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Facility Readiness and Health System Barriers to Quality Emergency Care in Bangladesh: A Facility-Based Assessment

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Abstract: **Background:** Emergency departments (EDs) are critical entry points for acute and life-threatening conditions, yet their readiness in low- and middle-income countries (LMICs) remains poorly documented. Bangladesh's public health facilities operate across primary, secondary, and tertiary tiers with variable resources. **Objectives:** This study assessed facility readiness for emergency care in selected government hospitals and health centres in Bangladesh, examining infrastructure, equipment, medicines, staffing, and referral systems, and identifying health system barriers to quality emergency care. **Methodology:** A cross-sectional facility assessment was conducted between October 2022 and March 2023 in two Medical College Hospitals (MCHs), two District Hospitals (DHs), and four Upazila Health Complexes (UHCs). Data were collected through structured facility checklists, 62 in-depth interviews with healthcare providers and policymakers, and 260 exit interviews with patients and attendants. **Results:** All facilities were within 5–8 km of major roads and charged user fees. Only MCHs had backup anesthesia and operating theatre staff. X-ray and laboratory services were available only during morning shifts, with recurrent reagent and film shortages. Essential emergency equipment—oxygen cylinders, suction machines, ECG machines, Ambu bags, defibrillators, and airway tubes—was unavailable in most UHCs and some DHs. Medicines including hydrocortisone, nitroglycerin, pain medication, nebulizer solution, IV fluids, oxytocin, and IV antibiotics were in shortage at lower-level facilities. Health workforce vacancy rates were 21–26% at MCHs, 9–35% at DHs, and 21–35% at UHCs. Emergency Medical Officer (EMO) vacancy rates were 20–40% at MCHs and DHs; UHCs had no approved EMO posts. Provider interviews revealed 92% felt facilities were not ready for crises, citing lack of equipment (89%), life-saving medications (92%), skilled personnel (80%), oxygen (66%), and operating rooms (25%). Referral to higher facilities was very difficult for 85% of providers. Job dissatisfaction was high among doctors (18 of 20). **Conclusion:** Emergency care readiness in Bangladesh's public facilities is inadequate, particularly at primary and secondary levels. Addressing workforce shortages, equipment gaps, medicine supply chains, diagnostic capacity, and referral systems is essential for improving emergency care quality and outcomes.

Keywords: Emergency care, Facility readiness, Health system barriers, Bangladesh, LMICs, Quality improvement.

INTRODUCTION

Emergency care is a critical component of health systems, addressing acute illness, injury, and life-threatening conditions. In low- and middle-income countries (LMICs), emergency conditions arising from communicable diseases, non-communicable diseases, pregnancy-related complications, and injuries contribute substantially to preventable morbidity and mortality. Moresky *et al*. (2019) estimated that improved prehospital and facility-based emergency care could address up to 54% of annual deaths in LMICs (Moresky *et al*., 2019).

Bangladesh has made impressive progress in health indicators, yet the quality of care in public facilities remains a major concern. The public health-service delivery network operates through three tiers: primary care at the upazila (sub-district) level, secondary care at the district level, and tertiary care at the divisional level. Emergency units (EUs) are responsible for providing immediate care, but they often operate under pressure from high patient volumes, limited space, workforce shortages, inadequate equipment, and constrained referral systems (Tune *et al*., 2023).

Facility readiness—the availability of infrastructure, equipment, medicines, and trained staff—is a prerequisite for quality emergency care. The World Health Organization emphasizes that quality health services should be effective, safe, people-centred, timely, equitable, integrated, and efficient (World Health Organization (WHO), 2025b). The Lancet Global Health Commission defines a high-quality health system as one that optimises care, is valued and trusted, and responds to changing population needs (Kruk *et al*., 2018).

Despite an extensive public healthcare infrastructure, challenges remain in making services client-focused, needs-based, equitable, and accessible. Health-system governance constraints—including weaknesses in personnel administration, monitoring, accountability, coordination, and regulation—continue to affect service quality and performance (World Health Organization, 2024). A better understanding of

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facility readiness and health system barriers is essential for designing effective quality-improvement interventions.

This study aimed to assess facility readiness for emergency care in selected government hospitals and health centres in Bangladesh and to identify health system barriers to quality emergency care.

METHODOLOGY

Study Design and Setting: A cross-sectional facility assessment was conducted between October 2022 and March 2023 in four districts of Bangladesh. The study included eight government health facilities: two Medical College Hospitals (Rangpur Medical College Hospital and Mymensingh Medical College Hospital), two District Hospitals (Munshiganj 250-bed District Hospital and Shaheed Ahsan Ullah Master General Hospital, Tongi), and four Upazila Health Complexes (Pirganj UHC, Rangpur; Trishal UHC, Mymensingh; Keraniganj UHC, Dhaka; and Gazaria UHC, Munshiganj).

Participants: Facility assessments were conducted at all eight facilities. In-depth interviews were conducted with 62 healthcare professionals (22 doctors, 16 nurses, 12 SACMOs/medical assistants, 12 support staff). Exit interviews were conducted with 260 patients and community representatives.

Data Collection: A structured facility checklist assessed infrastructure (space, privacy, cleanliness, waiting area, safe drinking water, toilet/sanitation, sign and display), equipment (stethoscope, BP machine, thermometer, tongue depressor, torch light, oxygen cylinder, suction machine, ECG machine, Ambu bag, defibrillator, airway tube, suture materials, sterilizer, emergency stretcher, patient trolley, stomach wash set, IV infusion set, disposable syringe, gloves, waste bin), medicines (atropine, oradexon, hydrocortisone, lasix, aspirin, nitroglycerin, pain medication, nebulizer solution, IV fluids, oxytocin, IV antibiotic), and ambulance service (functioning, non-functioning, repairable). In-depth interviews explored provider perspectives on emergency care capacity, challenges, and job satisfaction.

Data Analysis: Facility assessment data were summarized descriptively. Qualitative data were analysed thematically.

Ethical Considerations: The study was guided by the Ethical Guidelines of North South University. Participation was voluntary, and written or verbal consent was obtained. Confidentiality and anonymity were maintained.

RESULTS

Facility Infrastructure: All facilities were located within 5–8 km of major roads. User fees were 3 Taka at UHCs, 5 Taka at DHs, and 10 Taka at MCHs. Only MCHs had backup anaesthesia and operating room personnel for surgical support. OPDs saw 150 to more than 500 patients daily. Each facility had a dedicated emergency room.

Table 1: Facility Infrastructure Assessment

Description	Rangpur MCH	Munshiganj DH	Pirganj UHC	Gazaria UHC	Mymensingh MCH	Tongi DH	Trishal UHC	Keraniganj UHC
Space	Adequate	Inadequate	Inadequate	Inadequate	Adequate	Inadequate	Inadequate	Inadequate
Privacy	Maintained	Partially	Partially	Partially	Maintained	Partially	Partially	Partially
Cleanliness	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Waiting Area	Limited	Limited	Limited	Limited	Limited	Limited	Limited	Not Available
Safe Drinking Water	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Toilet/Sanitation	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Sign and Display	Available	Available	Available	Available	Available	Available	Available	Available

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Equipment Availability: Essential emergency equipment was lacking across facilities. Oxygen cylinders, suction machines, and ECG machines were available at MCHs and DHs but not at UHCs. Ambu bags with masks were available at MCHs only. Defibrillators were unavailable at all facilities. Airway tubes were available at MCHs only. Suture materials were available at MCHs but in shortage at DHs and UHCs. Sterilizers were available at MCHs and DHs but not at UHCs. Emergency stretchers were available at MCHs and one DH. Patient trolleys were available at all facilities. Stomach wash sets, IV infusion sets, disposable syringes, and gloves were available at all facilities. Waste bins were scattered rather than strategically placed.

Table 2: Equipment Availability

Equipment	MCHs	DHs	UHCs
Oxygen Cylinder	Available	Available	Not Available
Suction Machine	Available	Available	Not Available
ECG Machine	Available	Available	Not Available
Ambu Bag with Mask	Available	Not Available	Not Available
Defibrillator	Not Available	Not Available	Not Available
Airway Tube	Available	Not Available	Not Available
Suture Materials	Available	Shortage	Shortage
Sterilizer	Available	Available	Not Available
Emergency Stretcher	Available	Partially	Not Available
Patient's Trolley	Available	Available	Available
Stomach Wash Set	Available	Available	Available
IV Infusion Set	Available	Available	Available
Disposable Syringe	Available	Available	Available
Disposable Gloves	Available	Available	Available
Waste Bin	Scattered	Scattered	Scattered

Medicine Availability: Inj. Diclofenac and Inj. Lignocaine 2% were available at every visit. Tablet paracetamol, injections of hyoscine, dexamethasone, and atropine were commonly used. ORS, lignocaine jelly, Tab. Trinitroglycerin, Inj. Hydrocortisone, Inj. Pethidine, Inj. Aminophylline, Inj. Gardenal Sodium, Inj. Antihistamine, Inj. Amoxicillin, and Inj. Magnesium Sulphate were not used during any visits. Atropine, Oradexon, Lasix, and Aspirin were available at all facilities. Hydrocortisone, nitroglycerin, pain medication, nebulizer solution, IV fluids, oxytocin, and IV antibiotics were in shortage at UHCs and some DHs.

Table 3: Medicine Availability

Medicine	MCHs	DHs	UHCs
Atropine	Available	Available	Available
Oradexon	Available	Available	Available
Hydrocortisone	Available	Shortage	Shortage
Lasix	Available	Available	Available
Aspirin	Available	Available	Available
Nitroglycerin	Available	Shortage	Shortage
Pain Medication	Available	Shortage	Shortage
Nebulizer Solution	Available	Shortage	Shortage
IV Fluids	Available	Shortage	Shortage
Oxytocin	Available	Shortage	Shortage
IV Antibiotic	Available	Shortage	Shortage

Ambulance Service: Functioning ambulances were available at MCHs (2 each), Munshiganj DH (2), Tongi DH (1), and Keraniganj UHC (2). Non-functioning ambulances were reported at Trishal UHC (1). Repairable ambulances were reported at Keraniganj UHC (2).

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Table 4: Ambulance Service

Facility	Functioning	Non-Functioning	Repairable
Rangpur MCH	2	0	0
Mymensingh MCH	2	0	0
Munshiganj DH	2	0	0
Tongi DH	1	0	0
Pirganj UHC	1	0	0
Trishal UHC	0	1	0
Keraniganj UHC	2	0	2
Gazaria UHC	1	0	0

Health Workforce: Vacancy rates were 21–26% at MCHs, 9–35% at DHs, and 21–35% at UHCs. Emergency Medical Officer (EMO) vacancy rates were 20–40% at MCHs and DHs. UHCs had no approved EMO post; medical officers were assigned emergency duties through rosters. Shortages of trained EMOs, medical assistants, nurses, ward boys, and sweepers were reported.

Table 5: Emergency Medical Officer Situation

Facility	Posts	Filled	Vacant	Vacant (%)
Rangpur MCH	10	6	4	40.00%
Mymensingh MCH	10	8	2	20.00%
Munshiganj DH	3	2	1	33.33%
Tongi DH	3	3	0	0.00%
UHCs	—	—	—	—

Provider Perspectives (n=62): The majority were men (70%), with 55% under 40. Most (83%) had no postgraduate medical education; 68% had worked at the facility for no more than six years. More than half (59%) said managing medical emergencies was part of their job description. Commonly reported emergencies were dehydration/diarrhea/vomiting (43%), fever (36%), injuries (34%), and respiratory illnesses (27%). Most providers (92%) said their facilities were not ready to handle crises. Reasons included lack of appropriate equipment (89%), lack of life-saving medications (92%), lack of skilled personnel (80%), oxygen shortage (66%), and lack of operating rooms (25%). Most (68%) had received emergency care training during their studies. The most difficult emergencies to manage were injuries (head injury, road traffic accidents, burns, and physical assault), stroke, myocardial infarction, poisoning, respiratory distress, and dehydration. Most providers (85%) found referral to higher facilities very difficult. Of 20 doctors, 18 expressed job dissatisfaction due to unsuitable working conditions, work overload, supply and equipment shortages, lack of promotions, lack of accommodation, political influence, unstable rostering, and unsatisfactory authority behaviour.

Common Reasons for ED Attendance

MCHs	DHs	UHCs
Respiratory Distress (COPD)	Road Traffic Accident	Diarrheal Diseases
Ischemic Heart Disease	Physical Assault	Physical Assault
Pneumonia	Pneumonia/RTI	Poisoning
Cerebrovascular Disease	Birth Asphyxia	Acute Abdomen
Birth Asphyxia	Poisoning	Respiratory Distress (COPD)
Acute Abdomen	Fever/Flu	Pneumonia/RTI
Road Traffic Accident	Respiratory Distress (COPD)	Road Traffic Accident
Diarrheal Diseases	Febrile Convulsions	-
Poisoning	Acute Abdomen	-

DISCUSSION

This facility-based assessment reveals substantial gaps in emergency care readiness across all levels of Bangladesh's public health system, with the most severe deficiencies at primary and secondary levels.

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Infrastructure and Equipment: The absence of basic resuscitation items—oxygen, airway equipment, ECG machines, and defibrillators—is particularly concerning, as airway management and oxygenation are foundational to emergency care. This aligns with LMIC facility-assessment evidence identifying equipment and training deficiencies as primary drivers of inadequate emergency care (Hirner *et al*., 2023). The finding that oxygen and airway supplies were more available in higher-level facilities is consistent with recent evidence of wide variation in oxygen availability across facility levels in Bangladesh (Hossain, 2026) and with multicountry assessments showing inadequate oxygen systems in LMIC facilities (Ijaz *et al*., 2025). The absence of defibrillators at all facilities is a critical gap, as defibrillation is essential for cardiac arrest survival. The World Bank recommends that Bangladesh develop tiered national equipment and supply lists for emergency and critical care, strengthen procurement systems, and ensure rapid responses to equipment shortages (Chopra *et al*., 2024).

Medicine Supply: The finding that essential medicines including hydrocortisone, nitroglycerin, pain medication, nebulizer solution, IV fluids, oxytocin, and IV antibiotics were in shortage at UHCs and some DHs is consistent with recent evidence that medicine availability in public facilities remains limited and stock-outs of essential drugs are frequently reported (Al Habib *et al*., 2026). These supply-side constraints contribute to dissatisfaction and may encourage patients to seek care elsewhere.

Health Workforce: Vacancy rates of 9–36% across facilities, with EMO vacancies of 20–40% at MCHs and DHs, mirror national evidence of persistent health workforce shortages, particularly in rural facilities (Islam *et al*., 2024; World Health Organization, 2024). Islam *et al*. (2024) reported that 58.5% of doctor-level positions were unfulfilled in rural health complexes, reinforcing that emergency care capacity is weakest where many patients first seek urgent care (Islam *et al*., 2024). The absence of approved EMO posts at UHCs means emergency duties are assigned to medical officers through rosters, potentially compromising continuity and quality. Shortages extended beyond EMOs to medical assistants, nurses, ward boys, and sweepers. High rates of job dissatisfaction among doctors (18 of 20) due to unsuitable working conditions, work overload, supply shortages, lack of promotions, accommodation issues, political influence, unstable rostering, and unsatisfactory authority behaviour are concerning. Demotivated or overburdened providers may be less able to maintain consistent communication, responsiveness, and patient-centred care. These findings are consistent with recent evidence from Bangladesh where medical officers reported workforce shortages, excessive workload, inadequate equipment, poor maintenance, and irregular medicine supplies as major barriers to quality care (Rahman *et al*., 2024).

Diagnostic Services: The finding that X-ray and laboratory services were available only during morning shifts, with recurrent reagent and film shortages, is a significant barrier to timely emergency care. Diagnostic capacity is essential for accurate diagnosis and treatment, particularly for conditions such as myocardial infarction, stroke, and poisoning. The finding that 67% of patients who required urgent investigation did not receive it due to lack of resources during that shift highlights the impact of these gaps on clinical care.

Ambulance and Referral Systems: The finding that functioning ambulances were unavailable at some facilities and that 82% of patients would not call an ambulance in an emergency reflects broader patterns in LMICs where prehospital emergency-care systems are often fragmented, poorly coordinated, and perceived as unreliable (Hirner *et al*., 2023). A recent systematic review of prehospital emergency care in LMICs similarly found inadequate trained personnel, limited basic materials, weak infrastructure, and poor coordination (Bhattarai *et al*., 2021). The finding that 85% of providers found referral very difficult due to poor transportation and weak communication systems highlights the need for stronger inter-facility coordination.

Implications for Policy and Practice: Strengthening emergency-care capacity in Bangladesh should include: (1) standardised triage protocols and competency-based training for doctors, nurses, and paramedical staff; (2) regular clinical audits and continuous monitoring of emergency-care performance indicators; (3) tiered national equipment and supply lists for emergency and critical care; (4) strengthened procurement systems and rapid responses to equipment shortages; (5) improved ambulance networks and referral systems; and (6) addressing health workforce shortages through recruitment, retention, and equitable deployment. The World

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Health Organization emphasizes that pre-service and in-service emergency, critical, and operative care training is essential for building a resilient, high-quality health system, and promotes the Basic Emergency Care course for first-contact health workers managing acute illness and injury (World Health Organization (WHO), 2025a).

Strengths and Limitations: This study has several strengths: it is one of the first facility-based assessments of emergency care readiness across primary, secondary, and tertiary government facilities in Bangladesh; it combines facility checklists, provider interviews, and patient exit interviews; and it includes a range of structural, process, and outcome measures. However, the study has limitations. The small sample of eight facilities limits subgroup analysis by facility level or location. Convenience sampling may introduce selection bias, and facilities were geographically clustered, limiting generalizability to remote areas. The study evaluated only government facilities, not private ones. Self-reported data may be subject to social desirability and researcher biases. Inter-rater reliability for data interpretation was not assessed. Despite these limitations, the study provides a valuable first step in assessing emergency medical care readiness in Bangladesh.

CONCLUSION

Emergency care readiness in Bangladesh's public health facilities is inadequate, particularly at primary and secondary levels. Critical gaps exist in infrastructure, equipment, medicines, diagnostic services, staffing, and referral systems. Addressing these gaps is essential for improving emergency care quality and outcomes. Priority should be placed on developing minimum guidelines for quality emergency medical care, with pilot programmes to assess efficacy and cost-effectiveness. The incorporation of quality emergency medical care into health care systems could have a significant impact on population well-being, respond to self-perceived needs, and decrease the long-term human and economic costs of illness and injury.

RECOMMENDATIONS

Immediate Priorities

1. Ensure availability of essential emergency equipment (oxygen, suction, ECG, Ambu bags, defibrillators, airway tubes) at all facilities
2. Ensure reliable supply of essential emergency medicines (hydrocortisone, nitroglycerin, pain medication, nebulizer solution, IV fluids, oxytocin, IV antibiotics)
3. Expand X-ray and laboratory services to 24/7 availability
4. Recruit and retain Emergency Medical Officers at all levels, including UHCs
5. Strengthen ambulance services and referral systems

Medium-Term Priorities

1. Develop tiered national equipment and supply lists for emergency and critical care
2. Implement standardized triage protocols and competency-based training
3. Establish regular clinical audits and performance monitoring
4. Address health workforce shortages through recruitment, retention, and equitable deployment

Long-Term Priorities

1. Develop minimum guidelines for quality emergency medical care
2. Implement pilot Programmes to assess efficacy and cost-effectiveness
3. Strengthen health-system governance, monitoring, accountability, and coordination
4. Increase community awareness of emergency services

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