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An epidemic that shouldn't have occurred

Wrong decisions and negligence are to blame for the ongoing crisis

As of August 12, 2026, at least 885 deaths, mostly of children, from measles or measles-like symptoms have been reported in the country. This is a tragedy that is unacceptable because it was avoidable. Measles was largely eradicated in Bangladesh, thanks to the country's successful immunisation campaigns that earned praise worldwide. So why have we lost so many children to this disease this year, with new deaths being reported almost every day? A *Prothom Alo* investigation has found that negligence from several quarters at the policymaking level—from health ministry, DGHS and Expanded Programme on Immunization (EPI) to WHO and Unicef—led to major gaps in immunisation, resulting in this frightening epidemic.

The *Prothom Alo* report identified five factors leading up to the 2026 death toll. The first is a seven-month gap in measles inoculation because of repeated postponements in 2025. In the years after the last campaign in 2020, typhoid vaccination was prioritised, pushing back the vaccination for measles. It is estimated that around 92 percent of the children who died were not vaccinated for measles. Second, between 2023 and 2025, procurement of measles-rubella dropped by around 42 percent. Third, neither domestic nor international organisations raised the alarm about the increasing number of children staying unvaccinated, the shortage of vaccines, and the high incidence of infections.

The interim government has been largely blamed for the crisis as it abruptly changed the procurement policy, resulting in a deadly delay in getting the vaccines. Frequent strikes of health workers in 2025 disrupted the regular vaccine programmes and delayed the campaign as well. When the vaccines were finally provided in April 2026, a huge number of children had not been reached. Health experts said if the vaccination campaign had started at least six months earlier, the disease would either have not occurred at all or been so widespread.

In the coming days, the government, through the relevant agencies, must identify all the gaps in immunisation. Inoculation against certain diseases can never be put on hold. The health ministry and the DGHS must ensure that immunisation campaigns take place within the time period specified and that the coverage is wide enough to ensure immunity. Campaigns must reach areas that have been left out in the past. Vaccination must be prioritised after consultation with health experts. The government must make sure that the EPI provides accurate information regarding outbreaks of major diseases as well as vaccine shortages so that adequate quantities of vaccines are procured without delay. International organisations, too, must own up to their role in this tragedy—for not raising the alarm and not prioritising the need for timely measles vaccination.

Time to scale up rooftop solar

Govt must remove barriers to unlock its vast potential

While we often talk about expanding renewable energy, a new assessment by the Infrastructure Development Company Limited (Idcol) shows just how much potential we are leaving untapped. Reportedly, the country could generate more than 3,600 megawatts peak (MWp) of electricity from rooftop solar panels, but harnessing this potential would require an investment of Tk 16,295 crore. Given our growing energy insecurity, particularly as the entire country grapples with severe load shedding, the potential of solar power can no longer be ignored.

According to Idcol, the textile and garment industry alone could generate 2,815MWp from rooftop solar, given that Tk 12,669 crore is invested. Some companies have already benefited from rooftop solar. Ha-Meem Group has installed 17MWp across three factories, reducing diesel use by nearly 60 percent, while Walton Hi-Tech Industries has installed 33.8MWp and plans to expand it to 50MWp. Clearly, rooftop solar can reduce businesses' energy costs, strengthen energy security and cut carbon emissions. So, why is the sector still struggling to expand at the required pace?

We once had one of the world's largest off-grid solar programmes, but nearly half of the 60 lakh solar home systems installed in the past are now reportedly non-functional, according to a CPD survey. We therefore need a proper long-term strategy to expand solar energy. We can learn from Pakistan, which has seen a remarkable expansion of distributed solar, with an estimated 28-38 gigawatts deployed, mostly through rooftop and behind-the-meter systems. Meanwhile, Bangladesh currently has only 4,551 net-metered rooftop solar installations with a combined capacity of 213.3MW, per the CPD study. Financing constraints, high taxes on solar equipment, regulatory bottlenecks and institutional fragmentation continue to discourage investment. Some manufacturers have also complained about lengthy financing procedures and the need to make large upfront investments before reimbursement. These hurdles must be addressed if the government is serious about accelerating the transition to clean energy.

While it is encouraging that Idcol plans to increase its annual financed capacity from 129MWp this year to around 233MWp by 2029-30, the scale of the country's potential calls for greater ambition. To this end, banks and non-bank financial institutions should be encouraged to expand their rooftop solar portfolios. Besides, operational expenditure (OPEX) models can help smaller businesses overcome the barrier of high upfront costs. The government must also ensure that net metering, taxation, financing and grid integration policies work together. Rooftop solar can reduce pressure on the national grid, lower reliance on imported fossil fuels, strengthen energy security, and help the country meet its climate commitments.

A new chance to fix urban primary healthcare



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More than 40 percent Bangladeshis live in urban areas, 35 percent of whom reside in slums, according to the Bangladesh Bureau of Statistics' 2022 census. But urban primary healthcare services are still delivered by a fragmented mix of providers: the health ministry operates urban dispensaries and hospital outpatient departments, city corporations run some facilities, and NGOs manage contracted and donor-supported clinics. Private chambers, diagnostic centres, pharmacies, and informal providers deliver much of the first-contact care. Rapid urbanisation has created a larger, increasingly mobile and diverse population. The rise of non-communicable diseases (NCDs) is also creating the demand for continuous care that the existing urban primary healthcare system is not designed to provide.

The 2021 Urban Health Survey by the National Institute of Population Research and Training found that in city corporation slums, neonatal mortality reached 27 deaths per 1,000 live births in 2016-2021, while around 33 percent of under-five children were stunted, 16 percent wasted, and 28 percent were underweight. Only 53 percent of newborns in slums received a check-up from a medically trained provider within two days of birth. So, despite the concentration of health facilities in cities, access to comprehensive primary healthcare remains highly unequal.

In May, the government said 192 urban primary healthcare facilities were being transferred from the Local Government Division to the Directorate General of Health Services (DGHS). Earlier in April, the DGHS decided to set up 170 urban primary health and nutrition centres in Dhaka North, Dhaka South, and Chattogram city corporations, at a cost of Tk 1,157 crore. In July, the health minister said the government was considering an expansion of the Aalo Clinic model, given its success in providing healthcare to disadvantaged urban populations, and would apply its lessons to the 192 facilities mentioned above.

These initiatives could help address the fragmented delivery of urban primary healthcare. But in order to create an integrated and sustainable health system, more needs to be done. The National Urban Health Strategy 2020 identified the major problems plaguing urban healthcare: weak coordination between the health and local government ministries, inadequate public primary healthcare capacity, limited attention to slum residents and floating populations, absence of separate city health budgets, weak regulation of NGO and private providers, fragmented information and referral systems, and insufficient services for NCDs.

The lack of an accountable network connecting various urban healthcare providers must be addressed. Projects such as Surjer Hashi and Aalo Clinic helped fill this gap to some extent, particularly for maternal, newborn, child and reproductive health. But they remain geographically selective and project-dependent. There's the issue of finance, too. The ADB-supported model has relied largely on development financing. City corporations were expected to contribute around one percent of their revenues, but contributions were irregular and most did not establish fixed primary healthcare budget lines.



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This weakness became evident after June 2025, when an interim arrangement for some clinics split operating costs among NGOs, the Local Government Division, and city corporations. The DNCC has since introduced a dedicated health budget and resources for primary healthcare, but such arrangements remain exceptional rather than part of a predictable national financing framework. Besides, salaries, medicines, diagnostics, utilities, maintenance, and outreach require reliable recurrent expenditure. Requiring NGOs to generate a large share of operating costs through user charges also creates an equity problem: facilities intended for poorer populations become increasingly dependent on the patients' ability to pay. City corporations and municipalities have long lacked separate health budgets and have limited capacity to mobilise resources.

Urban primary healthcare also needs to expand its service scope to include diagnosis and treatment of hypertension, diabetes and other NCDs, which are steadily on the rise. At present, these patients often move among pharmacies, private chambers, diagnostic centres, NGO clinics, and hospitals.

Whereas rural healthcare has a defined community-based platform (combining facility work with household outreach) urban healthcare does not. Vaccinators and EPI personnel provide important services, while NGOs deploy outreach workers in selected areas, but these arrangements remain uneven. This gap is particularly important for NCDs and mobile populations: screening for hypertension does little if patients cannot be followed to ensure treatment initiation, medicine adherence, and completed referrals.

The DGHS needs to establish clinical standards for the essential service package, using satellite and mobile clinics for slum, working and floating populations, and developing a structured referral system and health information for urban primary healthcare. City corporations may retain responsibility to map all facilities in urban areas, assign facilities to defined catchment populations, and ensure community engagement, environmental health, and local accountability. It is also crucial to standardise and display NGO and private healthcare providers' fees, bringing non-government providers into the DGHS information system. The government can consider transferring physician and nurse posts from city corporation facilities to the DGHS and the Directorate General of Nursing and Midwifery (DGNM), considering the ongoing institutional transition.

The transfer of 192 centres to the DGHS may improve coordination, but it is important to ensure that these clinics function. Clinic operators need a clear, costed operational directive from the DGHS covering staffing, salaries, medicines, utilities, existing NGO personnel, and protection of services for poor patients. The DGHS project provides part of the answer. The 170 urban health centres are supposed to operate in two shifts through a hub-and-spoke model, with additional human resources, at least 80 percent availability of essential medicines, and full integration into the digital health information system. However, the new project covers three city corporations while the 192 transferred facilities span 12 city corporations and 23 municipalities. Moreover, the project is scheduled to end in June 2028. Development financing for three cities cannot substitute for a recurrent financing architecture for the nationwide urban primary healthcare system. The project should therefore also be used to design institutional, financing, and workforce arrangements.

The DGHS needs a recurrent allocation for clinical operations, while city corporations need protected health budgets. A financing plan to sustain services should be finalised. Urban primary healthcare also needs a community health workforce assigned to defined catchments, covering immunisation, health promotion, maternal and child health, NCD follow-up, climate-related illness, referrals, and outreach to migrants and floating populations. All facilities and contracted providers should be brought under a single referral, financing, and information architecture. The success of reform initiatives will be measured by whether mandate, money, and accountability finally follow all of the urban population.

How traditional credit ratings fail CMSMEs



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A retail store owner in any part of the country processes dozens of bKash or Nagad transactions an hour, pays suppliers every week by digital transfer, and never misses a utility bill. Yet when this merchant asks a commercial bank for a Tk 5 lakh loan to expand inventory, he is almost always politely refused.

The Cottage, Micro, Small, and Medium Enterprise (CMSME) sector accounts for nearly a quarter of Bangladesh's GDP and an estimated 87 percent of the active labour force. Bangladesh Bank (BB) last year set a target of 27 percent of total loan portfolios for CMSMEs by 2029. But despite circulars, refinancing schemes, and low-interest quotas, the financing gap persists—estimated by the International Finance Corporation (IFC) to be $2.8 billion. At the heart of this disconnect sits a credit rating framework that has been built to evaluate a factory, not a shop on the side of a footpath.

Credit risk evaluation in Bangladesh leans on two mechanisms: the central bank's Internal Credit Risk Rating (ICRR) framework and evaluations by external agencies under Basel III guidelines. Under the ICRR, 60 percent of a borrower's score is built on quantitative financial data: audited balance sheets, profit-and-loss statements, tax receipts, formal leverage ratios. The central bank exempts the smallest borrowers—including micro-credit and small enterprises below Tk 50 lakh—from ICRR. Even so, as per BB's March 2025 master circular, which formally recognised informal enterprises for the first time, cottage and micro borrowers need to present a Credit Information Bureau (CIB) report and collateral proof before a loan is cleared.

For a mid-sized manufacturing plant, these requirements make sense, but for a cottage or micro entrepreneur, they become a wall. An estimated 80 percent of CMSMEs operate informally, which typically means they do not work with a professional accountant and do not produce an audited statement. When given an informal ledger from such a business, the rating system only sees an entity it is unable to rate.

Of course, collateral is not even the first hurdle for the smallest borrowers. Bangladesh Bank's master circular requires banks to lend up to Tk 5 lakh collateral-free to every CMSME borrower, and up to Tk 25 lakh and beyond for specific cases, especially for women entrepreneurs. But collateral-free never means paperwork-free. Banks still need to see a business's trade license, sales history, and CIB report, and once a loan grows bigger, collateral requirements stack up as well.

Bank officials themselves admit the problem. Regulations already permit assets other than land as collateral, but lending practice has yet to catch up, particularly in manufacturing. A micro-merchant's wealth sits in inventory, receivables, and daily cash flow. But the value of these only counts once documented, and an informal ledger does not produce such documentation.

These merchants do leave a continuous, verifiable digital footprint in the form of payments through Bangla QR, invoices settled by mobile financial services (MFS), and utility bills paid on time. Because Bangla QR, recently made mandatory, is interoperable across banks and wallets, this data is technically poolable in a way it never was before. A business clearing Tk 15,000 a day in MFS transactions shows real liquidity and steady demand, a meaningful signal, though it speaks more to cash flow than to margin or true debt-service capacity, which any scoring model would still need to estimate rather than read off transaction volume. Traditional credit ratings offer a static snapshot of the past; digital transaction data, imperfect as it is, comes closer to real time.

Handing lending decisions to algorithmic models built on MFS and merchant data raises questions. Who audits the models for bias? What happens to a borrower's transaction history if a fintech platform folds or is breached? How does BB supervise scoring systems it does not build itself? These need to be resolved up front, rather than being an afterthought once a model goes live.

Two policy moves could help close this gap. First, BB should open a regulatory sandbox for Alternative Credit Scoring (ACS), letting fintech platforms and commercial banks jointly build scoring models based on MFS transaction volumes, utility payments, and digital merchant records, with oversight and data protection rules built in. Paired with this, the Credit Guarantee Scheme (CGS) should be wired directly into validated digital scores. Branch managers hesitate to extend uncollateralised loans because a non-performing loan reflects on their own career record. In contrast, a CGS backing loans cleared through audited digital scoring gives them cover to lend.

The central bank has already pointed towards part of the answer. Its March 2025 master circular created a new informal-enterprise category built around the Digital Business Identification (DBID) and Personal Retail Account (PRA) systems, capped at Tk 5 lakh in credit. What's needed now is the follow-through. Banks remain reluctant to accept a DBID or UBID registration in place of a trade license, so the reform sits half-used.

What Bangladesh needs is a scoring framework built for how the smallest businesses operate and the oversight to use that data responsibly. With these factors in place, the financing gap has a real chance of closing. But only upgrading the technology while skipping the safeguards means swapping one flawed gatekeeper for another. The retail store owner on a side street is not necessarily a good credit risk, but they have also never had the chance to be measured in terms which would help determine where they stand.

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