Climate-Induced Displacement Urban Poverty, and Neglected Primary Healthcare:
Financing Barriers and Policy Pathways For Equity in Bangladesh

1. INTRODUCTION

Climate-induced displacement has rapidly transformed urban demographics in Bangladesh, creating new health challenges in already resource-stressed urban slums. Displaced populations face significant barriers to primary healthcare due to poverty, lack of healthcare infrastructure, and ID-related access issues. Urban migration increases the demand for healthcare services, but existing systems struggle to address the health needs of displaced communities. This study examines the intersection of climate-driven migration with health access inequities, urban poverty, and weaknesses in the public health system.

2. OBJECTIVES

To explore how climate-induced displacement leads to urban poverty, limits access to primary healthcare, and exacerbates health inequities among displaced, low-income communities in urban Bangladesh.

SPECIFIC OBJECTIVES

- To map the pathways of displacement and urban settlement among erosion-affected communities.

- To document healthcare-seeking behavior, unmet health needs, and health risks among displaced slum dwellers.

- To assess the financial and institutional barriers to PHC service access.

- To analyze coping strategies and informal financing mechanisms used by displaced populations.

- To examine gaps in PHC service delivery and propose equitable, sustainable financing

3. METHODOLOGY

Data collection in five districts (Dhaka, Gazipur, Chandpur, Feni, and Noakhali). A total of 300 household surveys, 6 focus group discussions (FGDs), and 10 key informant interviews (KIIs) were conducted. Displaced populations living in informal urban settlements exhibit a diverse range of gender, age, and income characteristics.

CONCEPTUAL FRAMEWORK

The study uses the Health Access & Financial Risk Protection framework, integrating the Sustainable Livelihoods framework to explore how climate-induced displacement exacerbates health risks, financial vulnerabilities, and the need for equitable access to primary healthcare services.

HEALTH ACCESS FRAMEWORK

Identifies barriers (financial, infrastructural, social) preventing access to healthcare and explores the role of informal health systems (NGOs, community clinics).

SUSTAINABLE LIVELIHOODS

Focuses on how displaced populations manage to maintain their livelihood while dealing with healthcare access challenges.

KAP MODELS
(Knowledge, Attitudes, and Practices)

The KAP model was applied to assess community awareness, attitudes, and practices regarding healthcare access:

KNOWLEDGE:
Understanding of available healthcare services (public vs. community-based) and displacement health risks (chronic illnesses, child health).

ATTITUDES:
Trust in government healthcare systems versus preference for NGOs and community clinics.

PRACTICES:
Healthcare utilization patterns, including cost-related barriers and self-reported health practices (e.g., seeking care, preventive measures).

7. CONTACT INFORMATION

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4. RESULTS/MAJOR FINDINGS

The displaced population in urban slums, mainly due to climate disasters, faces long-term challenges, with 65% displaced for 5–10 years. Eighty percent prefer community-based services, while only twenty percent use government healthcare. Displaced populations face significant barriers to primary healthcare. Over 90% spend between 40 to 45 USD/month on healthcare, straining their finances. Approximately 60% of women and 40% of children lack access to antenatal care and vaccinations. To cope, 30% borrow or sell assets, increasing financial vulnerability.
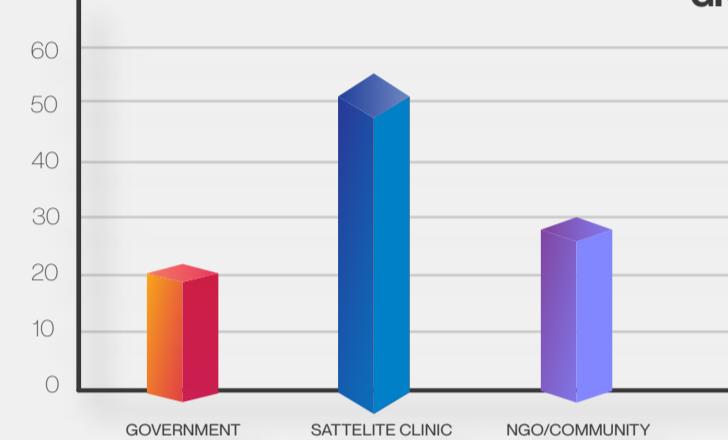

GRAPH 1
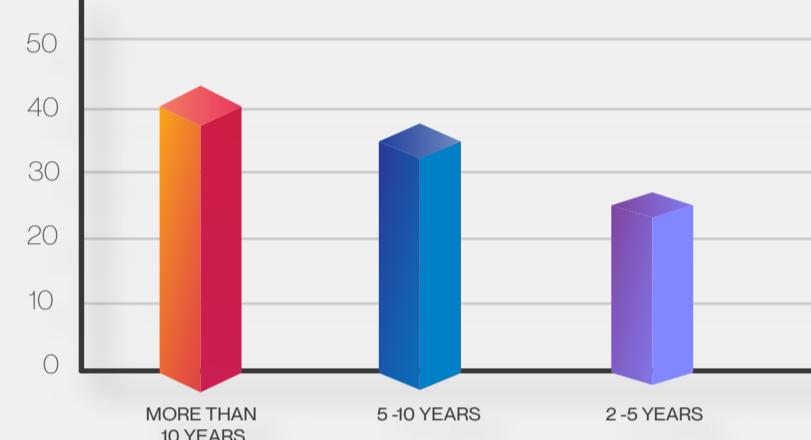
DESCRIPTION OF GRAPH 1:
DISPLACEMENT DURATION BREAKDOWN

This chart will show the duration of displacement experienced by the households in the study. The majority have been displaced for over 5 years, indicating a long-term trend of displacement.
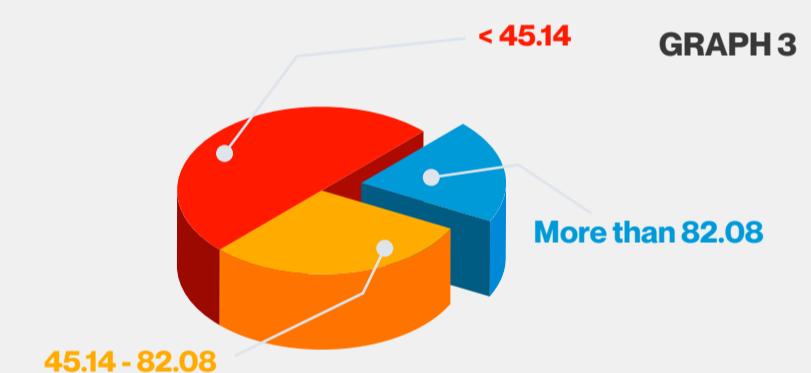

GRAPH 2

DESCRIPTION OF GRAPH 2:
HEALTHCARE SERVICE UTILIZATION DESCRIPTION

This chart will visually represent the preference for community-based healthcare services versus government-run services, highlighting the trust gap in formal healthcare.
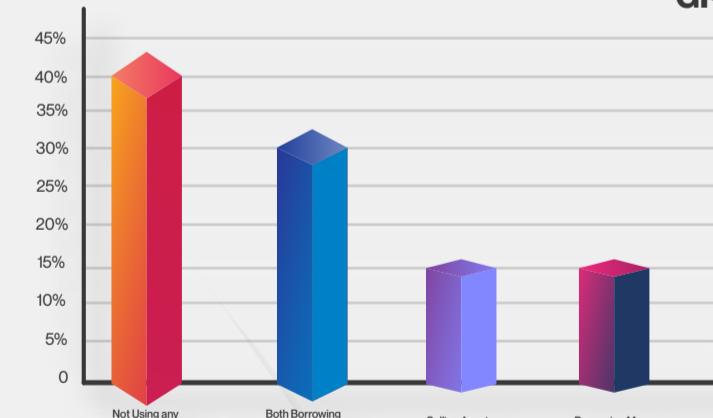

GRAPH 3
< 45.14
More than 82.08
45.14 - 82.08

DESCRIPTION OF GRAPH 3:
MONTHLY HEALTHCARE SPENDING BREAKDOWN (USD/MONTH)

This chart illustrates how displaced families allocate their healthcare budget, highlighting the financial strain they face each month.

GRAPH 4

DESCRIPTION OF GRAPH 4:
BARRIERS TO REPRODUCTIVE & CHILD HEALTH ACCESS

This bar chart illustrates the gender and age-related disparities in accessing essential healthcare services, including antenatal care for women and vaccinations for children.

GRAPH 5

DESCRIPTIONOF GRAPH 5:
COPING STRATEGIES FOR HELALTHCARE EXPANSES

This bar chart illustrates how displaced families cope with healthcare costs by borrowing or selling assets, highlighting the financial vulnerability they face.

5. CONCLUSION

- Health access for climate-displaced populations is a critical issue that goes beyond housing and livelihoods.

- Financing barriers prevent displaced individuals from accessing affordable healthcare services.

- There is a need for policy reform to facilitate portable health entitlements, mobile healthcare solutions, and inclusive financing mechanisms.

- Community-based healthcare models can bridge gaps, especially if they are integrated into the formal health system and supported by government initiatives.

6. POLICY RECOMMENDATION

PORTABLE HEALTH ENTITLEMENTS
Introduce ID-free health coverage for displaced populations, ensuring healthcare access regardless of documentation status.

MOBILE HEALTHCARE UNITS
Deploy mobile PHC units in urban slums to ensure equitable access to care for displaced families.

HEALTH WALLETS / E-VOUCHERS
Integrate digital health wallets or e-vouchers to reduce out-of-pocket expenditures and provide financial protection for displaced communities.

COMMUNITY HEALTH WORKERS (CHW's)
Train women and youth as CHWs to provide local healthcare and increase community trust in services.

URBAN DISPLACEMENT HEALTH REGISTRY
Introduce ID-free health coverage for displaced populations, ensuring healthcare access regardless of documentation status.

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