The screening exists. Completion is what's missing.

A partnership brief on closing the gap between preventive care that is offered and preventive care that is actually completed — across Bangladesh's community-clinic screening system.

THE PITCH IN 30 SECONDS

PROPOSED · IN DEVELOPMENT

PROBLEM	Bangladesh's national screening programme has reach and a registry — yet its own evaluation found that only **40.4% of VIA-positive women attended for colposcopy** (January 2018 – May 2023; Nessa et al., 2025). That is a completion-and-fidelity gap, not a science gap.
SOLUTION	A proposed **disease-agnostic completion engine**: it finds who is overdue, removes friction, and drives follow-through, run weekly on a fidelity dashboard. A predictive, explainable model is on the roadmap — not in the first pilot.
THE MODEL	**Embed, don't build** — the engine plugs into existing clinics and the national registry. In Bangladesh, friction reduction means the barriers that actually stop completion: transparent bundled pricing, literacy-tailored urgency communication, and one-visit / home-collection logistics.
EVIDENCE	Each mechanism carries quantified effect sizes from the CDC Community Guide; the programme's own evaluation identifies the uptake and follow-up gaps the loop is designed to close.
THE ASK	A first **private-network partner** to run the loop commercially — then a donor-supported public-programme pilot in a few upazilas to prove it at national scale. Step one is a 30-minute conversation.

THE PROBLEM — ADOPTION, NOT SCIENCE

69%
of health spending is out-of-pocket (WHO, 2025) — one hospitalization can push a household into poverty.

<1% of GDP
public health spending (World Bank, 2021) — prevention is under-resourced.

40.4%
of VIA-positive women attended for colposcopy in the national programme's own evaluation (2018–2023) — most positives never complete follow-up.

WHICH ONE ARE YOU? — DIFFERENT PARTNERS, DIFFERENT VALUE, SAME ENGINE

PRIVATE HEALTHCARE

Finish the tests you already start

You already run entry-test campaigns; the leak is conversion — price shock, urgency that never lands, second-visit logistics. The loop attacks all three. Coverage alone doesn't complete care; a designed loop does.

GOVERNMENT

Strengthen a programme that exists

DGHS NCDC, the national cervical & breast screening leadership, and the Community Clinic Health Support Trust — piloted in a few upazilas, closing gaps the programme's own evaluation identifies.

RESEARCH & NGO

Reach, rigor, and credibility

icddr,b, BSMMU, BRAC, Marie Stopes — publishable, scalable evidence that opens donor funding. Ethics via BMRC or BSMMU; evaluation partner to be confirmed.

THE PILOT LOOP — THREE CORE PILLARS, AND A THREE-PILLAR ROADMAP

CORE · WHAT THE FIRST SITE RUNS

- Service redesign & friction reduction
- Interoperable data infrastructure — one nightly de-identified 19-column file for the pilot
- Implementation enablement — training so the site runs and sustains it

ROADMAP · AFTER A VALIDATED PILOT, NOT IN THE FIRST PILOT

- Predictive AI, explainable
- Agentic & conversational outreach
- Algorithmic equity & governance

Identify → Rank by transparent rules (days overdue, days since a positive test, prior no-shows) → Reduce friction → Communicate (literacy-tailored) → Escalate (community-health-worker outreach) → Measure, incl. diagnostic follow-up after a positive result. No patient messaging is automated in the first pilot.

THE DEMONSTRATION

Embed the completion loop into a programme that already exists.

Rather than build something new, the engine embeds into the existing network of roughly 14,000 community clinics and the national electronic registry — piloted in a few upazilas, aligned to the national NCD and screening strategy — to close the uptake and follow-up gaps the programme's own evaluation identifies. Data stays within the programme's registry and DGHS control; HSREP is implementation lead; an independent academic partner evaluates. Disease-agnostic by design: the same loop applies to cervical and breast screening, hypertension, and immunizations.

Md Shafaat Ali Choyon — Founder, HSREP · MBA, MCIM, MPH, CHES®
hsraep.org/initiative · Book 30 min: calendly.com/shafaat-alic/30min
LinkedIn: /in/sacgrowthspecialist

An HSREP initiative in development. All designs are illustrative and future-tense; no patient data has been collected. The first pilot runs on transparent rules and existing staff; AI components are a roadmap item. Operational materials will be reviewed by counsel before any launch.

SOURCES — WHO Global Health Expenditure (2025) · World Bank health-financing indicators (2021) · Nessa et al., BMC Global and Public Health 2025;3:34 (colposcopy attendance among VIA-positive women, 2018–2023) · DGHS NCDC / NCCBCST national screening programme · e-HIS/DHIS2 evaluations, BMC Public Health & PLOS Glob. Public Health (2025) · CDC Community Guide (mechanism effect sizes).