Understanding Access to Primary Healthcare in Dhaka's Urban Slums: A Qualitative Inquiry into Community Perceptions & Health Equity Challenges

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Background

Access to primary healthcare (PHC) is essential for achieving Universal Health Coverage, yet remains limited in many low- and middle-income countries, including Bangladesh. Rapid urbanisation and epidemiological transition have led to a growing burden of non-communicable diseases (NCDs) such as hypertension and diabetes, particularly among the urban poor. Despite national policies and multiple PHC providers, access is shaped by financial constraints, service availability, and patient satisfaction. Marginalised groups, including the hijra community, face additional barriers due to stigma and discrimination. This study explores the facilitators and barriers to accessing and delivering PHC services in Dhaka city from both patient and provider perspectives.

Method

Study Design
Qualitative collective instrumental case study

Study Setting
Conducted in Dhaka North City Corporation (DNCC), Bangladesh.

Case Study Sites
Six PHC facilities selected: four NGO clinics (UPHCSDP) and two Government Outpatient Dispensaries.

Sample Size
30 patients and 18 healthcare providers.

Data Collection Timeline
December 2022 – August 2023.

Data Collection Methods
In-depth interviews and structured facility observations.

Analysis Software:
Using Nvivo 12

Findings

Costs and perceptions of cost

NGO clinics primarily provide maternal, neonatal, and reproductive health services, including antenatal care, postnatal care, immunisations, and family planning. Community members, especially men and Hijra individuals, often perceive these clinics as exclusively for women and children, which limits their use for general or NCD-related care. Although male patient visits are increasing, service priorities are still shaped by high demand and available funding for MNCH. Health care providers attempt to promote inclusivity through signage and outreach, but the perception of MNCH-focused care persists, restricting broader community engagement.

Availability of medicines, equipment, & operating hours

The availability of free essential medicines and basic diagnostics made GoDs highly attractive to patients across all groups, particularly for NCD care, despite limited laboratory services and short operating hours. Consistent access to drugs such as Amlodipine reduced out-of-pocket spending and encouraged repeat visits. In contrast, NGO clinics, largely oriented toward MNCH services, faced shortages of NCD medicines and often provided only short supplies, pushing patients to purchase drugs privately. Limited operating hours, longer queues, and a perceived focus on women and children further reduced access for working men and marginalised groups, highlighting how institutional priorities and service organisation can act as barriers to equitable PHC utilisation.

Behaviour of providers

Health care providers across study sites emphasised fairness and non-discrimination in service delivery; however, patients often reported poor communication, limited listening, and perceived favouritism toward higher socio-economic groups, which discouraged PHC use. While some patients—particularly those with longstanding relationships with facilities—reported positive, supportive experiences, others faced dissatisfaction due to unclear explanations and rude behaviour. Marginalised groups, especially hijras, experienced pronounced stigma, including denial of entry and discomfort caused by misgendering, which led them to avoid PHC facilities and seek care from pharmacies instead. Providers acknowledged these challenges and cited institutional constraints and fears of disrupting patient flow, highlighting how provider behaviour and facility norms can act as significant barriers to equitable access.

Perception of PHC focus on Maternity & Neonatal Child Health (MNCH)

Cost strongly shaped PHC utilisation across groups. GoDs were preferred as they provide consultations, limited diagnostics, and medicines free of charge, reducing financial barriers for vulnerable populations. NGO clinics, despite subsidised consultation fees (50 BDT) and safety-net "red card" provisions, were often perceived as expensive due to medicine costs, transport expenses, and lost wages. Limited awareness and use of red cards further reduced their effectiveness. As a result, men with NCDs, women, and hijra participants frequently avoided NGO clinics and relied instead on pharmacies and self-medication, delaying appropriate care.

Patient perceptions of NCDs

Gender and socio-cultural beliefs strongly shape health-seeking behaviors for non-communicable diseases (NCDs). Many men perceive NCDs like diabetes or heart disease as "rich people's illnesses" and believe physically demanding work protects them, often ignoring symptoms or relying on rest and home remedies. Some view these illnesses as divine punishment, further downplaying their severity. Men also prioritise work over health, while women are generally more aware, adhere to medications, and visit PHC facilities more regularly. Misconceptions and reliance on over-the-counter medicines like paracetamol further limit formal care-seeking among men.

Conclusion

Barriers to primary care utilisation are shaped not only by service limitations but also by patient perceptions of NCDs and PHC roles. Men and transgender populations are often excluded from MCH-focused clinics, while working hours and socio-cultural factors further limit access. Social networks can help reduce this exclusion. Context-specific strategies—such as public-private partnerships, financial protection, inclusive service redesign, and community engagement—are essential to address health inequities in Dhaka's urban populations.

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"CHORUS is funded by UK Aid from the UK Government, Grant 301132; however, the views expressed do not necessarily reflect the UK government's official policies"