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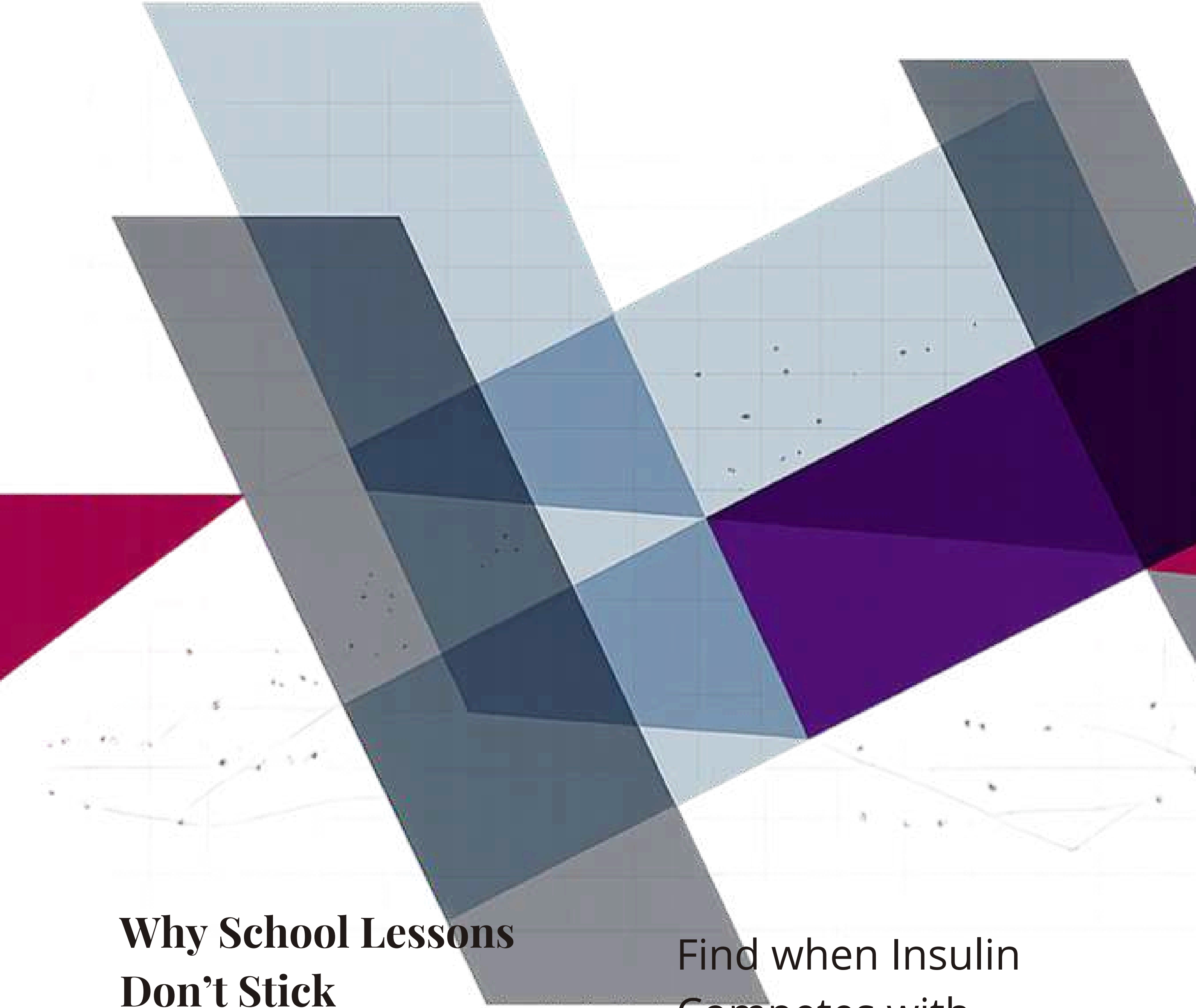
ThinkSpace



Why School Lessons Don't Stick

If prevention is the goal, why does so much health education fail to become usable knowledge?

Stories from the Ground

Find when Insulin Competes with School Fees

Diabetes is no longer just a medical diagnosis; it has become a long-term economic crisis that reshapes household budgets, choices, and futures

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Intro

All About Health and Health Systems, for Curious Minds

The Health Systems We Live With

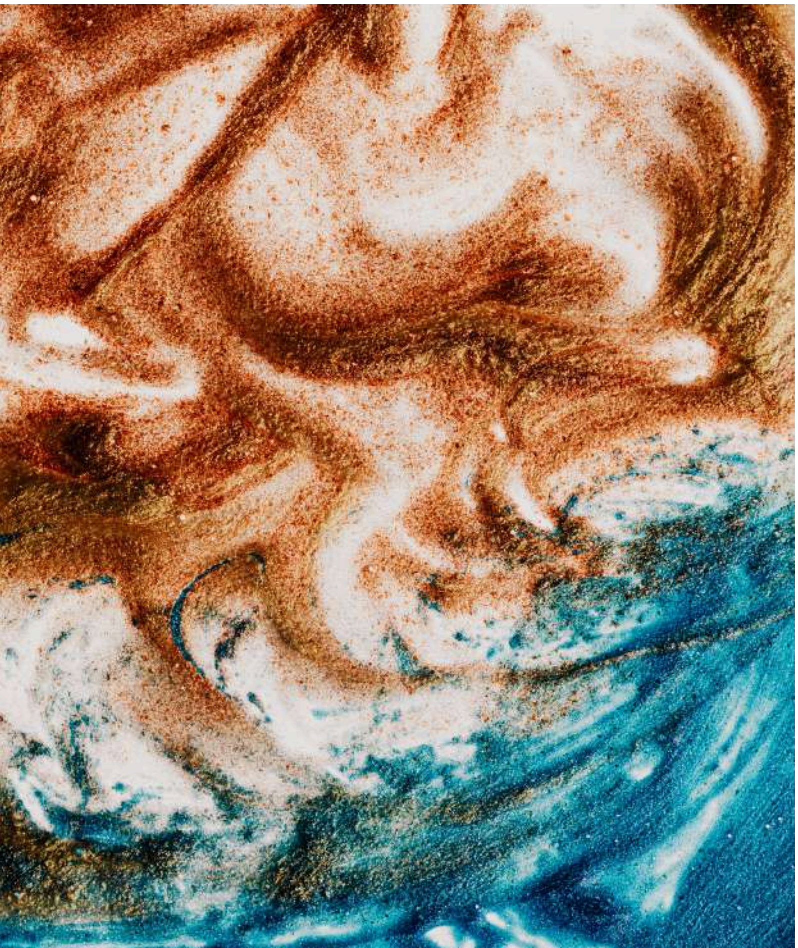
Cities shape how we live, work, and stay healthy in ways that often go unseen. Behind everyday choices about medicine, movement, food, and care are systems that quietly decide who is protected, who pays the price, and who is left to manage health risks alone.

This edition of ThinkSpace brings together research and field reflections from urban Bangladesh to explore those hidden systems. From pharmacy counters to public spaces and households, these stories show how health is shaped in real places and real lives.

We invite you to read and reflect, because understanding health systems is the first step toward changing them.

Index

Table of Contents



Article

The Hidden Tax on Health: Why Diabetes is Bankrupting Bangladesh's Families

Mira Bala (pseudonym), a 45-year-old mother of three, living in a small village in a district town with limited healthcare facilities, makes a calculation every morning how many blood sugar test strips she can afford this week. If she buys the full insulin prescription, her eldest daughter's college fees will be delayed another month, so she opts to buy less than her usual dosage. This isn't just a medical problem; it's a financial triage happening quietly in millions of Bangladeshi families, where being diagnosed with diabetes has become a slow-burning sentence to debt.

The case of Mira is not an isolated case, it is the face of a national epidemic. The recent findings of the Bangladesh Bureau of Statistics in 2024, have revealed that more than 11 percent of the adult population of Bangladesh are currently suffering with diabetes. (BBS Survey, 2024) The per-capita income of Bangladesh is Tk 339,221(Prothom Alo, 2025), yet to those who get diabetes, most of this already low income is directly spent on treatment. According to a study published in Health Policy OPEN in 2023, it was shown that an average patient incurs annual spending of Tk 25,473 that is about 11-12% of per-capita income on medicine, tests and routine check-ups (Hossain et al., 2023).

In the case of the complications, the annual expenses may go up to approximately 1lakh taka, nearly one-third of the income of the average Bangladeshi. Even these estimates conceal the actual burden. However, the per-capita income can only be considered an average; most of the low- and lower-middle-income families have significantly lower incomes. To them, managing diabetes does not require 10 per cent or 30 per cent- it may wipe out more than half of their annual wages. And since diabetes is a spending lifetime, the strain grows each year, and many families need to spend less on necessities, defer treatment, or become indebted.

> *“The most affordable insulin would absorb 10–15 percent of monthly earnings, making diabetes one of the most costly chronic illnesses to treat”*

The Anatomy of a Financial Poison

Insulin and oral anti-diabetic drugs have now taken a disproportionate portion of family income in Bangladesh; particularly of low and middle classes. A market review published in the Business Standard in 2024 indicates that the prices of major diabetes medicines have shot up in the past 5 years because of the reliance on imported raw materials and disruption of the supply chain. In the case of poorer families even the most affordable insulin would absorb 10-15 percent of monthly earnings, making diabetes one of the most costly chronic illnesses to treat (WHO, 2021). This implies that the patients will have a stipulated monthly charge which increases along with inflation, yet their income does not change.

The diabetes is crippled financially by three key forces:

To begin with, the dependency on imports increases prices. There exists a great deal of generic medicines produced in Bangladesh, but other important insulin analogs and innovative medications continue to be imported. Their price varies with the US dollar, thus, each fall of the Bangladeshi currency (Taka) increases the expenditure to the disadvantage of the patients against the institutions.

Second, healthcare is dominated by out-of-pocket expenditure. In Bangladesh, more than 67% of the health spending is spent as direct medicine expense of patients. (Bangladesh Health Watch analysis of National Health Accounts data, 2020). This creates a constant financial drain, especially in the case of a lifelong illness such as diabetes. The supply of essential insulin by the government is irregular and inadequate, and the patients have to purchase unregulated and uncontrolled prices offered in the private market.

Third, there are concealed expenses that slowly creep up. Blood glucose test strips cost 40-70 taka/unit and testing twice a day can amount to over 4,000 BDT per month which is usually more than the minimum wage of the country. When transportation, follow-ups, and the risk of complications are added to this – diabetes frequently pushes families into catastrophic health spending.

Diabetes is not merely a disease in Bangladesh. It has turned out to be an economic trap, choking the poorest families and making many able to enter into an economic crisis difficult to overcome.

Why Bangladesh's System Fails NCD Patients

The Bangladesh health system was developed to combat outbreaks, but not the diseases that remain with an individual for life. Consequently, diabetic patients have fallen into the gaps of the system that were never meant to support them. In the majority of primary health centres, the primary care remains dominated by maternal care, fever, infections and emergency care - whereas chronic illnesses need something altogether different: constant supervision, long-term counselling, frequent follow-up and the stable access to medicine. These are the fundamental components that are lacking in the system. An individual who is diagnosed at a camp, or in a local clinic, is often left without formal advice on what to do next. Electronic health records are not common and patients have to begin afresh whenever he or she visits a different doctor. There is also imbalanced training on the management of NCDs with rural areas experiencing the greatest imbalance as the frontline providers are overworked and they are not regularly given updated clinical guidelines.

In urban areas, the challenges are amplified. Rapid population growth, unplanned settlements and high-density living increase the risk factors for NCDs, while public primary care facilities are insufficient to meet the demand. Patients often rely on private clinics or pharmacies, paying out-of-pocket for inconsistent services. Citizens with diabetes are left alone to deal with a complicated disease without effective referral pathways or chronic-care models. This structural vulnerability and not only the cost makes diabetes a day-to-day challenge, also pushing patients through various facilities in the hope of finding one that can provide them with consistent care which the system was not fully prepared to provide.

The Urgent Call for Systemic Change

In Bangladesh, diabetes has ceased to be an individual health issue, it has turned out to be a systemic crisis. The health system should focus on providing more continuous care, rather than only short-term treatment to better support patients, especially those from low-income households. Increasing the availability of affordable insulin and other vital medicines in the public institutions would decrease the reliance on high-price pharmaceutical stores. NCD management, which is included in primary healthcare, should ensure the rural and marginalized groups are not left without care, while the urban health system faces another critical challenge: uncoordinated services and a dominance of unregulated private providers, which make it extremely hard to find consistent and quality care.

These need the assistance of skilled staff and frequent follow-ups in every sector. The creation of the system of referrals and digital health records can help to simplify the situation, also save time and money in the family by avoiding these issues. The poorest could be covered against disastrous health expenditure by specific financial safeguards, including subsidies or community-insurance programs. Adopting such systemic changes would ensure that care delivery of diabetes is predictable, affordable, and accessible, and households can control their health without going into debt or compromising the necessities.

Dealing with diabetes in Bangladesh will not be enough by solo effort, but it needs a multisectoral approach. Through enhancement of primary care, medicine availability, and incorporation of chronic disease management in the national health framework, the nation will be able to avoid monetary suffering and enhance the health outcomes. These reforms can be possible by bringing together healthcare providers, urban planners, education departments, transport authorities, and community organizations. Promoting healthier urban environments, regulating food systems, encouraging physical activity, and raising awareness about prevention are all essential. Coordinated policies across sectors can reduce risk factors, improve access to care, and support long-term health outcomes.

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Written by: **Sirat-E-Rowshan Islam**

Explainer

Addressing the Knowledge Deficit:

Health Education and Public Awareness in Bangladesh

Whenever someone goes through a difficult moment in life, a familiar regret tends to appear: “I wish someone had warned me earlier,” or “If only I had known about this risk in advance.” The same pattern holds true for health. For many diseases and health-related conditions, warning signs are missed, information arrives too late, and prevention becomes an afterthought rather than a habit.

In Bangladesh, the health information gap is hard to ignore. Unlicensed practitioners, fraudulent “supernatural” healers, and medical misinformation still attract people in both rural and urban areas. Self-medication is common, including for medicines that are meant to be taken only under medical advice. Distrust in formal healthcare institutions is also widely observed. All of this raises a difficult question: why does this gap exist, and who is responsible when warning signs are missed or risks are not understood?

The education system is often the first to be blamed. And it is a fair question. If education is meant to prepare people for real life, shouldn’t it also equip them with basic health knowledge that can shape decisions, reduce harm, and save lives?

A quick reality check for readers

Before we go further, consider these questions:

- Do you know how to recognize signs of a heart attack, and what steps to take immediately?
- Do you know that dengue can become more dangerous when the fever begins to subside, and how it differs from a common cold?
- Are you aware that tuberculosis (TB) remains a persistent disease in Bangladesh, and can you recognize key symptoms and prevention measures?
- Do you know how to clean and dress a wound safely?
- Do you understand the EPI (Expanded Programme on Immunization) vaccines, where to get them, and what to do if you’re unsure about schedules?
- Are you familiar with recommended maternal health practices and danger signs during pregnancy and childbirth?
- Do you understand why antibiotic misuse is harmful, and how it links to antimicrobial resistance?

Many of these topics connect directly to major drivers of illness and death. Yet in many communities, especially outside major cities, practical knowledge about prevention and early warning signs remains uneven.

Is the education system ignoring health education?

Not entirely. It would be inaccurate to say schools teach nothing about hygiene, disease prevention, or health-related topics. If you look through primary and secondary textbooks available through NCTB’s online listings, you will find health-related chapters across different subjects. Health content exists.

The problem is not absence. The problem is that health learning often fails to become usable knowledge.

Where do people actually learn health knowledge?

Teaching in Bangladesh is still heavily exam-focused. There is far less attention to real-life application, critical thinking, or changing everyday habits. Outside the classroom, public awareness campaigns on maternal health, immunization, TB, or HIV often have a stronger influence on what people remember and act on. This dependence on media campaigns points to a gap: school lessons do not consistently turn into practical health knowledge that people can apply in daily life. If you were able to answer the earlier questions, where did your knowledge come from? For many, it traces back to childhood TV programmes (like Meena), public campaigns, newspaper messaging, or billboards, not school chapters. Textbooks are less likely to be the first source that comes to mind and even when they are, it is worth asking how much practical understanding they delivered.

Why isn't existing health education proving effective?

Health education in the national curriculum doesn't fail because it's absent. It fails because it doesn't land. Health lessons appear here and there across different textbooks, but they don't build in a clear way from grade to grade. In primary school, students get basic messages on hygiene and nutrition, yet much of it stays general and easy to forget. As they grow older, health content becomes more detailed, but it also becomes more unequal. Students in the science stream are exposed to far more than those who are not, even though health literacy is something everyone needs.Even when the topics are covered, they are often taught as explanations rather than guidance. Students may learn what causes dengue or TB, but not what warning signs should trigger urgent action or what prevention looks like in everyday life. And some of the most common realities of Bangladesh, from infectious disease risks in certain seasons to the growing burden of non-communicable diseases, are not always taught in a practical, memorable way. So students learn enough to answer questions in exams, but not always enough to respond confidently when health decisions matter most.

What can be done?

Bangladesh's literacy levels are widely reported in the mid-to-high 70% range, with BBS reporting 77.9% functional literacy (age 7+) in 2023(BANBEIS, 2024). This matters because schools remain one of the few platforms that can reach people early, before harmful habits and misinformation become "normal."

Public health campaigns should continue, since they have played a major role in shaping awareness. But campaigns cannot carry the full burden of health learning for an entire population. The formal education system still has a role that no billboard can replace.

A realistic way forward is to treat health learning as a life skill that grows with age, not scattered facts that students memorise and forget. In early grades, the focus can be everyday habits and safety: hygiene, safe water, diarrhoea prevention, basic nutrition, and simple first aid. In middle grades, learning can reflect what students begin to face more directly: dengue prevention and warning signs, puberty and menstrual health, injury prevention, and how to spot common health misinformation. By secondary school, students can learn the basics that shape adult health: NCD risks (diet, tobacco, inactivity), safe medicine use, and why antibiotic misuse fuels antimicrobial resistance.

The method matters as much as the content. Short role-plays, case scenarios, and "what would you do?" discussions help students build practical judgment, not just exam answers.

Health regrets often begin with the same sentence: “I didn’t know.” If prevention is meant to become normal, health education needs to be taught in ways that stick, travel home, and show up when it matters.

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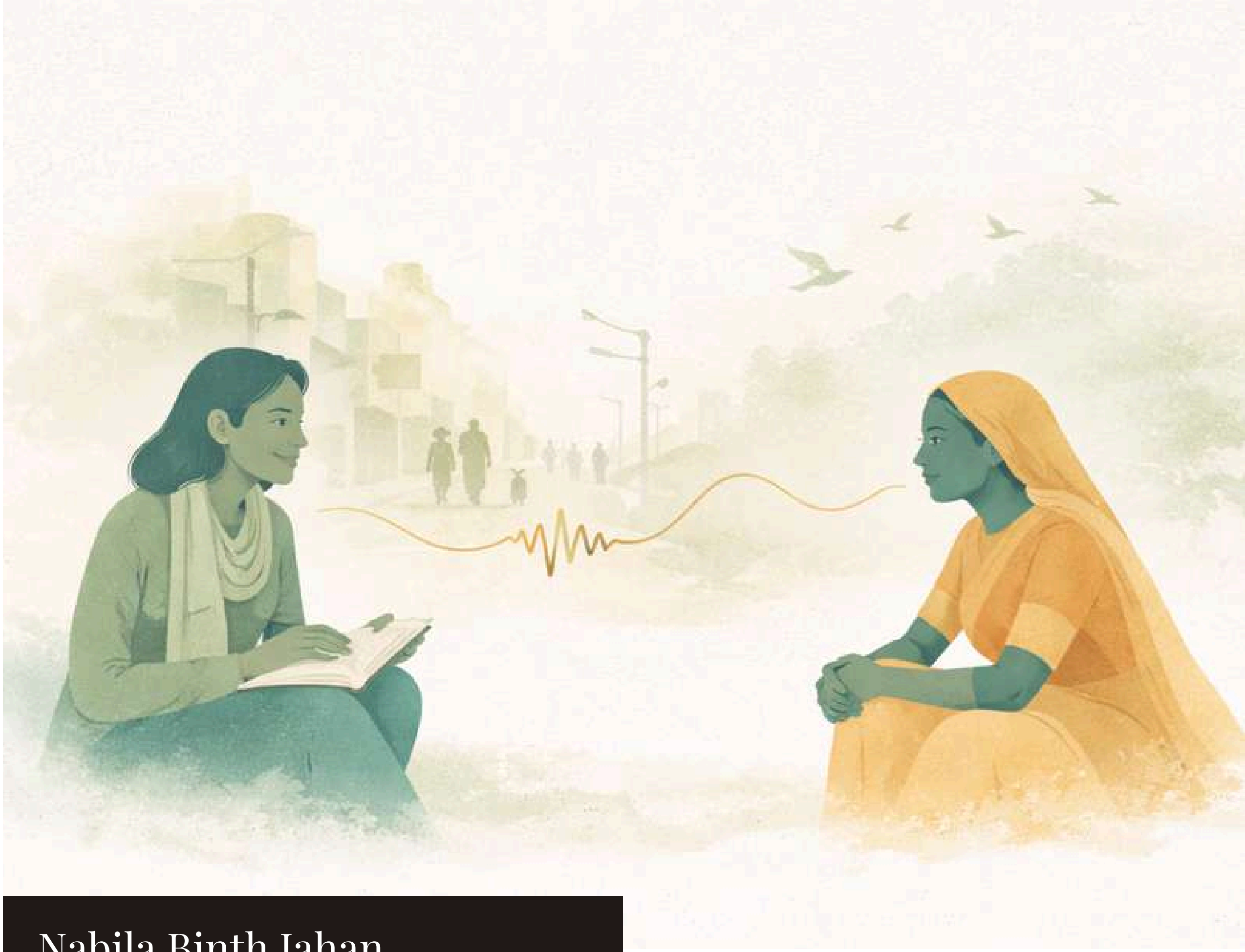
Written by: **Kazi Fatin Sami**



Nabila Binth Jahan

Listening Between Appointments, Streets, and Silence

Fieldwork rarely begins with a recorder switched on. More often, it begins with waiting, outside clinics, in narrow lanes, beside busy roads, or under the sun, hoping someone will spare a few minutes to talk. In the urban slum areas of Dhaka where CHORUS Projects 1 and 2 were conducted, that waiting was often long and unpredictable.

Working as a qualitative researcher on these projects offered a close view of how health systems function for different population groups. Beyond frameworks, protocols, and indicators, fieldwork showed a more complicated truth: access to health care is shaped by time, livelihoods, gender, and social power. Those same factors shape who can participate in research, when they can speak, and what it costs them to do so.

Engaging Participants in Their Daily Lives

Fieldwork in Dhaka's urban slums was rarely straightforward. From the start, data collection meant working around constrained schedules and the everyday realities of survival, informal labour, mobility, and social pressure.

Many participants worked long hours in informal or mobile jobs, where even a short interview could mean losing income. People checked the time repeatedly. Some agreed to speak only if we kept it brief. Interviews were postponed, interrupted, or completed in short segments between work tasks. Scheduling depended on narrow time windows, early mornings, late evenings, or brief breaks, and we often returned to the same lanes more than once to complete a single conversation.

Silence was not only the absence of words. Sometimes it was a glance that signaled someone was listening. Sometimes it was a pause before answering, as if the safest response was the shortest one. In a few cases, the interview had to happen in fragments, with certain topics avoided entirely. These moments were reminders that participation is never only about willingness. It is shaped by safety, privacy, and whether speaking openly carries social or economic risk.

Inside the Health Facilities

If community interviews were constrained by livelihoods and time, facilities brought a different kind of pressure. Clinics were consistently crowded and fast-paced. Patients waited shoulder-to-shoulder, and providers moved quickly from one person to the next. The next patient often stepped forward before the previous interaction had fully ended.

Conversations with doctors and nurses happened in brief gaps between consultations or at the end of long shifts. Providers were generally cooperative, but many were visibly fatigued and pressed for time, sometimes speaking while standing, scanning the waiting area, or apologizing for having to cut the conversation short. Even when people wanted to engage, the system rarely made space for it.

Reflections and Closing Thoughts

This experience reinforced one practical lesson : flexibility is not a helpful add-on in field research, it is the work. Future studies in similar settings should plan for shorter interview windows, repeated engagement, and schedules that respect the realities of participants' and providers' lives.

At the same time, adaptability does not erase inequity. Some people will always be harder to reach, not because they do not matter, but because their lives leave them less room to pause. If we want research to represent diverse urban realities, we have to design it around the people who have the least time, the least privacy, and the most to lose by speaking.

Data Desk

Behind the Numbers:

Verifying Immunization Coverage in the Rohingya Camps

Written by: **Ibrahim Hasan**

Some vaccination cards were crisp and complete, the kind you can read in seconds. Others arrived as blurred photos taken in low light, with smudged ink and handwritten dates that could be read two different ways. I spent a lot of time zooming in until the text almost broke apart, asking the same question again and again: does this record match a real child, a real date, and a dose given in the right window?

When I joined ARK Foundation in October 2025, I entered the final phase of a large immunization survey in the Rohingya camps. The question behind the work was simple, but it carried weight: are immunization services reaching every eligible child, reliably and fairly? In a setting where families have already faced repeated disruption, routine services are not truly “routine.” Records go missing, cards get damaged, names are spelled differently across documents, and one unclear digit can change the meaning of an entire vaccination history.

Across the camps, this work felt like a stress test of the system. We were not only trying to understand whether children had received vaccines, but whether they received them on schedule, in a way that provides full protection. The survey focused on three groups: mothers who had given birth in the past year, and young children in early toddlerhood. For mothers, we looked at protection through tetanus vaccination during pregnancy. For children, we reviewed the routine set of childhood vaccines that prevent serious infections, including illnesses like tuberculosis and measles that can spread quickly in crowded environments.

My role was data verification, the part of the process that decides whether analysis rests on solid ground or on assumptions. Most of my days were spent inside a master dataset covering tens of thousands of households. I checked identities, confirmed birth dates from vaccination cards, and compared recorded doses against timing rules. It was repetitive work, but it was not mechanical. Every day brought small decisions with big consequences.

One lesson became unavoidable: a dose written on a card is not always the same as a dose that counts. If a vaccine is recorded but given too early, or too close to a previous dose, the child may not receive the intended protection. That is why we treated “coverage” as more than a tally. We treated it as a question of timing, sequence, and completeness. Verification was slow because it had to be. When two entries looked like the same child with slightly different spellings, we traced them carefully so we did not double-count without erasing anyone. When a birth date did not align with the vaccination timeline, we returned to the card image and checked again, sometimes discovering that a single unclear month had shifted a dose from “on time” to “too early.” These were small details on a screen, but they shaped what the data could honestly say.

When the findings came together, the story was mixed. Many families had records, and early contact with immunization services appeared strong. But the closer we looked, the more we saw patterns that simple totals can hide: doses recorded outside recommended timing windows, children starting the schedule but not completing later doses, and pockets where performance was consistently weaker than surrounding areas. We also noticed reports of injection-site problems that need follow-up to understand causes and prevent recurrence. None of this is visible if you only ask, “Was a dose given?” It becomes visible when you ask, “Was it given correctly, and is every area being reached?”

A major part of our work was checking whether the data held together across different parts of the camps, not only overall. We worked through duplicates, missing information, and location inconsistencies, and we rechecked records when documentation was unclear. When servers lagged or images were difficult to interpret, the work did not stop. It simply slowed down and became more careful. We held ourselves to a “zero tolerance for error” standard because one wrong assumption can misdirect follow-up away from children who missed doses and communities that need support most.

This project reshaped how I think about impact. Behind every row of data is a family’s attempt to protect a child, and behind every inconsistency is a risk of being missed by the system. Real insight is not only counting vaccines. It is checking whether they were given on time, delivered safely, and reaching families fairly.

Accuracy does not live in the spreadsheet. It shows up later, in who gets followed up, where resources go, and whether gaps are fixed before they harm the children the system is meant to protect.

Closing the Gap:

How Urban Primary Health Care Can Achieve Health Equity

Bangladesh is urbanizing rapidly. More people are living in cities every year, and that growth increases demand for services of every kind, including health care. City corporations and municipalities are expected to deliver public services in urban areas, but they face real limits in staffing, funding, space, coordination, and service coverage. Meanwhile, rural health care has a more clearly defined structure and network through the Ministry of Health and Family Welfare. Urban primary health care, on the other hand, has long been shaped by split mandates and mixed delivery models. The result is a gap that people feel every day: between urban and rural services, and within cities themselves, where the rich can pay and the poor often cannot.

This is what health inequity looks like in practice. The urban poor are more exposed to risk and have fewer safe options when illness hits. Crowded living conditions, weak sanitation and drainage, limited access to clean water, and unsafe working environments can increase vulnerability to disease. At the same time, non-communicable diseases (NCDs) are rising across all income groups, including low-income urban households. NCDs do not behave like a short fever or a one-time infection. They demand screening, counselling, regular follow-up, and referral when complications appear. Yet many urban facilities and affordable clinics are still not set up to deliver that kind of steady, long-term care at scale.

Health equity means everyone has a fair chance to stay healthy and access care without being pushed into financial trouble. In urban areas, inequity often hides in plain sight. Resources are unevenly distributed. People face long waiting times, travel farther than they should for basic services, and struggle with out-of-pocket costs. Skilled providers may be limited where need is highest. Private facilities may be nearby, but they are priced out of reach for many households. When the only "available" care is unaffordable, access becomes a word on paper, not a reality.

Primary health care is the foundation of a functioning health system. When primary care is strong, it reaches people early, helps prevent illness, treats common conditions, manages chronic diseases, and connects patients to higher-level services when needed. Urban primary health care can narrow the equity gap, but only if it is designed around how people actually live and work in cities.

What strengthening urban primary health care should focus on

1) Make primary care reachable in daily life: Equity starts with access that fits real schedules. Urban primary health care centres need to be placed where underserved communities can reach them without spending half a day on transport and waiting. Location matters, but so do operating hours. Many urban residents work long shifts or depend on daily wages. If services are open only during standard office hours, people are forced to choose between income and care. Extending hours into early mornings, evenings, or select weekends can make care possible for those who cannot afford to miss work.

Reachability is not only about a building. Outreach matters, too. Community-based health workers, local partnerships, and clear information on where to go and what services are available can reduce confusion and delay. For families living in informal settlements, the "right" clinic can be hard to identify, and navigating the system can be exhausting. A simple, reliable pathway to care is part of equity.

2) Make urban primary care capable of managing NCDs and long-term needs: Cities are dealing with rising NCD risk, and primary care is where prevention and early management should live. Urban primary health care centres can offer practical services that reduce suffering and lower long-term costs: basic screening, early detection, counselling that matches people's living conditions, routine follow-up, and referral pathways that actually work.

This is also where continuity becomes a make-or-break issue. A one-time visit does not manage hypertension or diabetes. Patients need follow-up, reminders, and a record of what happened last time. Technology does not have to be complicated for this to work. Even simple digital registers or basic apps can help track visits, document test results, support referral, and follow up with patients. A small improvement in record-keeping can prevent missed follow-ups and repeated "starting over" at every visit. That is a real equity gain, since the people least able to return again and again are often the ones who need continuity the most.

3) Make services reliable and affordable by fixing the basics behind the counter: Many urban primary care facilities struggle with shortages: staff, equipment, diagnostics, medicines, and supplies. When basics are missing, patients are pushed into private markets or informal options, which increases out-of-pocket spending and deepens inequity.

This is where strategic purchasing matters, but it needs plain language. It means buying the right medicines and supplies, from reliable sources, based on what communities actually need, so stock-outs drop and patients are not forced to pay extra outside the facility. It also means planning procurement and service delivery so limited funds are spent on what protects people most, rather than on ad hoc fixes.

Affordability is not only about drug prices. It is about preventing the chain reaction that happens when services fail: repeated travel, repeated tests, time away from work, and partial treatment because money ran out. When a primary care centre is reliable, the "hidden costs" of seeking care shrink.

Urban health equity also depends on what sits outside the clinic. Clean water, safe housing, drainage, waste management, transport, and green space shape exposure and well-being. Health cannot be separated from urban development. Better coordination between local government and health providers can reduce the conditions that keep people sick and make clinics overflow.

Finally, urban Bangladesh needs more equity-focused research that reflects the lived reality of city communities, especially those in informal settlements. Without evidence on who is being left out and why, planning will keep missing the same groups. Equity-focused research can identify gaps, explain the drivers behind them, and support targeted policy recommendations that match local contexts.

A goal that is within reach

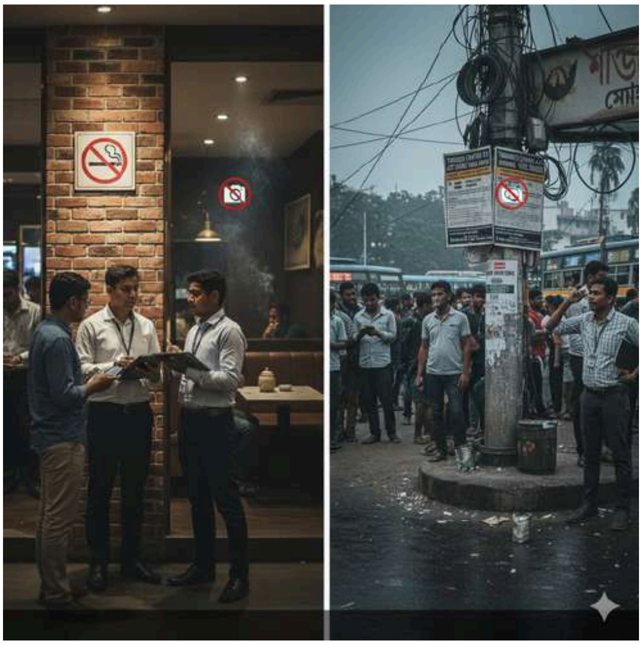
Health equity in urban Bangladesh is achievable, but it requires treating urban primary health care as the core of urban health systems, not an afterthought. Stronger access, stronger NCD-focused primary care, and more reliable and affordable services can shift what people experience when they seek help.

A city can build high-end hospitals and still leave millions without basic care. Urban health equity will not be won in the most expensive facilities. It will be won when primary care becomes reachable, trustworthy, and continuous for the people who keep the city running.

Written by: **Marhouba Khan Asfi**

Field Reality:

What We Learned While Assessing Smoke-Free Public Places



In some restaurants, the “No Smoking” sign was there, neatly placed on a wall. The smell told a different story. In transport hubs, the rules were visible on paper, but the pace and crowd made enforcement feel like an afterthought. That gap, between what the law says and what people breathe, is what our fieldwork set out to understand. Secondhand smoke (SHS) is the smoke inhaled by people who are not actively smoking, a mix of smoke from burning tobacco and smoke exhaled by smokers. It is involuntary exposure, and it is harmful. Globally, secondhand smoke contributes to serious heart and lung diseases and is linked to around 1.6 million premature deaths each year(World Health Organization, 2025). In Bangladesh, evidence suggests the burden is also substantial: one study estimated roughly 25,000 deaths annually due to SHS exposure, with major productivity losses from premature mortality (Faruque GM et al., 2020).

one study estimated roughly 25,000 deaths annually due to SHS exposure

Against this backdrop, ARK Foundation is implementing the Tobacco Free Cities implementation research project in Dhaka North City Corporation (DNCC) and Narsingdi Sadar Municipality, with support from the University of York and funding from the Global Alliance for Chronic Disease (GACD). The purpose is practical: to understand what makes enforcement difficult, and what contextual barriers shape compliance with the Tobacco Control Act in everyday public settings, particularly restaurants and transport hubs.

Where we worked, and what we looked for

To reflect different urban realities, we conducted observations in Banani, Mirpur, and Narsingdi.

Banani represented an upscale, highly commercial area with a dense restaurant environment. Mirpur represented a mixed-income setting within a growing entertainment and commercial zone. Narsingdi provided a semi-urban comparison.

In each area, we observed restaurants (at least one hour) and transport hubs (at least three hours). We focused on a few clear indicators that any visitor would notice: whether "No Smoking" signs were present and visible, whether active smoking was observed, and whether there were clear signs of smoke exposure such as ashtrays, cigarette butts, or a persistent smell.

What the field made clear

The biggest lesson was that collecting reliable evidence in real public spaces is rarely straightforward. In restaurants, long observation periods were sometimes disrupted by peak-hour crowds and staff expectations that observers should place orders or explain their presence repeatedly. In more sensitive settings, such as shisha venues and bars, access and documentation were complicated by security and operating restrictions.

Across both restaurants and transport hubs, ethical and privacy considerations also limited photography. Even when active smoking was visible, capturing images inside premises was often not appropriate. This meant our documentation relied heavily on careful observation, structured note-taking, and consistency across data collectors.

Talking to people: the survey reality

After observations, we conducted brief interviews with restaurant restaurant owners, managers, staff, and customers to understand what they knew about the law, how they viewed it, and what they practiced in daily operations. Since each interview took 15–20 minutes, participation was not always easy. Owners and staff were often unavailable during busy hours, while customers cited time constraints, leading to refusals or incomplete interviews. Some restaurants had irregular operating hours, requiring repeated schedule adjustments.

One moment captured the "field reality" perfectly. During a visit to a restaurant near a college at around 5:00 PM, an interview with the manager was interrupted by a sudden rush of students after classes ended. The manager was the only staff member and had to switch immediately to serving customers. We could not shift to interviewing customers either, because most were uniformed students under 18 and ineligible under our ethics protocol. We returned after 9:30 PM, once the rush had passed, to complete the interview.

Why this matters

These observations are not just background details. They show how compliance is shaped by crowd dynamics, business pressures, venue type, and what is realistically enforceable in public spaces. In the field, smoke-free policy is not a
checkbox. It is a series of small decisions, made in busy places, that determine whether people are protected or exposed.

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Written by: **Lenik Chakma**

Methods in Motion

Where Antibiotics Enter the City:

what we are learning with drug sellers in Mirpur

Late afternoon in Mirpur, the pharmacy counter is busy. Someone wants "something strong" for a cough that has not gone away. Another person asks for an antibiotic by name, confidently, like it's a household staple. The drug seller has seconds to respond. Refuse, and risk losing the customer to the next shop. Provide it, and quietly add to a problem Bangladesh is already fighting: antimicrobial resistance (AMR).

In urban Bangladesh, pharmacies are often the most accessible health touchpoint. Drug sellers, both licensed and unlicensed, are the people who translate illness into medicine, advice, and reassurance. That influence makes them central to AMR, whether we treat them as part of the solution or pretend they are not part of the system.

With support from the CHORUS Innovation Fund (Round 2), ARK Foundation is implementing a study on drug sellers and AMR in urban health settings of Bangladesh, with technical support from the University of Leeds and financial support from the UK Foreign, Commonwealth & Development Office (FCDO). The goal is practical: understand how formal and informal drug sellers dispense antibiotics in the city, what pressures shape those decisions, and what realistic pathways exist to strengthen knowledge and practice in ways that reduce inappropriate antibiotic use.

Starting with the ground reality: mapping 1,100 pharmacies

Before asking drug sellers about antibiotics, we needed to understand the landscape they work in.

ARK researchers were trained and conducted a pharmacy mapping exercise across 15 wards of Mirpur, covering 1,100 pharmacies between 28 March 2024 and 4 April 2024. What emerged was a clear snapshot of a mixed marketplace: 551 pharmacies (50%) were licensed under the Directorate General of Drug Administration (DGDA), while 549 (50%) were operating without a license.

That 50/50 split is not just a statistic. It is a reminder that "the system" is not one neat, fully regulated structure. Antibiotics move through both formal and informal channels, and any serious AMR response in cities must take that reality seriously. If half the pharmacy network sits outside formal licensing, then efforts that focus only on licensed outlets will miss a large part of where antibiotic decisions happen.

The trust question: why a DGDA letter mattered

During mapping, many drug sellers were open to conversation but cautious about participation in later activities. A recurring message was simple: if the regulator supports the work, participation feels safer.

In response, ARK engaged with relevant personnel in DGDA's AMR cell through several meetings, shared the study objectives and planned activities, and ultimately received a DGDA letter of support to facilitate implementation. On paper, it is a short document. In practice, it helped remove a barrier that was shaping willingness to engage. It also signaled something broader: that addressing antibiotic dispensing practices requires not only evidence, but relationships and institutional alignment.

Listening at scale: a survey with 400 drug sellers

With the mapping list as a sampling frame, a structured survey was conducted between September and October 2024 among 400 drug sellers, randomly selected from the mapped pharmacies. The survey explored drug sellers' knowledge, attitudes, and day-to-day practices related to antibiotic dispensing, as well as their interest in training.

In a magazine piece, it is tempting to jump straight to results. But this work is not just about "what people know." It is about the conditions that shape what people do: customer expectations, competition between shops, informal norms, and the risks drug sellers perceive when they say no. Capturing that reality requires both numbers and context.

Seeing the wider system: interviews with key stakeholders

To understand the broader environment drug sellers operate within, ARK conducted four in-depth interviews with potential stakeholders, including representatives from DGDA, CDC, and senior public health leaders with experience in antimicrobial and AMR-related work.

These conversations focused on gaps and opportunities for strengthening drug seller capacity, the practical constraints that influence dispensing behavior, and the economic and contextual incentives that can drive inappropriate antibiotic sales. The point was not to assign blame. It was to understand how policy, enforcement, market dynamics, and public expectations intersect at the pharmacy counter.

Turning experience into story: participatory videos with drug sellers

Data matters. Stories do too, especially when the aim is to shift understanding, build empathy, and open space for change.

As part of the CHORUS Innovation Fund work, ARK organized a five-day participatory video development workshop from 18-22 May 2025 at the DISA Training Center in Mirpur, Dhaka. Drug sellers from nine pharmacies participated in interactive sessions facilitated by ARK researchers and a digital media specialist.

The workshop was designed to surface real pressures and decision points: why antibiotics get requested, why they get dispensed, what rules feel unclear or impractical, and what trade-offs drug sellers feel forced to make. Through guided storytelling and role-play, participants translated lived experience into scripts that reflected the realities of antibiotic dispensing in an urban setting.

From this process, two scripts were drafted. After review and revision with local and international experts, both scripts were finalized. Filming then took place with the participation of drug sellers at their own pharmacy sites in two areas of Mirpur. Following editing, two participatory videos were produced.

Bringing people into the room: showcasing and feedback

The videos were not created to sit on a hard drive. A showcasing event was held with drug sellers, community representatives, and DGDA officials to screen the videos and gather feedback on quality and content. That feedback is being incorporated, and the videos will be finalized after revisions.

Alongside the showcasing, group discussions were conducted with participating drug sellers to document their reflections on the workshop and filming process, including what felt useful, what was challenging, and how they experienced telling their own stories in a structured, public-facing format.

What this is building toward

AMR is often discussed as a technical crisis. At the pharmacy counter, it looks like something else: a negotiation between health needs, customer demands, business survival, and uneven regulation.

This study is assembling multiple forms of evidence, from mapping and surveys to stakeholder perspectives and participatory videos, to support a more realistic response to antibiotic misuse in urban Bangladesh. The intention is two-fold: strengthen drug seller capacity in ways that fit their working realities, and support dialogue with regulators and other stakeholders on what is feasible, fair, and effective.

Over time, the evidence and materials generated through this work are expected to help shape training approaches, sensitization efforts, and collaborative discussions that recognize drug sellers not as outsiders, but as a group with influence, constraints, and potential to contribute to healthier antibiotic use in the city.

Written by: **Asiful Haider Chowdhury**

Equity Lens

When Public Spaces Aren’t Truly Public:

Making Physical Activity Safer for Women and Girls in Urban Bangladesh

A park can be five minutes away and still feel unreachable. For many women and adolescent girls in urban Bangladesh, the barrier is not a lack of interest in being active. It is what surrounds the activity itself: the walk to the space, the fear of harassment, the absence of privacy, poor lighting, and the sense that a public space is not really meant for them. When those conditions exist, physical activity becomes one more thing that requires negotiation and compromise.

This matters for health, not only recreation. Regular physical activity reduces the risk of non-communicable diseases (NCDs), supports mental wellbeing, and improves quality of life. When women and girls cannot safely use public spaces, their options shrink. Activity becomes limited to what can be done indoors or within tightly controlled routines, rather than sustained, enjoyable movement in open environments.

Recognising these challenges, the Community-Led Responsive and Effective Urban Health Systems (CHORUS) programme supported an Innovation Fund project to better understand the condition and usability of physical activity spaces and to co-design a practical community tool that can support improved planning and local advocacy.

The study focused on three questions:

What spaces are available, and what condition are they in?
We assessed physical activity facilities and public spaces in two urban settings: Dhaka North City Corporation (DNCC) and Khulna City Corporation (KCC).

Who can use these spaces, and what makes them feel safe or unsafe?
We explored how women, adolescent girls, and other marginalised groups experience these spaces, focusing on safety, accessibility, comfort, and usability.

What can communities use to advocate for better spaces?
We co-designed a participatory Citizen Scorecard to help communities assess spaces and engage decision-makers on what needs to change.

How we did it
We used a Participatory Learning and Action (PLA) approach. In practice, this meant working directly with urban residents to map physical activity spaces, discuss lived experiences of using (or avoiding) those spaces, and assess facilities using structured observation checklists. Community members contributed throughout, including adolescents, older women, caregivers, and persons with disabilities.
This approach helped compare what is "available" on paper with what is actually usable in daily life, and it allowed different groups to describe the same space from their own realities.

When space exists but access doesn't
A consistent message from community discussions was that many spaces that "exist" do not feel usable for women and girls. Sometimes the barrier was physical. Sometimes it was social. Often, it was both.

Across discussions and observations, participants described practical barriers that kept spaces out of reach:

- Basic amenities were missing or unusable. In some locations, toilets were absent or not functional, which made longer stays unrealistic for women, adolescent girls, older adults, and caregivers.
- Lighting shaped when spaces felt possible. Several participants described evenings as effectively off-limits, not because the space disappeared, but because poor lighting increased discomfort and fear.
- Harassment and being watched changed behaviour. Some women and girls described feeling "observed" or questioned in public spaces, even when no one directly approached them, which discouraged regular use.
- Maintenance affected trust. Poor upkeep, broken features, and visible neglect made some spaces feel unsafe or simply not worth the effort to use.
- Accessibility was uneven. Participants noted that entrances, paths, or layouts could make spaces difficult for persons with disabilities and caregivers with

children, limiting who could benefit.

Together, these realities point to a simple truth: access is not only about the presence of infrastructure. It is about whether women and girls can use that infrastructure without fear, discomfort, or social consequences.

What we built together: the Citizen Scorecard

One of the main outputs of this work was the co-design of a Citizen Scorecard, a simple community tool to assess how inclusive a physical activity space is and to support local advocacy for improvements.

The scorecard was developed through participatory sessions where community groups discussed their experiences, ranked what mattered most, and then agreed on simple, observable criteria that could be scored consistently. The goal was to translate lived experience into a structured format that supports accountability and action.

The scorecard enables residents to review a space, score key features, document concerns, and identify priorities for change. It also creates a shared, practical basis for discussion with local authorities and other stakeholders.

The scorecard focuses on areas that communities identified as most relevant for women and girls, such as:

- Safety (visibility, perceived security, and harassment risk)
- Lighting and timing (whether the space feels usable beyond daylight hours)
- Basic amenities (toilets, seating, and drinking water)
- Privacy and comfort (features that reduce discomfort and support sustained use)
- Accessibility (paths, entrances, usability for persons with disabilities and caregivers)
- Maintenance and management (cleanliness, repairs, and clarity on responsibility)

The value of the scorecard is not only the score itself. It is the process of communities naming what “inclusive space” means in practice and using that evidence to support clearer responsibility for change.

Why this is a health equity issue

When women and girls cannot safely use public spaces, the health burden is not shared equally. Over time, fewer opportunities for movement contribute to higher NCD risk and reduced wellbeing. The issue is not only that spaces are limited; access is uneven, shaped by safety, design, and social norms.

Improving public spaces for women and girls is not just an infrastructure upgrade. It is a health equity priority linked to prevention, wellbeing, and whether cities support all residents to live healthier lives.

What happens next

This work points toward a practical path: improve facilities based on what women and girls actually need, and strengthen accountability by using community-led tools like the Citizen Scorecard. With support from local authorities and relevant stakeholders, the tool can help guide more inclusive planning and budgeting, clearer responsibility for

safety and maintenance, and stronger community voice in neighbourhood decisions.
A space that women and girls cannot use safely is public only in name. Creating environments that are safe, usable, and welcoming is one of the simplest steps cities can take toward healthier lives and fairer urban development.

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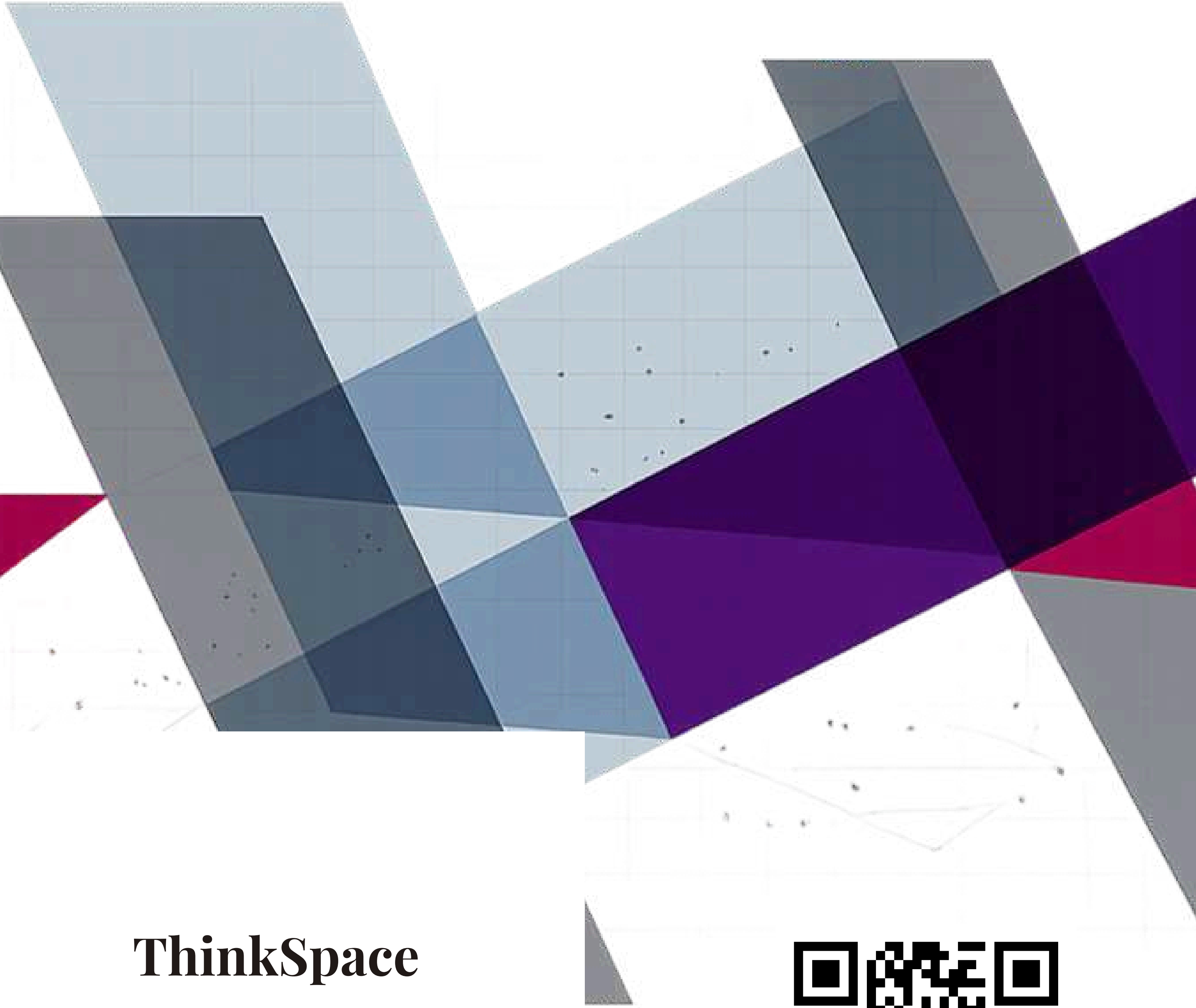
Written by: **Umme Salma Anee**

"The future of public health is already learning, playing, and asking questions"

Health systems, policies, and research often feel abstract. But they all begin here, with children learning, playing, asking questions, and imagining a future they have not yet been warned away from.

What children learn early shapes how they care for themselves, their families, and their communities. When knowledge arrives on time about health, dignity, and possibility, it becomes protection. When it arrives late, it becomes regret.

This magazine is about evidence, systems, and action. But its real audience is the future. If we want healthier cities and fairer systems, we must start by making sure the next generation grows up informed, supported, and able to choose better paths.



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