongest driver of urban inequality
- Environmental and infrastructure challenges are widespread in cities
- The UDI enables targeted, evidence-based urban planning
- Provides a scalable framework for LMICs

**Team: Sampurna Kakchapati, Shirish Maharjan, Sabina Marasini**
**(Detail Link : UDI - a Hugging Face Space by Shirish15)**

# Developing a Small Area Heat Vulnerability Index (HVI) for Dhaka

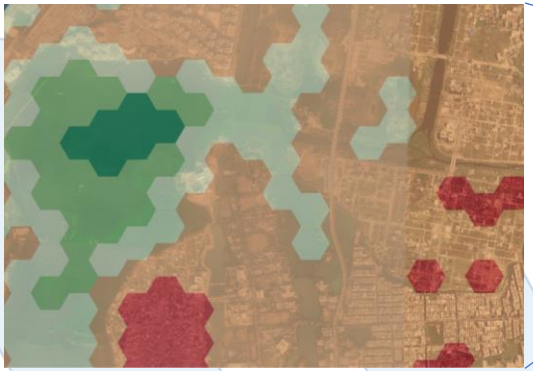
**Anisur Rahman Bayazid**
**BRAC James P Grant School of Public Health, Bangladesh**

# Developing a Small Area Heat Vulnerability Index (HVI) for Dhaka

**Exposure:**
Land Surface Temperature (LST), Population Density, Roads, Industry, Sky View Factor (SVF)

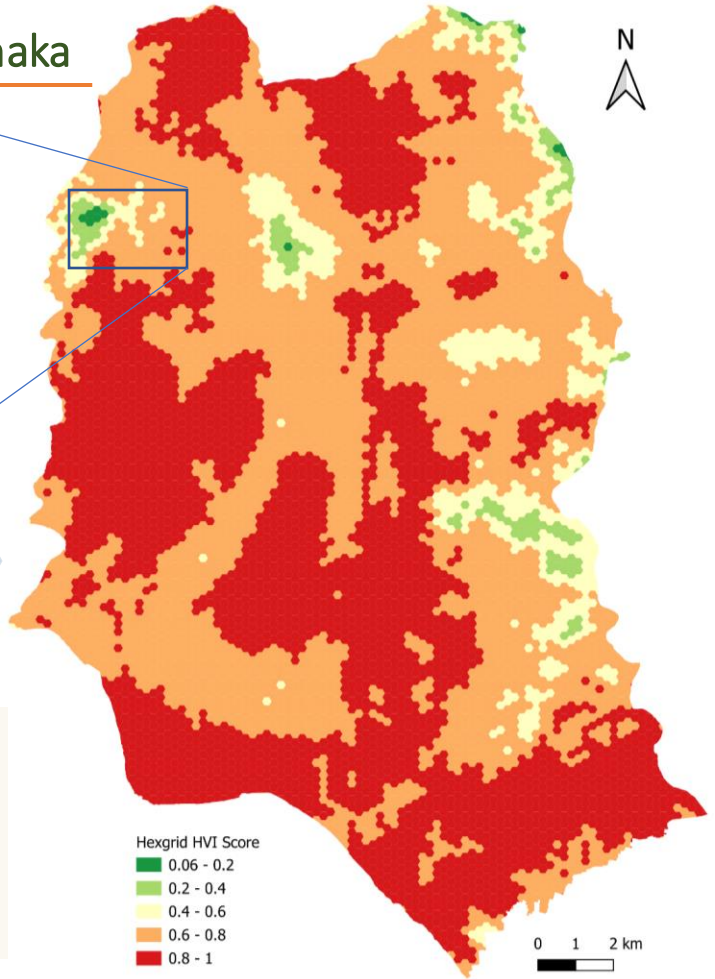
**Sensitivity:**
Poverty Rate, Informal Settlements, Building Density, Normalized Difference Built-up Index (NDBI)

**Adaptive Capacity:**
Blue Spaces, Green Spaces, Availability of Healthcare Facilities, Nighttime Light Intensity



Vulnerability
=
Exposure + Sensitivity – Adaptive Capacity

Data Source: Open source data
Data Resolution: Resampled to 30x30 meter pixel
Data Processing: z-score normalization
Weight Derivation: 2-step PCA
Grid Size: 250 square meter Hexagon
Administrative Boundary: DNCC and DSCC wards




*Anisur Rahman Bayazid, Zahidul Quayyum*

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BRAC JAMES P GRANT SCHOOL OF PUBLIC HEALTH

# Exploring the Potential of Drug Sellers in Shaping the Approach to AMR in Urban Settings

Asiful Chowdhury, Badruddin Saify
ARK Foundation, Bangladesh

# Key Findings : Mapping and KAP Survey

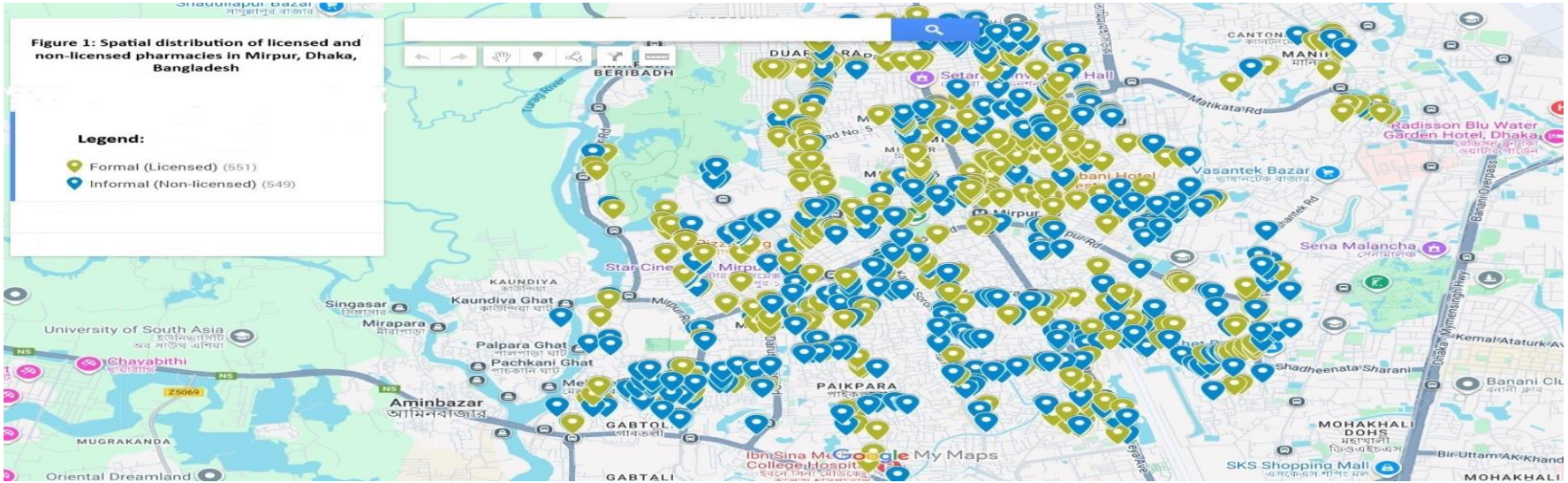
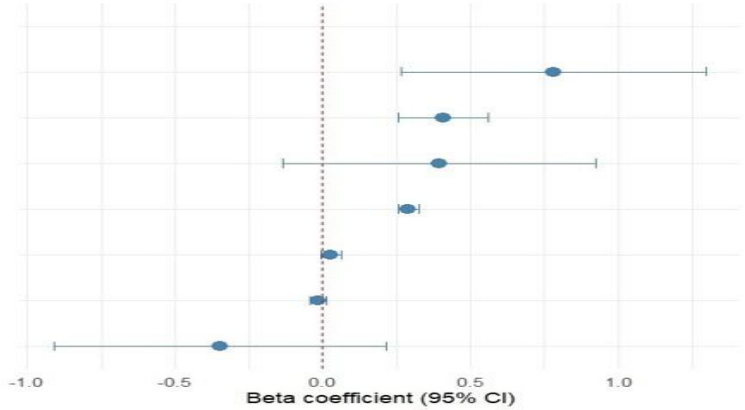



**Figure 5: Adjusted β-coefficients for factors associated with practice of drug sellers regarding antimicrobial resistance**

| Variable | B | 95% CI | p-value |
|---|---|---|---|
| Type of pharmacy : Licensed | 0.78 | (0.26, 1.3) | 0.00313 |
| Knowledge score | 0.41 | (0.26, 0.56) | 2.23e-07 |
| Education: Graduate or above | 0.39 | (-0.13, 0.92) | 0.143 |
| Attitude score | 0.29 | (0.25, 0.33) | 1e-43 |
| Duration of training/experience | 0.03 | (-0.01, 0.06) | 0.11 |
| Age | -0.01 | (-0.04, 0.01) | 0.301 |
| Pharmacy grade A/B/C | -0.35 | (-0.91, 0.21) | 0.224 |

Adjusted R-squared: 0.5367



## Key Findings : FGDs, KIIs and Participatory Video

- Drug sellers reported Pharmacies are frequently used as first point of care
- Face multiple pressures that drive inappropriate antibiotic dispensing
  - Customers requesting antibiotics without prescription
  - Financial constraints
  - Competition among pharmacies
  - Influence from pharmaceutical representatives
- Stakeholders highlighted gaps in training, regulatory enforcement, and monitoring & supervision systems
- Digital innovations in antibiotic dispensing and better regulation of pharmaceutical promotion were also identified as potential strategies to improve antibiotic stewardship
- Both emphasized need for structured training, stronger monitoring & supervision, and community awareness

PV development training workshop

PV shooting at a pharmacy

Showcasing of Participatory Video

# Co-design and evaluate a citizen score card to promote physical activity for adolescent girls and women in urban Bangladesh

Farid Ahmed, Salma Anee & Samina Huque
ARK Foundation, Bangladesh

# Promoting Physical Activity among women in Urban Bangladesh

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## Issues:

- Limited access to safe public spaces
- Gender & Cultural constraints
- High cost of facilities

## Approach

- Co-designed Citizen Score Card
- Community-Government engagement
- Guided by Socio-Ecological Model

# Promoting Physical Activity in Urban Bangladesh
# From community voice to system change

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**Impacts**:

- School opened playgrounds for community use
- City corporation planning recreational spaces
- Multi-stakeholder dialogue initiated


***Community accountability mechanisms can drive inclusive urban health action for women***

# Identifying and Mitigating the Impact of Urban Crimes on the Wellbeing of Urban Dwellers Health Facilities in Nigeria

**Ethelbert C. Agu**
**Health Policy Research Group (HPRG), University of Nigeria, Nsukka**

Health Policy Research Group University of Nigeria

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# FROM EVIDENCE TO IMPACT SERIES: WEBINAR 4
# IDENTIFYING AND MITIGATING THE IMPACT OF URBAN CRIMES ON THE WELLBEING OF URBAN DWELLERS AND HEALTH FACILITIES IN NIGERIA

## BACKGROUND

In recent years, insecurity and crime have reportedly escalated in Nigeria, affecting individuals' overall health, social, economic, and political well-being. Increased socioeconomic challenges have resulted in increased insecurity issues across Nigerian cities. The urban crime project conducted qualitative and quantitative studies in Onitsha and Aba to understand the commonly experienced crime problems and how they impact health and health service delivery.

## KEY FINDINGS

1. Major causes of crime include: economic instability, unemployment, poor parental guidance, poverty, substance abuse etc.
2. We found theft and burglary, armed robbery, kidnapping for ransom, cultism and gang violence, drug-related crimes, sexual and domestic violence, homicide, transport-facilitated crimes, and politically related unrest are key crimes affecting urban health in Nigeria.
3. Theft, robbery, and drug-related crimes were the most frequently occurring crimes in Onitsha and Aba, with reports indicating their occurrence three or more times in the past year. These crimes significantly disrupt healthcare access and service delivery.
4. Nearly 1 in 4 people report being directly impacted by crime in the cities.
5. Nearly 1in 3 people report significant long term health concerns as a result of crime.
6. Crime disrupts health service delivery, drives health worker absenteeism, increases illness burden, and delays access to care, especially at night, posing a serious threat to achieving Universal Health Coverage.

## POLICY IMPLICATIONS

1. Strengthening urban health resilience requires embedding security into primary healthcare planning and financing through a multisectoral “health-in-all” approach that integrates security, community governance, justice and health systems.
2. Use of multisectoral approach to tackle insecurity by creating employment and youth engagement opportunities and use of local and state wide security systems.
3. Strengthen law enforcement agencies and promoting community policing can help address these crimes.
4. Encourage collaboration between healthcare providers, law enforcement, and community organizations can enhance the effectiveness of interventions.
5. Provide accessible and specialized treatment/rehabilitation services for drug abuse since it is identified as a major driver of crime and related mental health concerns.
6. Implementing robust security measures in health care facilities can prevent the loss of health equipment and ensure the safety of staff and patients.

# Improving Adolescent Mental Health through a Co-design Approach

Abhigyna Bhattarai, Grishu Shrestha
HERD International, Nepal

# Addressing Adolescent Mental Health in Cities: A Multisectoral Framework

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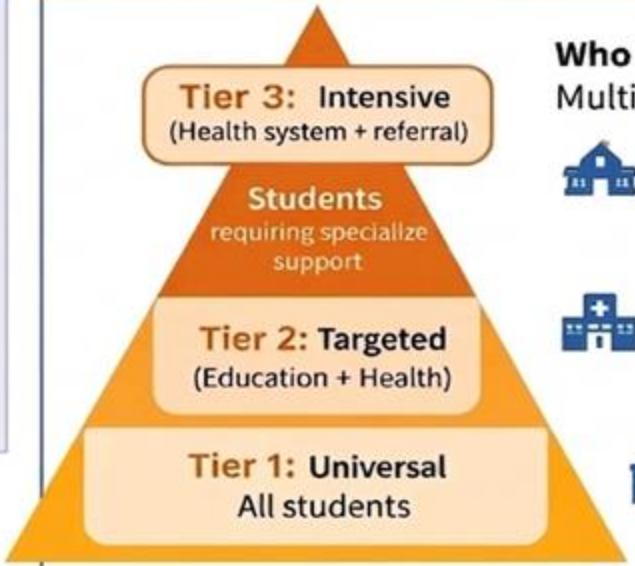
## Drivers of Urban Mental Health Inequity

- Academic pressure & family expectations

- Poverty, peer relationships, social stress

- Limited awareness & access to support

## Improving school environment + early identification system




**Who needs to act?**
Multisectoral roles

**Education**
Safe schools, awareness, early identification

**Health**
Screening, counseling, referral

**Government**
Coordination, budgeting, accountability

**Local governments** must **coordinate** education, health and community services to identify and support vulnerable adolescent- ensuring **equity and coverage**

# Public Expenditure Tracking of an Urban Health System

**Badruddin Saify**
**ARK Foundation, Bangladesh**

# Health Budget and Expenditure of Dhaka North City Corporations (DNCC)

## Context

- Till July 2025, Primary Healthcare services for urban citizen were provided through third-party vendors under the UPHCP-II with financing from Asian Development Bank
- From July 2025, DNCC took over the charge of the healthcare service delivery and currently follows the same modality to provide the healthcare services

## Financing Health Care Services by DNCC

- The Ministry of Finance (MoF) does not provide specific line-item budgets to the City Corporation (DNCC) for health; MoF categorizes budgets into four broad types (General, Special, Support, Transfer). DNCC receives its funding under the "Transfer Budget" category, which is distributed to Local Government Institutions

- DNCC received a block amount under their Recurring Grants for Primary Healthcare Services under Economic Code “3631109” from government’s ‘Operating Budget’ from Ministry of Finance→ Ministry of Local Government and Rural Development →Local Government Secretariate → Dhaka North City Corporation ( Total Allocation: 10 Crore BDT; DNCC Allocation 2 Crore BDT) for FY 24-25

- DNCC generated revenue through their own services and their allocated health budget consists of both Grants and their own revenue, which are around 187.75 crore BDT for FY 25-26 under the Mosquito Control and Health (3% of total Budget); FY 24-25 budget data shows 8 Crore BDT of Health Tax collected but no clear expenditure recorded of the tax collected

- DNCC Health Department Activities broadly Include: a) Primary Healthcare Services (provided through project based facilities; now managed by DNCC); b) Mosquito and Epidemic Control; C) Food Safety and Tobacco Control; d) Slaughter House Sanitation; e) Animal Birth Control; f) Birth and Death Registry

# Primary Healthcare services

- Comprehensive Reproductive Healthcare Centres (CRHCCs) which manages primary healthcare centres (PHC) and Satellite Clinics, now operates under a cost sharing model; 50% of total budget to be earned by facilities through user fees, 25% cost shared by DNCC and 25% are by MoLGDRD
- 100% of income generated daily by facilities is deposited into a joint account with DNCC. Ownership is shared, and every expenditure requires central approval.
- A quarterly reimbursement system based on bill vouchers and audits. Salaries/rent are prioritized, while direct govt funds cover medicines

# Issues

- DNCC Health Budget Expenditure are yet to be reported through iBAS++ (government's central tracking system); they are currently consolidated at DNCC Accounts office manually
- There is no single broad economic code for DNCC health department or its activities, which make it complex to track different expenditures down to CRHCC and PHC
- Sudden take over of Primary Healthcare services from Project to DNCC creates different systematic gaps including, procurement, funds reimbursement delays and lengthy manual reporting and complex auditing system

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# Session 2:
# Engaging Communities - What barriers to good health do low-income urban residents face and how can city services be accountable to all?

# Ethnographic Study of Intersecting Inequities Experienced by Urban Poor in Kathmandu, Nepal

**Abriti Arjyal**
**HERD International, Nepal**

# Reaching and Understanding Urban Health Inequities: Applying an Intersectional Approach to inform Urban Health policy strengthening in Nepal

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## Key findings

**Urban marginalized population**

- Migration as a foundational axis
- Land tenure insecurity
- Ethnicity, religion & informal support systems
- Informal occupations & hidden livelihood strategies
- Less educated & health illiteracy
- Unsafe & congested housing
- Environmental vulnerability related to climate change
- High burden of chronic diseases such as NCDs, respiratory and mental health

**Non-linear care seeking pathways**

**Common first contact point:**

**Informal providers**
- Home remedies
- Traditional healers
- Local pharmacies

**Intersecting factors**
- Economic constraints
- Gender, ethnicity & religion
- Trust & social networks
- Legal & migration status

**Subsequent contacts:**

**Formal providers**

**Public facilities:**
- Urban health centers
- Tertiary government hospitals
- Semi-government hospitals
- Specialized hospitals

**Private facilities:**
- Private clinics
- Private hospitals
- Private specialist centers

**Intersecting factors**
- Economic adjustment
- Experience-based choices
- Gendered power relations

## Key message

Urban health inequities arise from intersecting vulnerabilities, demanding intersectionality-informed strategies to overcome structural barriers and ensure equitable access to care

- Targeting multiple vulnerabilities
- Flexible & proximate service delivery
- Gender-responsive & inclusive protection
- Community-embedded governance

# Preferences for Primary Healthcare Providers among Urban Slum Dwellers of Dhaka City, Bangladesh: A Discrete Choice Experiment

**Md Zahid Hasan**
**PhD Researcher, University of Leeds**

# What urban slum dwellers value most when choosing primary healthcare providers: evidence from a discrete choice experiment

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**DCE with 6 attributes**

- Travel time
- Waiting time
- Provider type
- Recommendation
- Consultation fees
- Medicine costs

**304**
respondents

**Two**
slums

**Two**
hypothetical illness conditions

# Mean coefficients from random parameter logit model

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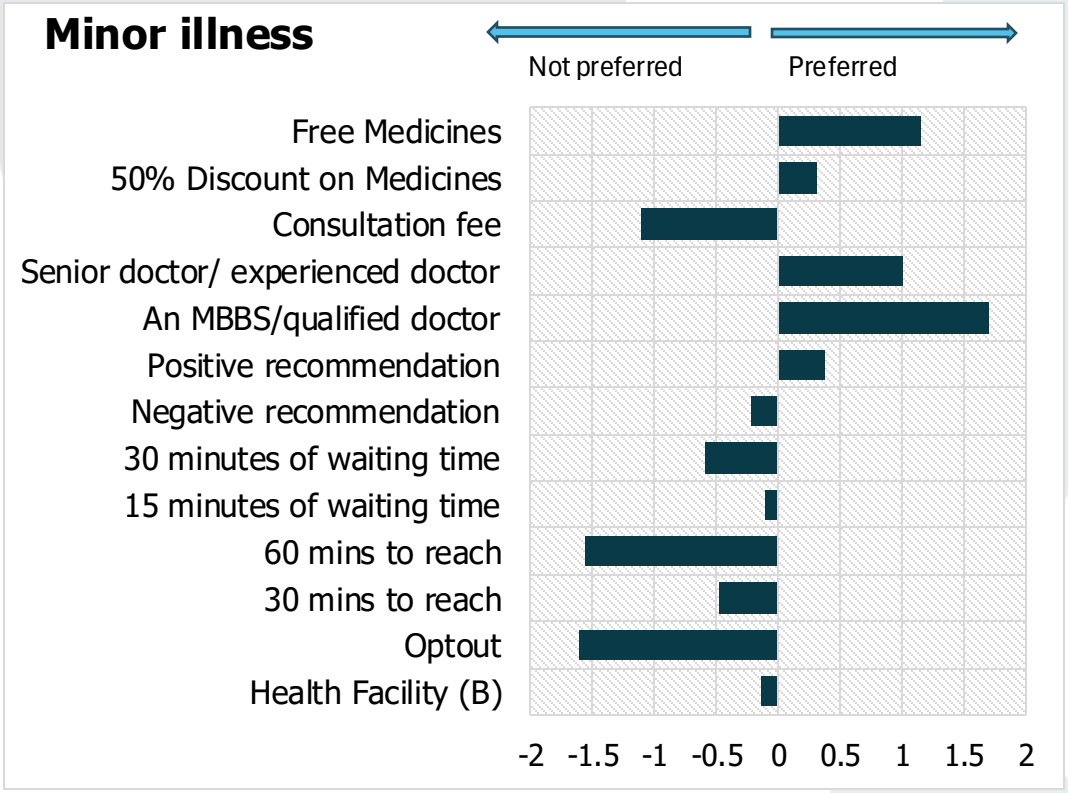


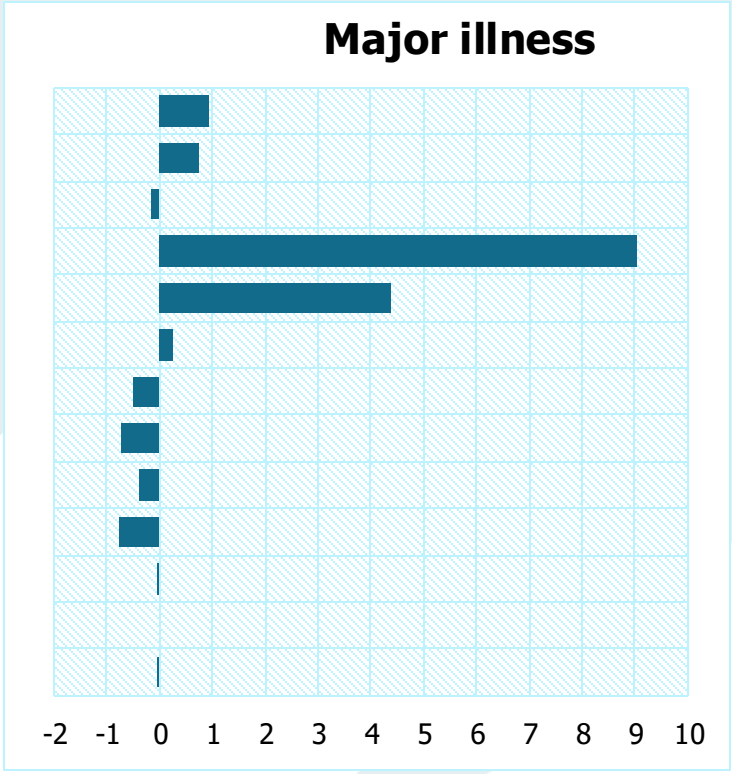

# Extending Health Insurance to Informal Sector Workers in Ghana

**Jemima Catherine Ambamaah Sumboh**
**PhD Researcher, University of York**

# Extending Health Insurance to Informal Sector Workers in Ghana

Jemima Catherine Ambamaah Sumboh | PhD Research

**Why this matters**

In Ghana, 71.3% of employed people work in informality, yet many remain outside effective health insurance coverage and face out-of-pocket spending when care is needed.

**What I did**

- Systematic review of how health insurance affects UHC goals for informal workers in LMICs.
- National secondary analysis of Ghana NHIS and financial risk protection.
- Mixed-method Q-sort + qualitative study to identify preferred insurance design features.

**What I found**

- Insurance is more sustainable than paying out-of-pocket, but design must go beyond enrolment alone.
- NHIS offers some protection for inpatient care, but does not fully prevent catastrophic spending or impoverishment.
- Informal workers do not want one identical scheme: five distinct design viewpoints emerged.

**What it means**

- Universal coverage for informal workers needs tailored contribution, benefit and purchasing arrangements.
- Policy should actively involve informal workers in scheme design and implementation.
- The core message: **one model will not fit all.**

**Key message**

**Extending health insurance to Ghana's informal sector is essential for UHC, but progress depends on designing flexible, worker-centered models rather than scaling a single standard package.**

# Quality and Patterns of Antimicrobial Dispensing and Consumption in Urban Slums in Ebonyi State, Nigeria

**Chibuike Agu**
**Health Policy Research Group (HPRG), University of Nigeria, Nsukka**

# What we found

- Antimicrobial use is widespread and largely unregulated within informal, community-based care settings.
- Demand is strongly shaped by misconceptions and gendered beliefs.
- Patent medicine vendors (PMVs) are under pressure to meet client expectations
- Regulatory systems are fragmented and weakly enforced


## What needs to change

- Engage PMVs as partners
- Address community demand
- Strengthen regulatory coordination and transparency
- Channels for community feedback and accountability

# Assessing the Level of Multi-Sectoral Involvement in Water, Sanitation and Hygiene (WASH) for Improving Health in Urban Poor Settings in Anambra State, Nigeria

**Iheomimichineke Orjiakor**
**Health Policy Research Group (HPRG), University of Nigeria, Nsukka**

# BARRIERS FACED BY URBAN SLUMS IN ANAMBRA STATE (EVIDENCE)

## MULTI-LEVEL BARRIERS

### INDIVIDUAL
Low awareness of safe WASH practices.
Resistant behaviors.

### COMMUNITY
Weak community leadership.
Poor enforcement of rules.
Limited capacity to mobilize residents.

### INSTITUTIONAL
Weak regulation and inspection systems. inadequate technical expertise.
Limited coliaboration.

### POLICY
Inadequate funding.
Service delivery bottlenecks.
Weak regulatory enforcement.

## WHAT WE DID (Community engagement at scale)

CO-DESIGNED INTERVENTIONS (18) with 30+ STAKEHOLDERS

BUILT CAPACITY OF STAKENOLDERS ON SAFE WASH PRACTICES AND PRINCIPLES
37 trained across sectors and levels

COMMUNITY WASH EDUCATION CAMPAIGNS (400+ RESIDENTS reached)

ESTABLISHED AND INAUGURATED COMMITTEE FOR SAFE-GUARDING BOREHOLES (34 members)

ESTABLISHED AND INAUGURATED SCHOOL WASH CLUBS (4 secondary schools 96 club members)

## MEASURED IMPACT (Community/Household)

| SAFE WATER STORAGE/ TREATMENT PRACTICES | SAFE HYGIENE PRACTICES | OPEN DEFECATION | OTHER SANITATION PRACTICES | KNOWLEDGE OF PREVEN-NTING WASH DISEASES |
|---|---|---|---|---|
| 37.2% to 67.9% | 45.6% vs 78.1% | 53.4% ↑ 9.0% ↑ | 33.3% up 72.5% | 53.6% vs 77.7% |

BASELINE EVIDENCE VS ENDLINE EVIDENCE

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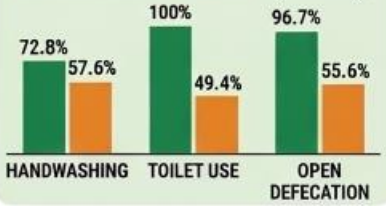
## BEHAVIOURAL IMPACT (Schools)




## KNOWLEDGE IMPACT

SCHOOLS

97-99% vs 20-48%
SAFE WASH KNOWLEDGE


OVERALL KNOWLEDGE SCORE (p+0.007)

STAKEHOLDER CAPACITY


Mean knowledge 23.1 to 31.2 (P<0.001)

## SYSTEM-LEVEL IMPACT (Community governance)

BOREHOLE MAINTENANCE
REDUCED VANDALISM
COMMUNITY MONITORING

## HEALTH SIGNALS

REPORTED REDUCTION IN ILLNESS

DECLINE IN DIARRHOEAL CASES

## KEY MESSAGE: WHAT DRIVES ACCOUNTABILITY

COMMUNITY CO-DESIGN
↓
Passive Users

+

COMMUNITY GOVERNANCE
↑
Active Monitors and Enforcers

=

IMPROVED ACCESS & ACCOUNTABILITY

- STAKEHOLDER CAPACITY DEVELOPMENT
- BEHAVIOUR CHANGE COMMUNICATION
- LOCAL ACCOUNTABILITY STRUCTURES

SUSTAINABILITY:
Government financing
Regulatory enforcement
Technical expertise & support

## 🔥 BOTTOM LINE

"Accountability improves when communities co-design, monitor, and co-govern services—but must be backed by strong public systems."

# Disbursement of Resources for Primary Healthcare by Local Government and the Impact of Context, Decision Space, Capacity and Stakeholder Power. A Rapid Ethnography

Henry Delali Dakpui
School of Public Health, University of Ghana

# To what extent are the urban poor involved in resource allocation and disbursement for Primary Health Care? A rapid ethnographic case study of one municipality in Greater Accra, Ghana

Lauren J. Wallace[1], Henry Delali Dakpui[1], Irene A. Agyepong[2], Rumana Huque[3], Helen Elsey[4] and Andrews A. Ayim[5]

[1]School of Public Health, University of Ghana, Accra | [2]Ghana Ghana College of Physicians and Surgeons, Accra, Ghana | [3]University of Dhaka, Dhaka, Bangladesh | [4]Department of Health Sciences, University of York, York, United Kingdom | [5]Policy, Planning, Monitoring and Evaluation Directorate, Ghana Health Service, Accra, Ghana

## BACKGROUND

- Urban poor rely heavily on PHC, yet access gaps persist in cities
- Community engagement (inclusive and broad-based) is mandated in local government legislation
- The extent to which the urban poor are involved in decisions about disbursement of resources for PHC remains unclear

## WHAT WE DID

- Single case study design using a rapid ethnographic approach
- Observations of 2024 municipal planning and budgeting process (76 hours)
- Key informant interviews (n=13) with key stakeholders
  - Dep't & unit heads, assembly members, zonal council
- Desk review of policies and plans
- Thematic analysis, validated through dissemination forum

## KEY FINDINGS

**Who are the urban poor ?** People in the municipal who are not meaningfully employed and cannot afford basic necessities (e.g. hawkers, truck pushers, petty traders, waste disposers, the homeless etc).

### THE INTENDED ROLE OF THE URBAN POOR

- Communities are consulted for several purposes
  - (including needs assessment and reviewing budgetary implementation)
- Input gathered through town halls, and key stakeholders
  - Dep't of social welfare, assembly men, heads of community groups and associations

### WHAT HAPPENS IN PRACTICE

- Irregular town hall meetings
- Ad hoc consultations when specific activities sponsored
- Representatives do not necessarily represent the interests of the urban poor

Due to

- Limited capacity (planning unit, zonal council, department of social welfare)
- Public engagement not a political priority
- Urban poor individuals not well defined or mapped (lack of data and understanding)

## IMPLICATIONS FOR URBAN HEALTH SYSTEMS

- PHC priorities may not reflect the needs of urban poor communities
- Engagement processes risk becoming symbolic rather than meaningful
- Weak community influence in planning and budget process undermines accountability and trust

*La Nkwantanang Madina Municipality is a largely urban municipal district in the Greater Accra Region of Ghana, with a population of about 244,676 people (2021 census).*

# Level of Small Area Poverty and Urban Health in Dhaka: Estimation, Validation and Visualisation

Farzana Sehrin
BRAC James P Grant School of Public Health
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# Small Area Estimation of Urban Poverty in Dhaka

*Ground-Level Validation & Visualization for Equitable Urban Health Systems*
*— CHORUS Pillar 4*

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RESEARCH ON URBAN HEALTH

## Objective

- Estimate ward-level poverty across 129 wards of Dhaka City using Small Area Estimation (SAE)
- Validate model predictions through ground-level household survey
- Generate actionable poverty maps to inform equitable health resource allocation

## Methods

- SAE predictive model using HIES 2022 + National Census 2022
- Ground validation: 3,612 households across 20 wards (top 20% & bottom 20% strata)
- GIS-based spatial mapping of poverty hotspots at ward level

## Findings

- Ward-level estimates: 129 wards across DNCC & DSCC — avg 8.5% extreme poor, 17.4% poor, 19.6% rich, 10.5% extreme rich per ward
- GIS poverty maps identifying hotspots — poverty clusters in Sabujbag, Shah Ali, Banani; wealth concentrates in Bimanbandar, Khilkhet, Dhanmondi
- Validated model accuracy — MAE, RMSE, sensitivity & specificity
- First ward-level disaggregated poverty evidence for Dhaka's informal urban

## Why Validation Matters

- Confirms model predictions match real household conditions in complex urban settings
- Builds policy trust — decision-makers need evidence that is ground-truthed, not just modelled
- Detects systematic errors (e.g. under-counting slum residents) before policy use
- Produces a reliable, scalable tool that other South Asian cities can adopt with confidence

## IMPACT → HEALTH SYSTEMS & URBAN EQUITY

**VISIBILITY**
Makes the urban poor visible — counters HMIS & census under-coverage in slums

**TARGETED SERVICES**
Ward-level data enables pro-poor placement of primary & preventive care

**EQUITY**
Reduces urban health inequity (CHORUS Pillar 4) in informal settlements

**STRONGER SYSTEMS**
Evidence for fair resource allocation & pro-poor urban health planning

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# Understanding and addressing health communication needs of slum dwellers in Ghana (Ashaiman) and (Ngenuvu/Enugu) Nigeria

**Delali Kumapley**
**School of Public Health, University of Ghana**

# FINDINGS

**What communities prefer:**

- Institutional methods: market associations, landlord associations, religious settings
- Town-crying (remains highly valuable)
- Health workers and community volunteers (most trusted)
- Mobile vans for dense areas

**What is contested:**

- TV and radio penetration (important but contested)

**Critical gaps:**

- No formal feedback mechanisms – residents yearn to give feedback on health messages, services, and programmes, but have received none
- Research engagements are a rare (and abnormal) opportunity for feedback
- No documented standard procedures – the system has no formal health communication guide

# The Incentive Trap & The Way Forward

**The challenge:**

- Health communication thrives on incentives (e.g., insecticide-treated nets, perks to patronise PHC)
- When incentives stop → interest declines → trust weakens
- No documented transition strategy exists

**The digital paradox:**

- Push toward digitalisation, but health workers remain central – not technology alone
- Residents with limited digital access are left behind

**Recommended actions:**

- Document good practices into a formal health communication guide
- Build permanent feedback loops (e.g., landlord association) that outlast research
- Train and support health workers continuously as trusted messengers
- Phase out incentives transparently with a clear communication plan

**Bottom line:** Without feedback, documentation, and incentive-transition plans, even the best messages lose credibility in urban slums.

# Understanding How Information and Research Evidence are Communicated by News Media to Inform Urban Health Policies and Practices: Case Studies from Nepal and Bangladesh

**Sulata Karki**
**HERD International, Nepal**

# Health Journalism and Policy Influence

## Objective

- To understand journalistic practices and explore the influence of news media on health policy decisions

## Key findings

- Experts and government data prioritize, though shaped by political influence & access
- Research evidence valued, but underused due to interpretation challenges
- Journalists face training and financial constraints for investigative health reporting
- Health policymakers raised concerns about credibility of media-reported information
- Limited institutionalized collaboration between media and health stakeholders
- Media influence on policy is indirect, stronger during crisis and through public pressure

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## Methods

- Cross-country mixed-method study
- 758 journalists (Nepal: 526|Bangladesh: 232)
- 30 key informant interviews

- Improve access to reliable and timely information
- Strengthen journalists' capacity to interpret and use research evidence
- Enhance collaboration between media and health stakeholders including policymakers
- Reduce external pressures on media to enable independent, accountable and equitable reporting

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