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# RAPID HEALTH FACILITY ASSESSMENT: BANGLADESH

## SUMMARY REPORT

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## ACRONYMS

<b>MoHFW</b>	Ministry of Health and Family Welfare
<b>GFF</b>	Global Financing Facility for Women, Adolescents and Children
<b>PHC</b>	Primary Health Care
<b>UHC</b>	Upazila Health Complex
<b>UHFWC</b>	Union Health and Family Welfare Center
<b>DGHS</b>	Director General of Health Services
<b>BMRC</b>	Bangladesh Medical Research Council
<b>SACMO</b>	Sub-Assistant Community Medical Officer
<b>FWV</b>	Family Welfare Visitor
<b>WASH</b>	Water, Sanitation, and Hygiene
<b>IPS</b>	Integrated Power System
<b>PPE</b>	Personal Protective Equipment
<b>FFP2</b>	Filtering Face Piece
<b>ANC</b>	Antenatal Care
<b>PNC</b>	Postnatal Care
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>ORS</b>	Oral Rehydration Salts
<b>BCG</b>	Bacillus Calmette-Guerin
<b>NCD</b>	Non-communicable diseases



## TABLE OF CONTENTS

OVERVIEW .....	5
KEY FINDINGS .....	6
METHODOLOGY.....	7
Survey questionnaire .....	7
Sampling approach .....	8
Data collection .....	11
Data analysis .....	11
RESULTS .....	14
External shocks and impacts on health services.....	14
Infrastructure .....	17
Medical supplies and equipment .....	26
Human Resources.....	38
RECOMMENDATIONS .....	43
NEXT STEPS .....	52
ANNEX .....	53
SOURCES .....	80
ABOUT THE GFF'S FREQUENT ASSESSMENTS AND SYSTEMS TOOLS FOR RESILIENCE (FASTR) RAPID-CYCLE ANALYTICS AND DATA USE INITIATIVE.....	81



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## OVERVIEW

The Frequent Assessments and System Tools for Resilience (FASTR) rapid-cycle health facility phone survey aims to provide up-to-date snapshot of primary health care (PHC) facility performance, ultimately supporting and strengthening PHC systems for improved reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes. Survey results highlight gaps and challenges in service delivery readiness and assess the impact of shocks on health facility resilience. The survey equips decision-makers and health stakeholders with timely insights into core health system capacities, helps identify priority areas for intervention, and enables the assessment of intervention impacts over time.

In Bangladesh, the Ministry of Health and Family Welfare (MoHFW) is conducting the FASTR rapid-cycle health facility phone survey with support from the Global Financing Facility for Women, Adolescents, and Children (GFF) and the World Bank. The first quarterly round of data collection was completed in the third quarter of 2024, with three additional rounds planned through 2025. This report presents the results from the first round of data collected, which focused on assessing the impact of recent disruptive shocks on health services and evaluating the availability of critical infrastructure, human resources, and medical supplies and equipment in Upazila Health Complexes (UHC) and Union Health and Family Welfare Centers (UHFWCs).

For more information on the GFF's FASTR initiative, visit our [website](#) and the [FASTR Resource Repository](#). Contact us at [fastr@worldbank.org](mailto:fastr@worldbank.org).



## KEY FINDINGS

**The first round of the rapid health facility phone survey highlighted key service delivery challenges:**

- **Among the 392 facilities surveyed, 70 (15%) reported recent disruptions in service delivery due to external shocks, primarily natural disasters.** Severe flooding from Cyclone Remal and heavy monsoon rains in some regions caused considerable infrastructure damage, power outages, and road blockages, leading to transportation challenges for patients and medical supplies and ultimately reducing service utilization and quality.
- **Considerable gaps in the availability of essential medical supplies were identified at Union Health and Family Welfare Centers (UHFWCs),** which reported having on average only 39% of the survey's tracer essential medicines in sufficient quantity. The most critical shortages were found in the availability of oxytocin (available in sufficient quantity at just 20 of the 198 surveyed UHFWCs – 10%), magnesium sulfate (16%), and oral rehydration salts (16%). While UHCs demonstrated stronger overall supply readiness, key gaps persisted in the availability of hypoglycemic drugs and antimalarials at these facilities. Facility managers frequently cited chronic stock depletion and insufficient monthly commodity allocations as primary causes of these shortages.
- **Critical infrastructure challenges were also identified at UHFWCs,** with only 13 of the 198 surveyed UHFWC facilities (7%) meeting all key infrastructure standards. Although most facilities reported access to water, power, and communication services, critical gaps remained – particularly in the availability of cleaning protocols and improved, separate toilets for facility staff, women, and individuals with limited mobility. Across all facility types, only 11 of 392 facilities (3%) reported continuous electricity in the week preceding the survey. Other major issues highlighted by facility managers included lack of potable water, deteriorated buildings, and insufficient space, beds, and rooms.
- **Facility managers reported considerable staffing and training challenges.** Among the 198 surveyed UHFWCs, 18 (9%) reported having no licensed healthcare provider available, and only 10 had at least one nurse or midwife. Staff training coverage was low, with facilities reporting receipt of only 26% of required trainings in the past two years, and particularly limited access at UHFWCs. Staffing shortages, high workloads, and lack of training were widespread across all facility types, and were reported to directly hinder service delivery.



## METHODOLOGY

### Survey questionnaire

The FASTR rapid-cycle health facility phone survey base questionnaire was adapted to Bangladesh by the MoHFW, with additional technical input provided by the Global Financing for Women, Children, and Adolescents (GFF), the World Bank, and Mitra Associates. The base questionnaire included both quarterly, expected time variant indicators (such as the availability of medicines, supplies, basic utilities, shocks, and resiliency) and annual indicators. A combination of open and close ended survey questions were used to quantify and then contextualize service delivery challenges from the perspective of the facility manager. Additional questions tailored to the Bangladesh context were included to address unique country priorities, particularly on mental health, persons with disabilities, and climate-related adaptations.

Over the four rounds, the survey instrument has and will continue to collect data on structural quality (such as infrastructure, human resources, supplies and equipment), process quality (such as leadership and coordination, community engagement, and quality improvement), health facility financing (including insurance, out of pocket payments, financial autonomy, and public financial management), and resiliency (the occurrence of shocks and facilities' ability to respond).

The survey instrument is structured to be administered in a staggered approach over four rounds, with some survey modules deployed exclusively in specific rounds. In Bangladesh, the first round of the survey tool captured data on external shocks, critical infrastructure, medical supplies and equipment, and human resources in the first survey round. Information related to facility financing, community engagement, health service availability, quality



improvement processes, leadership and coordination, as well as emergency preparedness and response will be collected in the following survey rounds (see Table 1).

**Table 1: Bangladesh FASTR survey design, across quarterly survey rounds**

	Round 1	Round 2	Round 3	Round 4
<b>Survey modules</b>				
Shocks	X	X	X	X
Resilience to Shocks		X	X	X
Infrastructure*	X	X	X	X
Medical supplies*	X	X	X	X
Workforce and Staffing	X			
Financing		X		
Community Engagement		X		
Services			X	
Quality Improvement Processes			X	
Leadership and Coordination				X
Emergency Preparedness and Response				X

Note: In the above table, X indicates that at least some (or all) of the survey module's questions are asked in the survey round. \* Indicates that the survey module includes a mix of annual and quarterly questions.

## Sampling approach

A nationally representative panel sample of 400 UHC and UHFWC facilities was drawn from the national master list of functional primary health care (PHC) facilities, which served as the sampling frame. At the request of the Director General of Health Services (DGHS), community clinics and higher-level referral facilities were intentionally excluded from the sampling frame. A stratified systematic probability sampling approach was used to select the survey sample, with explicit stratification by facility type and implicit stratification by administrative



division. This design ensured adequate representation across both facility types and geographic areas. To allow for sufficiently precise estimates for UHC facilities—targeting margins of error below 5%—these facilities were intentionally oversampled. Survey weights were subsequently applied to all national-level estimates to correct for this oversampling, ensuring that each facility type was proportionally represented in the final results (see *Data Analysis* section for more details).

Initially, 200 UHC and 200 UHFWC facilities were selected, but 6 UHC and 2 UHFWC facilities did not respond to the survey; no replacement facilities were used. As a result, **a total of 392 facilities** were surveyed in the first round. Table 2 outlines the distribution of sampled facilities across facility types, geographic areas (urban vs. rural), and administrative divisions. A total of 194 UHC and 198 UHFWC facilities were sampled, each representing each approximately half of the survey sample. Most of the facilities surveyed were located in rural areas (71%), closely mirroring the urban/rural distribution of health facilities in Bangladesh (Bangladesh Health Facility Survey, 2022).

**Table 2: Survey sample, by facility type, geography, and administrative division**

	Selected sample size	Percentage of total sample
<b>Bangladesh</b>	<b>392</b>	<b>100.0%</b>
UHC	194	49.5%
UHFWC	198	50.5%
Urban	114	29.1%
Rural	278	70.9%
Barishal	30	7.7%
Chattogram	84	21.4%
Dhaka	73	18.6%
Khulna	48	12.2%
Mymensingh	31	7.9%
Rajshahi	53	13.5%
Rangpur	45	11.5%



	<b>Selected sample size</b>	<b>Percentage of total sample</b>
Sylhet	28	7.1%

Table 3 presents the margins of error for the sampling at the national level, as well as by facility type and administrative division. The national-level margin of error is relatively low, at 4%, meaning that the actual national value of an indicator is likely to lie within 4 percentage points of the survey estimate. Margins of error for different facility types are also low, around 5%. However, division-level estimates display higher margins of error (ranging from 9% to 15%), and should therefore be interpreted with greater caution. Given these high margins of error, the results primarily focus on national-level estimates and estimates by facility type, while additional division-level estimates are presented in the Annex.

**Table 3: Margins of error, by facility type and administrative division**

	<b>Selected sample size</b>	<b>Number of facilities in the sampling frame</b>	<b>Percentage of sampling frame</b>	<b>Margin of error (MOE)</b>
<b>Bangladesh</b>	<b>392</b>	<b>5118</b>	<b>7.7%</b>	<b>4.0%</b>
UHC	194	423	45.9%	4.4%
UHFWC	198	4,695	4.2%	5.7%
Barishal	30	372	8.1%	14.5%
Chattogram	84	1066	7.9%	8.6%
Dhaka	73	984	7.4%	9.3%
Khulna	48	662	7.3%	11.5%
Mymensingh	31	431	7.2%	14.3%
Rajshahi	53	654	8.1%	10.9%
Rangpur	45	594	7.6%	11.8%
Sylhet	28	355	7.9%	15.0%

Note: Margins of error presented in the above table were calculated based on a confidence level of 90% and a prevalence level of 50%. Results indicate that, at the national level, there is a 90% chance that the real national value lies within  $\pm 4.0$  percentage points of the measured/surveyed value.



## Data collection

Mitra and Associates conducted the data collection via computer assisted telephone interview (CATI), in partnership with the MoHFW. Health facility managers were the respondent. Phone interviews lasted 60 minutes on average. Informed consent was obtained at the beginning of each interview. Data collection for the first round was conducted between July 14 and September 02, 2024, with delays experienced due to political unrest in July and August. Ethical clearance was received from the Bangladesh Medical Research Council (BMRC) of the MoHFW.

Out of the 400 health facilities included in the sample, 8 facilities (6 UHC and 2 UHFWC) did not respond to the survey. All 6 UHC facilities declined to provide information over the phone, indicating that data should be collected in person. One UFWC required a letter from the Director General of Family Planning (DG FP) before sharing information, and the other UFWC was no longer operational.

## Data analysis

A simple descriptive analysis was conducted for all indicators included in the survey. The results are primarily presented as cross-sectional estimates at the national level. Indicators related to medical supplies and equipment were disaggregated by facility type due to considerable differences in the expected availability of tracer items between UHC and UHFWC facilities. Additional results, disaggregated by facility type and administrative division, are provided in the annex of the report.

Survey weights were applied to all national-level estimates. Weights are calculated as the inverse probability of selection for each sampled facility based on the sampling frame. This adjustment accounts for the sampling design and ensures that the contribution of facilities



to the total estimate is proportional to their representation in the country. In the survey sample, UHC facilities were over-represented, accounting for 50% of the sample despite representing only 8% of PHC facilities in the sampling frame. Conversely, UHFWC facilities represented about 50% of the sample but 92% of the sampling frame. The oversampling of UHC facilities aimed to produce reliable estimates at that level (with margins of error below 5%). To account for this oversampling and ensure national representativeness, survey weights were applied. These weights adjust for the overrepresentation of UHCs in the sample by reducing their influence on national estimates, while increasing the weight of UHFWC facilities, ensuring that each facility type is represented in proportion to its actual distribution across the country<sup>1</sup>.

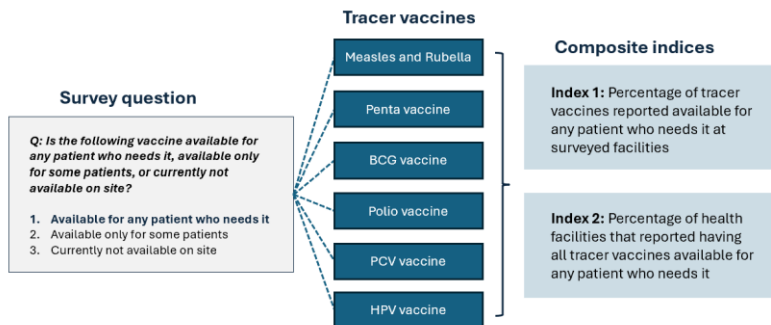
Composite indices were constructed to identify key service delivery readiness gaps and effectively summarize results. Two main types of composite indices were used for each service delivery domain across tracer indicators: (1) the average percentage of tracer items reported available at facilities, and (2) the percentage of facilities with all tracer items reported available. Figure 1 illustrates the construction of such indices, using vaccine availability as an example.

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<sup>1</sup> Note that estimates reported by facility type are unaffected by survey weights; only national-level estimates are adjusted using weights to correct for the sample's facility-type distribution.



**Figure 1: Construction of composite indices for vaccine availability**





## RESULTS

Results from the first round of the survey are presented below. Results are self-reported by health facility managers.

### External shocks and impacts on health services

#### 1. Presence of disruptive events in the past three months

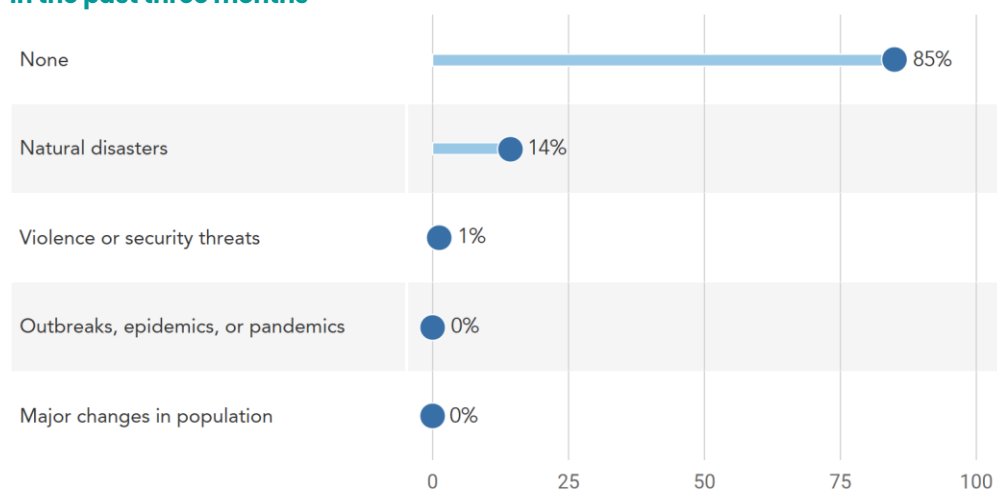
Out of the 392 health facilities surveyed, 70 (15%<sup>2</sup>) reported an external event affecting their community and their ability to provide health services in the three months preceding the survey. Natural disasters were the most reported shock, affecting 59 (14%) of all surveyed facilities (Figure 2). Facility managers who reported a shock described flooding from Cyclone Remal and heavy rains due to the Monsoon season at the time of the survey.

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<sup>2</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



**Figure 2: Percent of facilities reporting a disruptive event affecting the community in the past three months**



Note: The above figure shows the percentage of facilities that answered the question 'Over the past three months, have any of the following events affected the community that this facility serves?'

## 2. Impact of external shocks on health services

Most facilities that reported having been impacted by recent external shocks reported that the event caused changes in health service utilization, with 42 of the 70 facilities affected by recent shocks (73%<sup>3</sup>) noting a decline in service use due to the shock, and 11 of the 70 facilities noting an increase in service use (6%). This impact varied by facility type. While 22 of the 29 UHFWC facilities affected by recent shocks (76%) reported decreased service utilization,

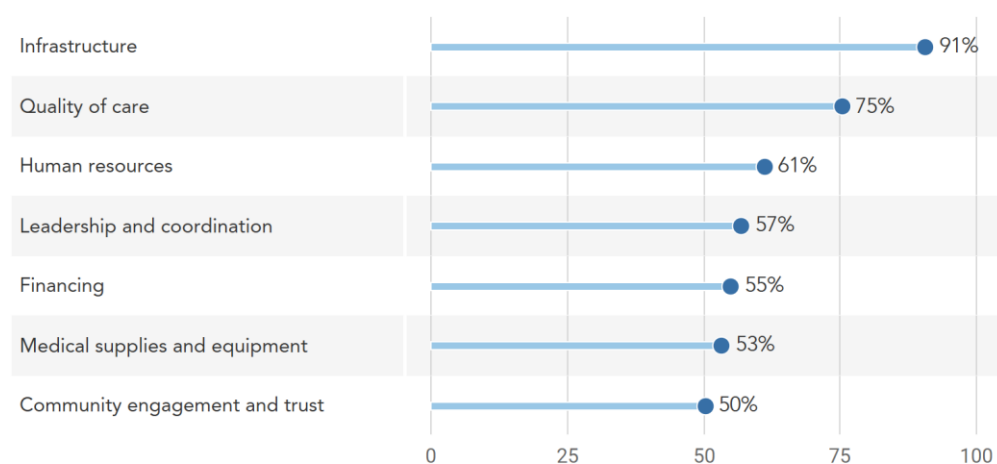
<sup>3</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



effects among UHC facilities were more varied, with 20 of the 41 affected UHC facilities (49%) indicating a decrease and 11 (25%) an increase in health service use (see Annex Table 2).

When asked which service delivery domains were adversely affected by recent shocks, 56 of the 70 facilities affected by recent shocks (91%<sup>4</sup>) reported increased challenges with infrastructure, and 51 (75%) reported increased challenges with quality of care (Figure 3). More than half of the facilities also reported adverse impacts across all other service delivery domains included in the survey, such as human resources and medical supplies and equipment.

**Figure 3: Percent of facilities reporting challenges with service delivery that have been caused by recent shocks (among facilities reporting at least one shock affecting their health services, N = 70)**



<sup>4</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



Note: The above figure shows the percentage of facilities that answered either 'strongly agree' or 'agree' to the question 'To what extent do you agree or disagree that this facility has had a challenge with the following areas because of the shock?'. The values presented in the graphs above are limited to health facilities that reported at least one shock affecting their health services (N=70).

Qualitative questions enabled facility managers to expand on these issues, describing that flooding caused severe physical infrastructure damage (such as broken doors, windows, roofs, and inundated rooms), power outages, and road blockages, leading to significant access and transportation challenges for patients and for the delivery of commodities. These difficulties, coupled with an increase in disease outbreaks (such as diarrhea or skin diseases) and staff shortages exacerbated by the higher demand, were reported to lead to reductions in the quality of care provided.

## Infrastructure

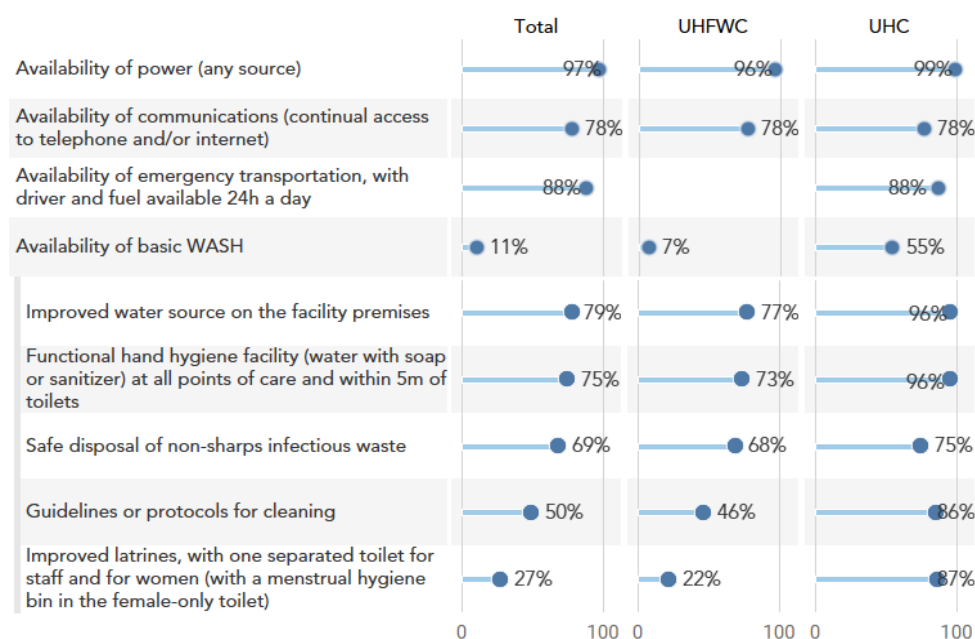
### 3. Availability of adequate infrastructure

On average, facilities reported having 68% of the survey's tracer infrastructure items, with only 9% of health facilities reporting having all key infrastructure tracers. These infrastructure tracer items include the availability of a power source, continuous access to communications (telephone service and/or internet), emergency transportation (an ambulance or other four-wheeled motor vehicle with a driver and fuel available 24/7, either stationed at the facility or available on-call), and basic WASH (Water, Sanitation, and Hygiene). For basic WASH to be considered available, facilities needed to have an improved water source on-site, functional hand hygiene facilities (i.e., water with soap or alcohol-based sanitizers) at all points of care and within 5 meters of toilets, safe disposal practices for non-sharps infectious waste, guidelines or protocols for cleaning, and improved latrines – with one separate toilet for staff, one toilet exclusively for women, and a menstrual hygiene bin in the female-only latrine.



While most facilities reported having access to electricity and communication services, only 121 out of the 392 surveyed health facilities (11%) met all essential WASH infrastructure standards (Figure 4). Infrastructure availability was significantly higher at UHCs, where an average of 88% of WASH tracer items were present, compared to 66% at UHFWCs. UHFWCs, in particular, demonstrated much lower availability of WASH. Of the 194 surveyed UHCs, 107 (55%) met all WASH criteria, compared to just 14 UHFWCs (7%). The most frequently missing WASH-related items at UHFWCs were separate improved latrines for staff and women (available at only 22% of facilities) and cleaning guidelines or protocols (46%).

**Figure 4: Percent of facilities reporting adequate infrastructure, by facility type**



Note: Emergency transportation availability was excluded from the analysis for UHFWC facilities, as this service is not expected to be provided at that level. Improved water sources were defined according to WHO guidelines and



included: piped supply, tube wells or boreholes, public taps or standpipes, protected dug wells, protected springs, and rainwater. Safe methods for the disposal of non-sharps infectious waste included: burning in a functional incinerator with fuel available; open burning in a pit or protected ground; disposal in a covered or protected pit, pit latrine, or ground without burning; or offsite removal with storage in a covered container or other protected environment. Improved toilet types, as per WHO standards, included: flush toilets connected to a piped sewer system, septic tank, or pit latrine; ventilated improved pit latrines; pit latrines with a slab; and composting toilets.

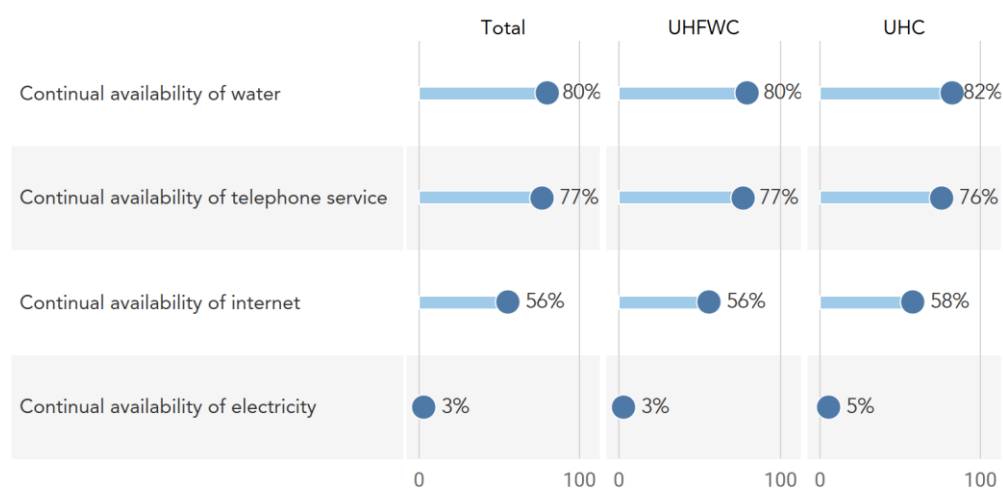
290 of the 392 surveyed facilities (75%) reported infrastructure challenges that hindered their ability to deliver health services. Via qualitative questions, facility managers emphasized severe issues related to old and deteriorated buildings (e.g., broken windows, roofs, and cracks allowing water seepage), shortages of beds and rooms, lack of potable water (sometimes due to high iron content), inadequate latrines, and frequent power outages without functioning alternative generators.

#### **4. Availability of routine utilities and communications**

Only 11 of the 392 surveyed facilities (3%) reported having continual access to power, water, and telephone or internet service in the past seven days. While most facilities had continual water access and telephone service, only 15 of the surveyed facilities (3%) reported having continuous electricity in the week preceding the survey (Figure 5). The continual availability of routine utilities was relatively homogeneous across facility type.



**Figure 5: Percent of facilities reporting availability of routine utilities and communications in the past seven days, by facility type**



Note: The above figure shows the percentage of facilities that ‘yes’ to the question: ‘In the past seven days, was there any time when this facility did not have [water/telephone service/internet/electricity] available?’.

Although nearly all of 392 facilities surveyed reported having a source of power available, only 273 (49%<sup>5</sup>) had an alternative power source in case of outages. Additionally, only 214 of the 392 facilities (28%) reported having an alternative power source that is functional. The availability of a functional alternative power source was higher among UHCs, with 169 of the 194 surveyed facilities (87%) reporting one, compared to just 45 of the 198 UHFWCs (23%).

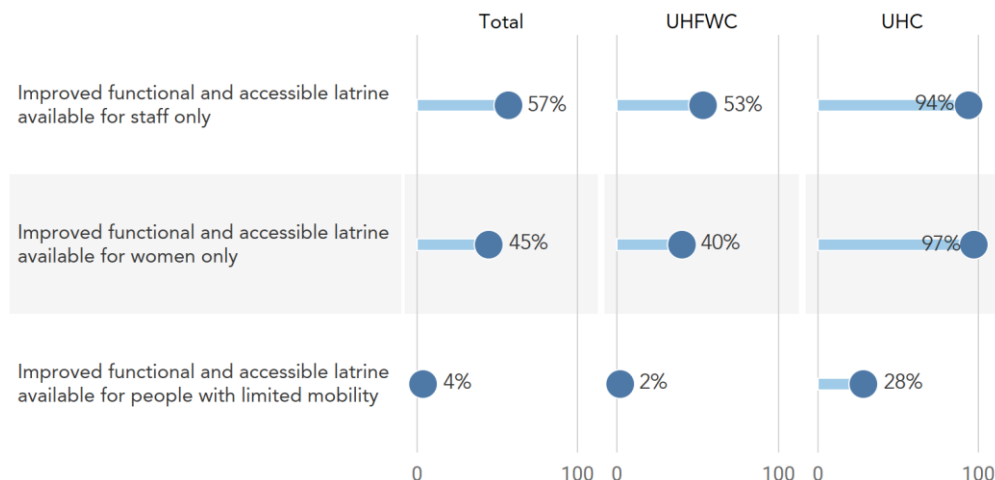
<sup>5</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



## 5. Latrine availability for designated groups

Among the 380 facilities that reported having at least one improved toilet, only 280 (57%<sup>6</sup>) reported a functional, accessible, and private latrine available for staff only, and only 262 (45%) reported a toilet for women only (Figure 6). UHC facilities demonstrated better availability of latrines for designated groups, with nearly all having separate toilets for staff and women only. However, the availability of separated latrines for individuals with limited mobility was notably low across all facility types, with only 57 facilities (4%) reporting having one available on site.

**Figure 6: Percent of facilities reporting at least one improved, functional, accessible, and private latrine designated for three groups, by facility type (among facilities reporting having an improved toilet available, N = 380)**



Note: The above figure shows the percentage of facilities that answered 'yes' to the question: 'Is there at least one

<sup>6</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



improved, functional, and accessible toilet that can be locked designated for the following groups?'. The values presented in the graphs above are limited to health facilities that reported having at least one improved latrine available (N=380).

## 6. Frequency of water availability and cleaning in female-only toilets

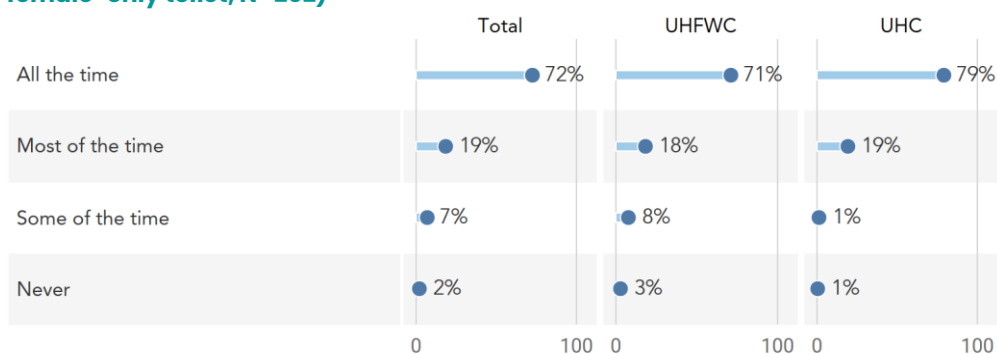
Nearly all of the 262 facilities that reported having at least one improved, functional, and accessible female-only toilet reported that water was available either all or most of the time in those toilets (Figure 7). While most facilities indicated that female-only toilets were cleaned daily or more frequently, 51 facilities (32%<sup>7</sup>) reported cleaning every 2-3 days only, and 9 facilities (9%) reported cleaning once a week or less (Figure 8). UHC facilities reported more frequent cleaning of female-only toilets, with 83 of the 186 surveyed facilities reporting at least one improved female-only toilet (45%) indicating they were cleaned more than once a day, compared to only 3 of the 76 UHFWC facilities (4%).

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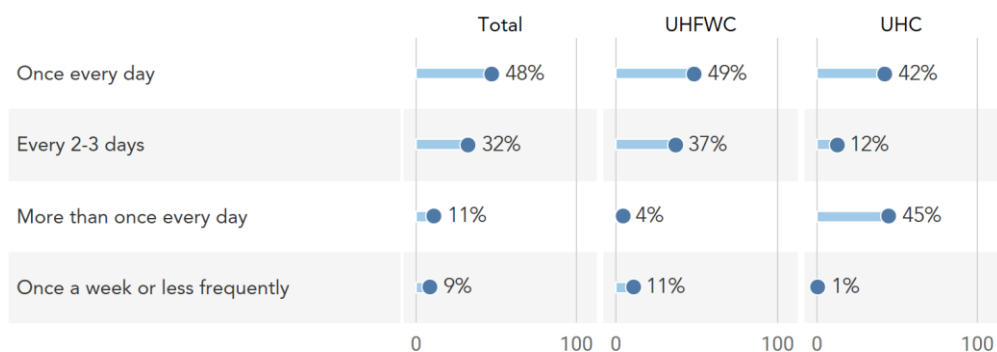
<sup>7</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



**Figure 7: Percent of facilities reporting frequency at which female-only toilets have water available, by facility type (among facilities reporting having an improved female-only toilet, N=262)**



**Figure 8: Percent of facilities reporting frequency at which female-only toilets are cleaned, by facility type (among facilities reporting having an improved female-only toilet, N=262)**



Note: The above figure shows the percentage of facilities that answered to the questions: 'How often do the toilets available for females-only have water available?' and 'How often are the toilets available for females-only'



cleaned?'. The values presented in the graphs above are limited to health facilities that reported having at least one improved, functional, and accessible female-only latrine available (N=262).

## 7. Availability of gender friendly accommodations

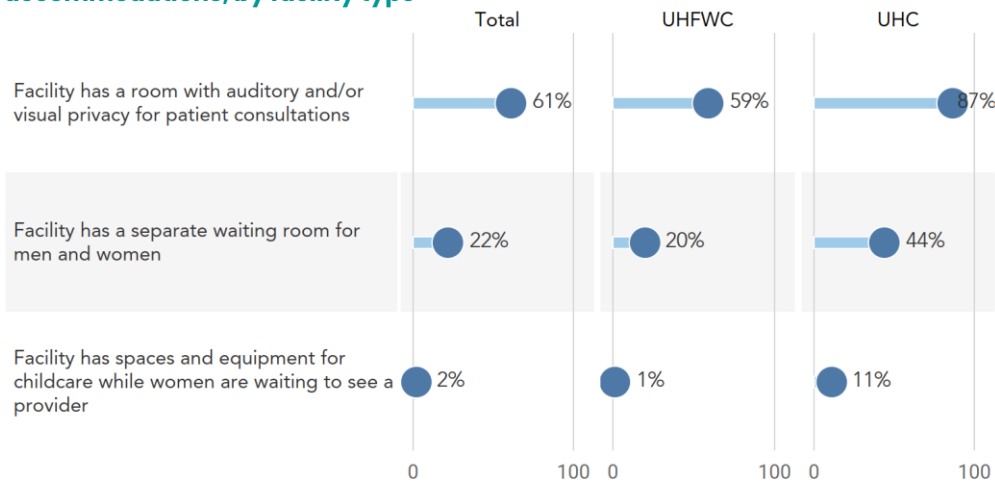
The availability of gender-friendly accommodations was relatively low among the surveyed health facilities. Only 23 of the 392 surveyed facilities (2%<sup>8</sup>) reported having spaces and equipment for childcare available for women while they wait to see a provider (Figure 9). Additionally, only about 124 facilities (22%) had separate waiting rooms for men and women. Privacy was also variable, with 286 facilities (61%) indicating that they had a room with auditory and/or visual privacy for patient consultations. UHC facilities demonstrated higher availability of gender-friendly accommodations, with 168 of the 194 surveyed UHC facilities (87%) offering private rooms for consultations and 85 (44%) providing separate waiting rooms for men and women. However, the availability of childcare spaces remained low, reported by 21 UHC facilities only (11%).

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<sup>8</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



**Figure 9: Percent of facilities with childcare facilities and gender-friendly accommodations, by facility type**



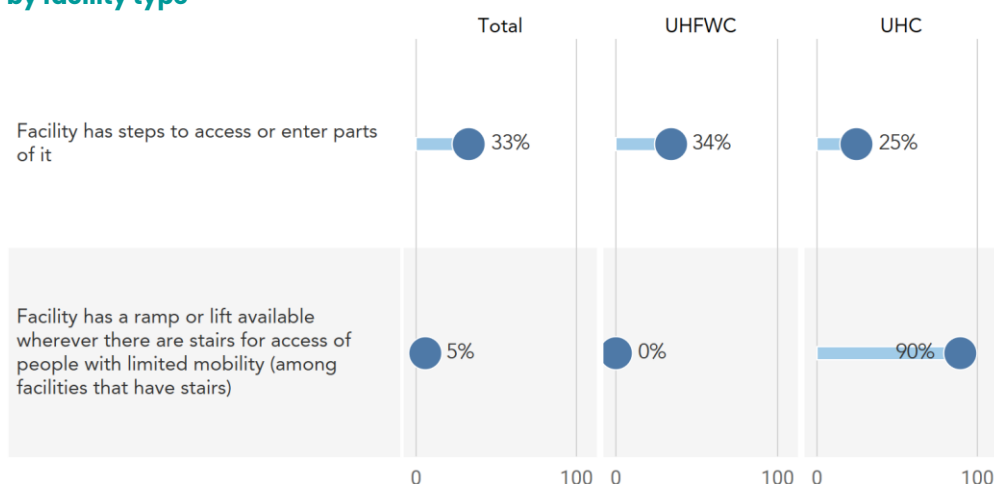
Note: The above figure shows the percentage of facilities that answered 'yes' to the questions: 'Is there a room with auditory or visual privacy available in this facility for patient consultations'; 'Is there a separate waiting room for men and women at this facility'; and 'Are there spaces and equipment for childcare at this facility while women are waiting to see a provider?'

### 8. Accessibility for persons with disabilities

Accessibility for persons with disabilities was reported to be very limited at UHFWC facilities. Among the 67 UHFWCs that reported having stairs or steps, none had a ramp or lift to accommodate individuals with limited mobility (Figure 10). In contrast, among the 48 UHCs with stairs, 43 (90%) reported having a ramp or lift available on site.



**Figure 10: Percent of facilities with accessibility for persons with limited mobility, by facility type**



Note: The above figure shows the percentage of facilities that answered 'yes' to the questions: 'Are there steps to access or enter any part of this facility?'; and 'Is there a ramp or lift available whenever there are stairs in this facility, ensuring accessibility for people with limited mobility?'. The values presented for the second indicator in the above figure are limited to health facilities that reported having stairs (N=115).

## Medical supplies and equipment

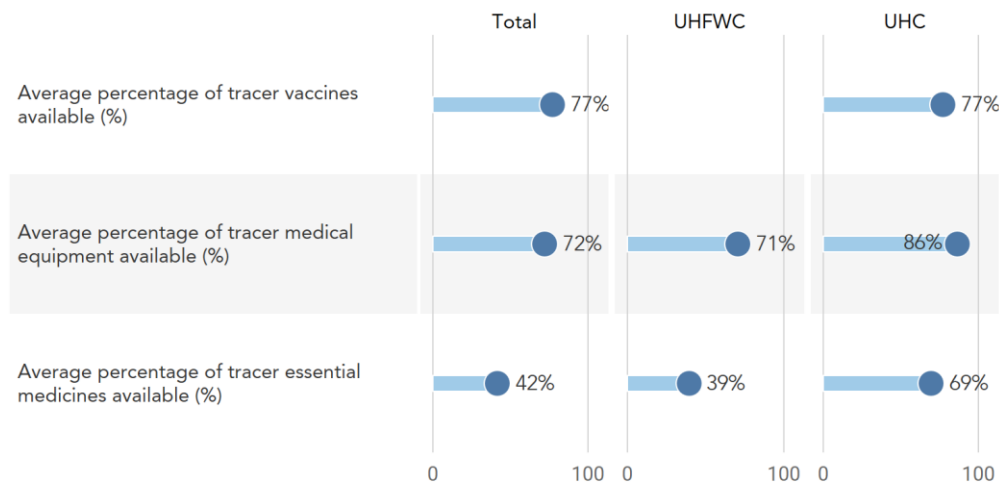
### 9. Availability of medical supplies and equipment

Health facilities reported having only 55% of the survey's tracer medical supplies and equipment available for all patients who required them on average. Additionally, none of the facilities reported that they had all of the survey's tracer medical supplies and equipment available in sufficient quantity, compared to a target of 100% availability. UHC facilities demonstrated relatively strong supply readiness, with 77% of items available on average,



compared to 53% at UHFWC facilities. Facilities indicated considerable gaps in the availability of tracer medicines, especially at UHFWCs (Figure 11).

**Figure 11: Average reported availability of medical supplies and equipment currently available for all patients that require them , by facility type**



Note: The above figure shows the percentage of different types of tracer medical supplies and equipment included in the survey that are available, on average, for all patients that require them at facilities. UHFWC facilities were removed from the index calculation for vaccines, given that vaccines are not supposed to be stored in those facilities.

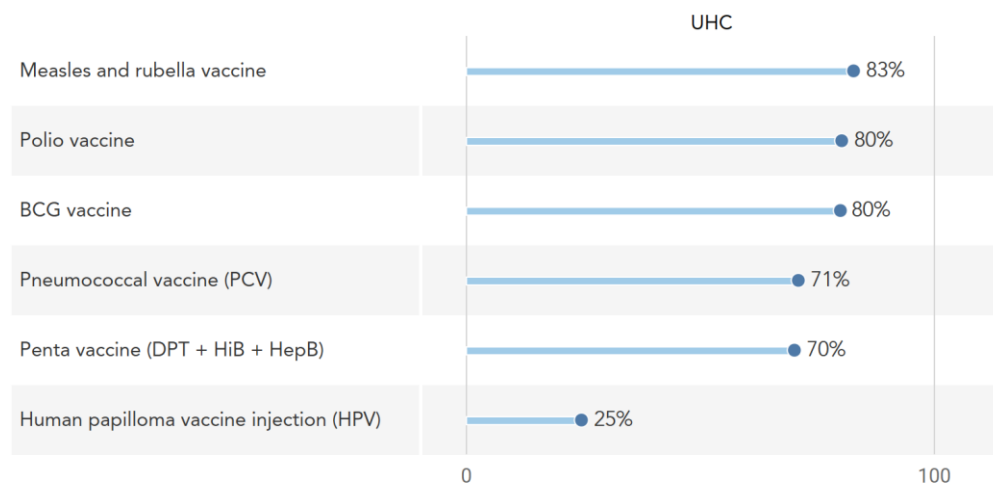
## 10. Essential vaccines

Vaccine availability was moderate, with UHC facilities reporting an average 77% of the survey's tracer vaccines available on-site for all patients who required them. 60% of UHC facilities had all tracer vaccines available for all patients in need, compared to a target of



100% availability. These indices were calculated based on the list of five vaccines included in the survey: measles and rubella vaccine, polio vaccine, BCG vaccine, pneumococcal vaccine (PCV), and pentavalent vaccine. Most vaccines were accessible in over 70% of UHC facilities, and 48 of the 194 surveyed UHCs (25%) reported having human papilloma virus (HPV) vaccines available for all patients that require them (Figure 12).

**Figure 12: Percent of facilities with essential vaccines currently available on-site for all patients that require them (UHC facilities only)**



Note: The above figure shows the percentage of facilities that answered 'available for any patient who needs it' to the question: 'Are the following vaccines available for any patient who needs it, available for only some patients, or currently not available on-site?'. UHFWC facilities were removed from the index calculation for vaccines, given that vaccines are not supposed to be stored in those facilities. HPV vaccines were also excluded from the vaccine availability index calculations, as these vaccines are not expected at facilities.

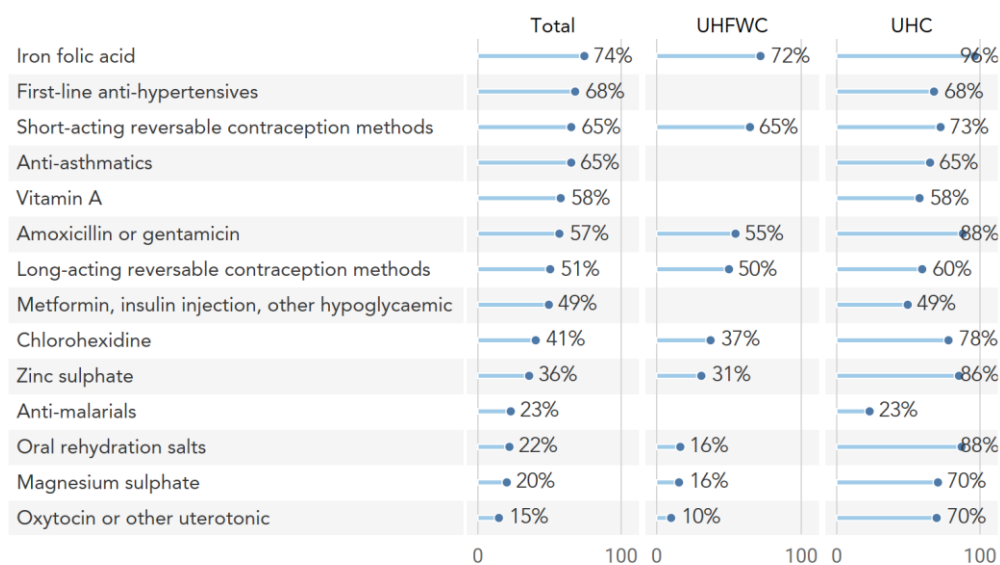
## 11. Essential medicines



Health facilities reported having only 42% of the survey's tracer essential medicines available on-site for all patients that require them on average. Nearly none of the facilities reported the availability of all 14 tracer essential medicines in sufficient quantity, compared to a target of 100% availability. These indices were calculated based on the list of 14 essential medicines included in the survey (listed in Figure 15 below). UHC facilities demonstrated better availability of essential medicines, with 69% of the survey's tracer items available on average, compared to 39% at UHFWC facilities. The most significant gaps were observed in the availability of oxytocin, magnesium sulfate, and oral rehydration salts (ORS), which were available in fewer than one in five UHFWCs. Furthermore, only 108 of the 198 surveyed UHFWCs (55%) reported having sufficient stocks of antibiotics, such as amoxicillin or gentamicin. Although the availability of tracer medicines was generally higher at UHCs, fewer than half reported having sufficient stocks of hypoglycemics (such as metformin or insulin) and antimalarials (Figure 15).



**Figure 15: Percent of facilities with essential medicines currently available on-site for all patients that require them, by facility type**



Note: The above figure shows the percentage of facilities that answered 'available for any patient who needs it' to the question: 'Are the following essential medicines available for any patient who needs it, available for only some patients, or currently not available on-site?'

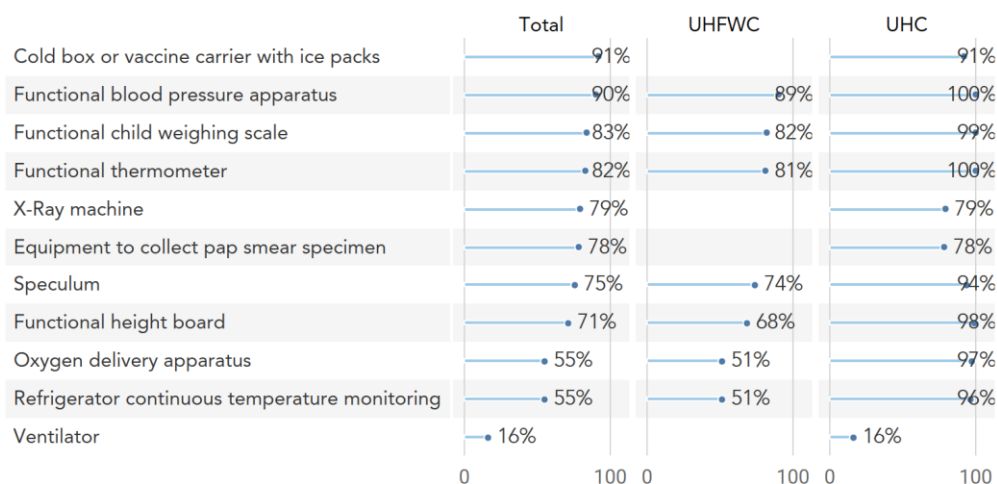
## 12. Medical equipment

On average, health facilities reported having 72% of the survey's tracer medical equipment available and functional on-site, compared to a target of 100% availability. This index was calculated based on the list of 11 basic medical equipment included in the survey (listed in Figure 16 below). UHC facilities demonstrated better availability of essential equipment, with 86% of the survey's tracer items available on average, compared to 71% at UHFWC facilities.



The most significant gaps were observed in the availability of ventilators at UHCs (available in 31 of the 194 surveyed UHCs – 16%), as well as functional refrigerators, functional oxygen delivery apparatuses, and functional height boards at UHFWCs (Figure 16).

**Figure 16: Percent of facilities with medical equipment currently available and functional at the facility, by facility type**



Note: The above figure shows the percentage of facilities that answered ‘yes’ to the question: ‘Are the following pieces of equipment currently available and functional?’.

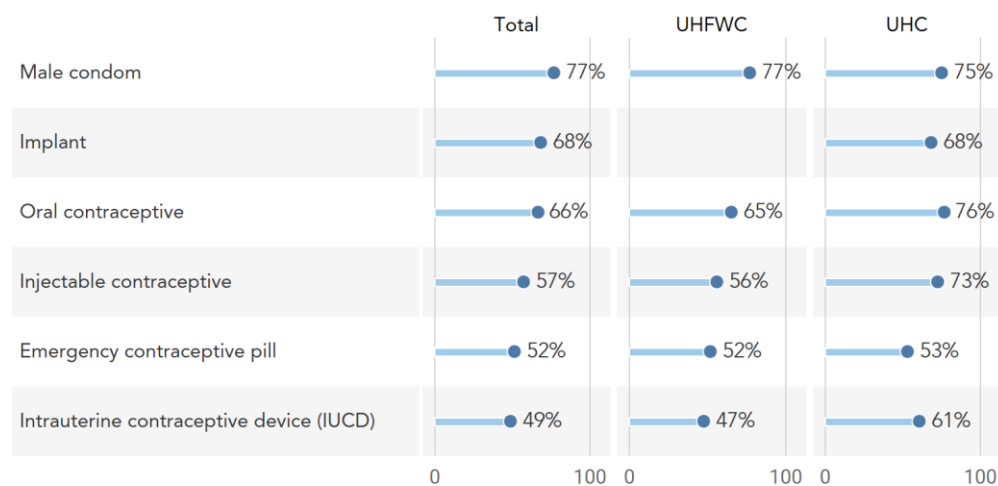
### 13. Contraceptive methods

On average, health facilities reported having 60% of the survey’s tracer contraceptive methods available, compared to a target of 100% availability. This index was calculated based on the list of six contraceptive methods included in the survey (listed in Figure 17 below). UHCs reported better overall availability than UHFWCs, though gaps were observed



across both facility types. The most notable shortages were in intrauterine contraceptive devices (IUCDs), available at only 211 of the 392 surveyed facilities (49%), and emergency contraceptive pills, available at 204 facilities (52%) (Figure 17).

**Figure 17: Percent of facilities with reversible contraceptive methods currently available on-site for all patients that require them, by facility type**



Note: The above figure shows the percentage of facilities that answered 'available for any patient who needs it' to the question: 'Are the following short-acting reversible contraception methods available for any patient who needs it, available for only some patients, or currently not available on-site?'.

#### 14. Strategies used in case of stock shortages

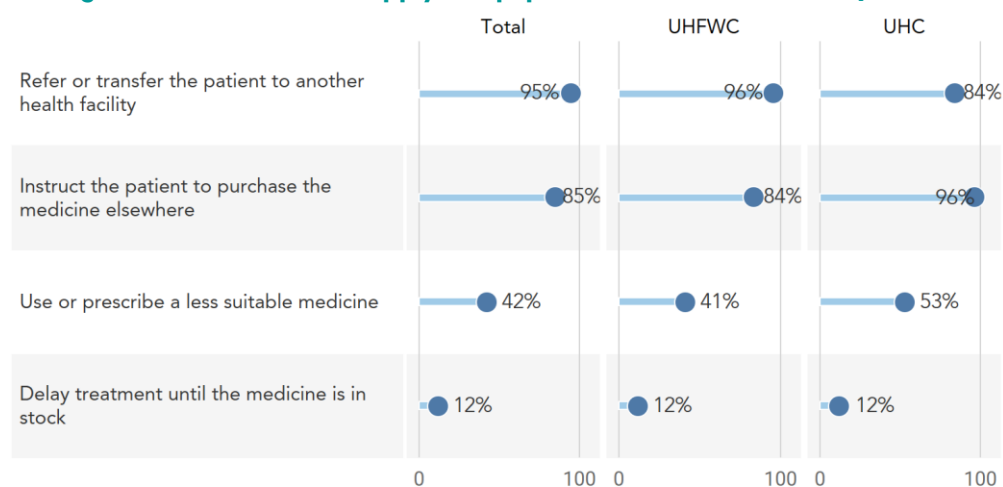
Among the 392 health facilities that reported at least one tracer medical supply or equipment item unavailable at the time of the survey, 353 facilities (95<sup>9</sup>) indicated they

<sup>9</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



referred patients to another facility, and an equal number (85%) reported advising patients to purchase the required medicines elsewhere (Figure 18). However, a notable share of facilities resorted to less appropriate responses: 183 (42%) reported prescribing a less suitable alternative, and 46 (12%) said they would delay treatment until the item was restocked. These patterns were relatively consistent across facility types.

**Figure 18: Percent of facilities reporting strategies used when a patient requires medication that is unavailable on-site, by facility type (among facilities reporting having at least one medical supply or equipment unavailable, N = 392)**



Note: The above figure shows the percentage of facilities that answered the question: 'You indicated that at least one of the essential medicines was not available on-site. When a patient needs a medication that is not available on-site, what does this facility do?'. The values presented in the graphs above are limited to health facilities that reported having at least one tracer medical supply or equipment unavailable, corresponding to all the surveyed facilities (N = 392).

## 15. Frequencies of order and receipt of medicines

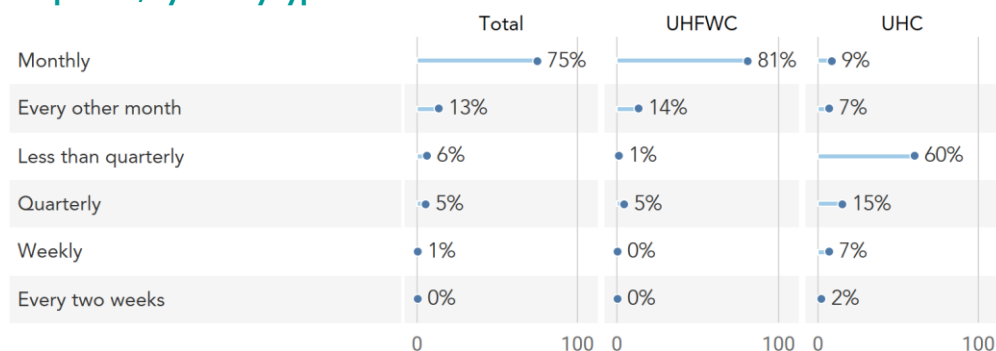


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Among the 392 surveyed health facilities, most reported placing and receiving medicine orders on a monthly basis (Figures 19 and 20). However, the frequency of ordering and receiving medicines varied by facility type. In UHFWC facilities, monthly ordering was the norm—160 of the 198 surveyed UHFWCs (81%) reported placing orders monthly, and 170 (86%) reported receiving supplies on a monthly basis. In contrast, the majority of UHCs reported ordering and receiving medicines quarterly or less frequently—147 UHCs (76%) for orders and 149 UHCs (77%) for receipts.

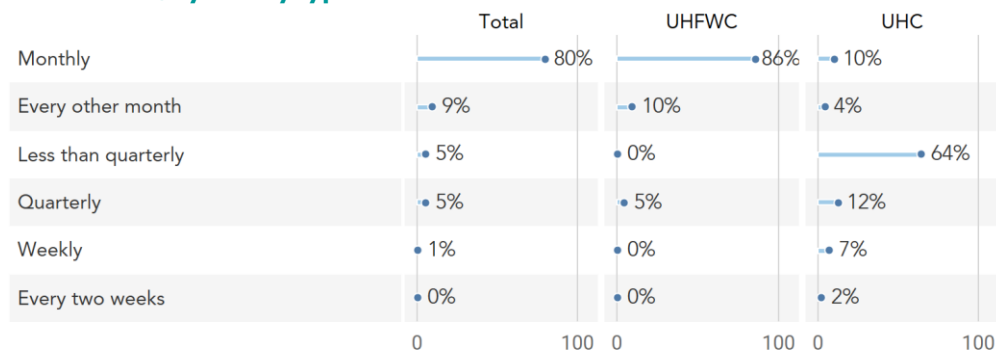


**Figure 19: Percent of facilities reporting frequency at which orders for medicines are placed, by facility type**



Note: The above figure shows the percentage of facilities that answered the question: 'How often does this facility place orders for medicines?'

**Figure 20: Percent of facilities reporting frequency at which orders for medicines are received, by facility type**



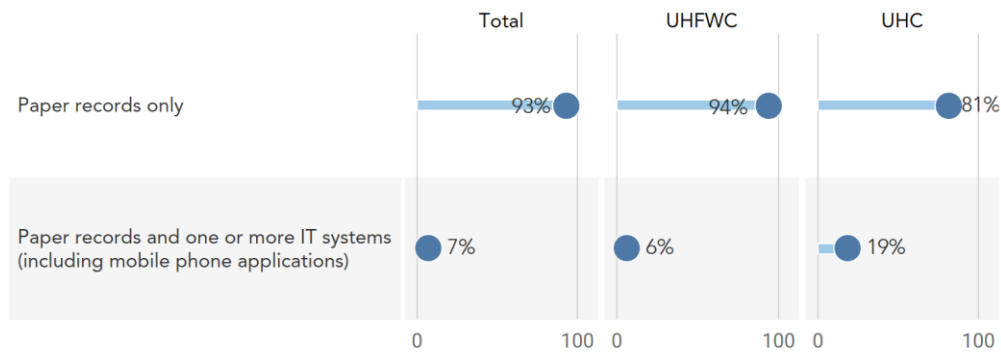
Note: The above figure shows the percentage of facilities that answered the question: 'How often does this facility receive deliveries of medicines?'



## 16. Methods for medicine record keeping

Among the 392 facilities surveyed, nearly all (344 facilities, or 93%) reported using only paper records to document the receipt, inventory, and dispensing of medicines. Only a few (48 facilities, 7%) reported using a combination of paper records and one or more IT systems (including mobile phone applications), and none reported sole use of IT systems (Figure 21). Among the 48 health facilities that used a mix of paper records and IT systems, 16 (39%) indicated that the IT systems were not always functional in the past seven days. The methods used were relatively consistent across facility types; however, UHC facilities were more likely to employ a combination of paper records and IT systems (19% of the 194 UHCs surveyed, compared to 6% of 198 UHFWCs surveyed) (Figure 21).

**Figure 21: Percent of facilities reporting methods for recording the receipt, inventory, and dispensing of medicines, by facility type**



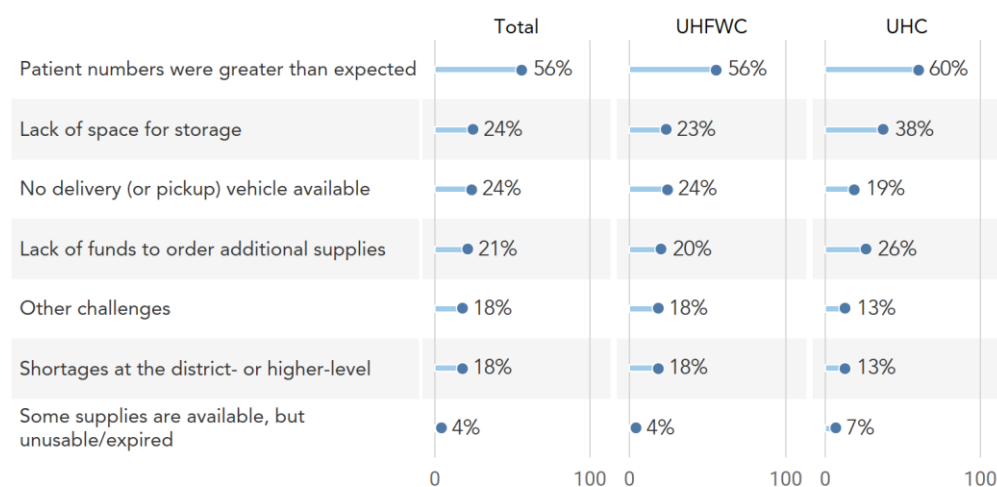
Note: The above figure shows the percentage of facilities that answered the question: 'How does this facility record the receipt, inventory, and dispensing of medicines?'

## 17. Self-reported medical supplies challenges



Among the 392 health facilities surveyed, 312 (86%<sup>10</sup>) reported challenges with medical supplies and equipment; and 232 (65%) indicated that these challenges had limited or hindered their ability to deliver services. The most reported challenge was an unexpected increase in patient numbers, reported by 226 of the 392 surveyed facilities (56%). Facilities also widely reported other issues, such as lack of storage space, or unavailability of delivery (or pickup) vehicles (Figure 22).

**Figure 22: Percent of facilities reporting specific challenges related to medical supplies in the past three months, by facility type**



Note: The above figure shows the percentage of facilities that answered 'yes' to the question: 'Have you experienced any of the following medical supplies-related challenges in the past three months?'.

<sup>10</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



During qualitative questions, most facility managers described severe and chronic shortages of commodities due to stock depletion before new orders arrive at the end of the month. They also highlighted significant problems with outdated or malfunctioning equipment, particularly X-ray machines at UHC facilities. These challenges were described to lead to notable reductions in the quality and quantity of services provided from the perspective of facility managers, sometimes preventing staff from delivering critical maternal, delivery, and emergency care. Additionally, among the 206 facilities that reported providing supplies to community health workers, 44 (37%<sup>11</sup>) indicated an inability to fulfill a CHW supply request in the past three months.

## Human Resources

### 18. Availability of staff cadres

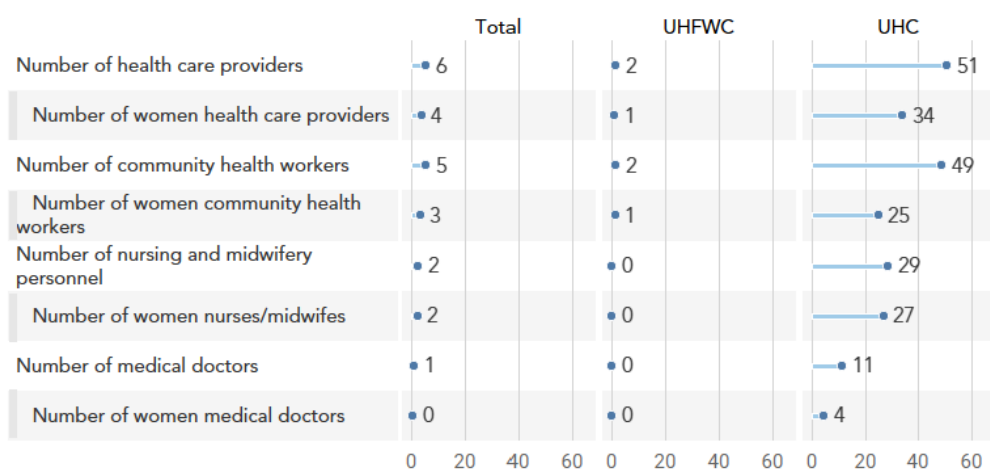
On average, UHFWC facilities had two licensed healthcare providers, with most facilities reporting either one or two providers available (Figure 23). Among the 198 surveyed UHFWC facilities, 18 facilities (9%) indicated that they had no licensed healthcare providers on-site, only 11 facilities (6%) reported having at least one medical doctor, and only 10 facilities (5%) reported having at least one nurse or midwife.

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<sup>11</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



**Figure 23: Average number of health care providers available at health facilities, by facility type**



Note: The above figure shows average number of reported cadres for each category, either total or female-only. 'Health care providers' were defined in the survey as any licensed medical staff including doctors, health assistants, nurses, traditional medicine providers, and dental services providers, but excluding volunteers and community health workers. 'Medical doctors' include generalists and specialist medical practitioners with a doctoral degree. 'Community health workers' here refer to community health workers that are either managed by the facility or who provide services within the facility's catchment area.

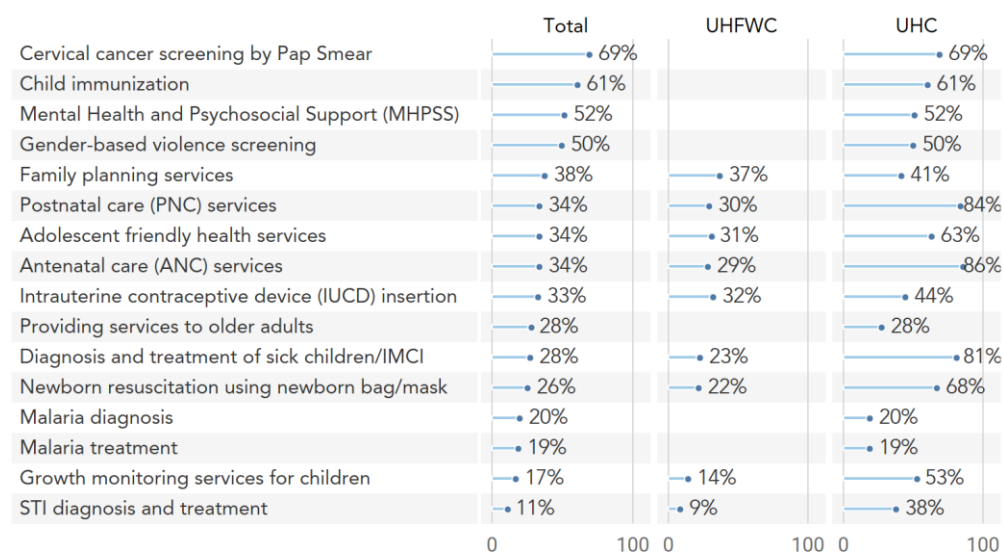
### 19. Reported availability of provider training in the past two years

Facility managers reported substantial gaps in staff training, with health facilities reporting receiving of only 26% of the tracer trainings over the past two years, on average. This training index was based on the 16 staff trainings included in the survey (listed in Figure 24 below). Almost none of the surveyed facilities reported having received all tracer trainings within the past two years. UHC facilities reported better training availability, with 54% of tracer trainings available on average, compared to 23% at UHFWC facilities. However, significant gaps remained even at UHCs: fewer than half reported recent trainings in malaria diagnosis and



treatment, services for older adults, STI diagnosis and treatment, IUCD insertion, and family planning. Training availability was especially limited at UHFWCs, where none of the 16 trainings were reported in more than half of facilities (Figure 24).

**Figure 24: Percent of facilities that received staff trainings in the past two years, by facility type**



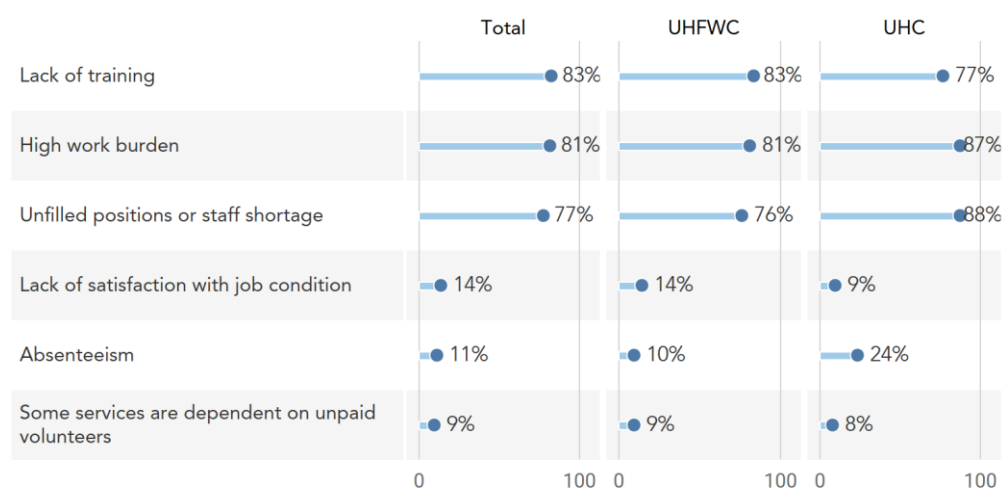
Note: The above figure shows the percentage of facilities that answered 'yes' to the question: 'In the last 2 years, did the health care providers at this facility receive in-service training on any of the following services?'. 'Providing services to older adults' and 'Mental Health and Psychosocial Support (MHPSS)' were added to the list of tracer services during the questionnaire adaptation to the country context.

## 20. Self-reported human resources challenges



Among the 392 health facilities surveyed, 363 (92%<sup>12</sup>) reported challenges with human resources; and 272 (68%) indicated that these challenges had limited or hindered their ability to deliver services. The most frequently cited issues were lack of training, high workloads, and unfilled positions due to staff shortages (Figure 25). UHC and UHFWC facilities reported similar levels and types of human resource challenges, although issues with absenteeism were reported more commonly by UHCs.

**Figure 25: Percent of facilities reporting specific challenges related to human resources in the past three months, by facility type**



Note: The above figure shows the percentage of facilities that answered 'yes' to the question: 'Have you experienced any of the following staffing challenges in the past three months?'.

<sup>12</sup> Proportion obtained after applying survey weights (see the *Data Analysis* section of the report for more details on the weighing approach).



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During qualitative questions, facility managers described significant and chronic staffing shortages. Commonly cited gaps including shortages of doctors, nurses, SACMOs/FWVs, and support staff like cleaners and security guards. A lack of training and skilled personnel was also widely reported. These challenges were described as hindering facilities' ability to deliver care according to best practices.



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## RECOMMENDATIONS

The key recommendations from the first round of the phone survey are outlined below, structured according to the SMART framework (Specific, Measurable, Achievable, Relevant, and Time-bound) to ensure they are actionable and result-oriented.

### **Recommendation #1: Mitigating and preventing infrastructure damage and transportation challenges in areas affected by recent floods.**

**Assessment:** Health facilities reported significant disruptions due to recent floods caused by Cyclone Remal and heavy monsoon rains in the three months preceding the survey. Facility managers emphasized important damage to critical infrastructure, including broken windows, doors, roofs, and flooded rooms, which disrupted service delivery and compromised the quality of care. Additionally, flooded roads created severe transportation challenges, limiting access to health services and reducing utilization, while also hindering the delivery of essential medical supplies to primary care facilities.

To mitigate these challenges, facility managers reported the adoption of alternative approaches, such as boat deliveries of supplies and the deployment of medical teams from nearby hospitals. These strategies could be further explored and complemented by exploring additional solutions, such as telemedicine consultations, electronic prescriptions, drone deliveries of medical supplies, and increased support from community health workers. To enhance facility resilience, preventive measures could also be implemented, including the establishment of crisis stockpiles of medical supplies in health facilities to improve emergency preparedness and response capabilities and ensuring that supplies are stored at a higher-than-ground level to minimize the impact of flooding. Finally, prioritizing the renovation of physical infrastructure is essential to repair damage caused by flooding and enhance design standards, thereby strengthening resilience against future storms and floods.

**Commented [VA1]:** @Munirat Iyabode Ayoka Ogunlayi and @Nondini Lopa to advise on this section

**Commented [NL2R1]:** Let me have the meeting with Vviane on 23rd and understand it so that I can further discuss with DGHS team.

**Commented [RN3]:** We have re-formatted the results per the Ministry's feedback, but we suggest that the country team support in filling these in based on the country context.

**Commented [RN4]:** Another idea would be to sit with the Ministry to go through the results and then discuss and fill the table together, as a way for the Ministry to think through applying the findings towards recommendations.



Objective	Action (Specific)	Indicators (Measurable)	Potential implementation barriers and mitigation approaches (Achievable)	Relevance	Timeline (Time-Bound)
<b>Strengthen infrastructure to withstand floods and cyclones, reducing damage and service disruption.</b>	<ol style="list-style-type: none"> <li>1. Conduct vulnerability assessments of existing infrastructure.</li> <li>2. Upgrade physical structures (walls, roofs, drainage).</li> <li>3. Develop and implement flood-resistant building standards.</li> </ol>	<ol style="list-style-type: none"> <li>1. # of facilities with upgraded flood-resilient infrastructure.</li> <li>2. Frequency of flood-related damages.</li> </ol>	<p><b>Barriers:</b> Funding limitations; technical knowledge gaps</p> <p><b>Mitigations:</b> Secure budget allocation, partner with engineering experts, pilot resilient designs.</p>	Critical for maintaining healthcare access and safety during extreme weather events.	3-12 months for assessments and upgrades; ongoing monitoring and maintenance.
<b>Maintain continuous health service delivery during disasters through contingency and preparedness planning.</b>	<ol style="list-style-type: none"> <li>1. Develop and test emergency response and contingency plans.</li> <li>2. Establish stockpiles of essential supplies and medicines</li> </ol>	<ol style="list-style-type: none"> <li>1. Stockpile adequacy and coverage.</li> <li>2. # of staff trained in emergency response.</li> </ol>	<p><b>Barriers:</b> Lack of awareness or readiness; resource constraints.</p> <p><b>Mitigations:</b> Conduct regular drills, seek support for resource procurement.</p>	Ensure health services remain accessible and effective during climate and disaster events.	<p>1-3 months for planning and training</p> <p>Quarterly drills</p> <p>Continuous review and updates</p>



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	3. Train staff on emergency procedures and remote service options.				
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**Recommendation #2: Improving the availability of medical supplies at UHFWC and UHC facilities, particularly essential medicines**

**Assessment:** Considerable gaps in the availability of medical supplies were reported in UHFWC and UHC facilities. Most notable gaps were identified for medicines. Only 10% of UHFWC facilities reported having oxytocin in sufficient quantity, and only 16% reported sufficient magnesium sulphate and oral rehydration salts (ORS), despite reported increases in diarrhea cases at the time of the survey. Although cervical cancer is the second most common cancer among women in Bangladesh (WHO, 2023<sup>13</sup>), only 25% of UHC facilities reported having adequate stocks of HPV vaccines, indicating the need for continued efforts in vaccine rollout throughout the country. Similarly, as per the national strategic plan for malaria elimination and prevention 2024–30<sup>14</sup>, 17.74 million people in 13 districts are at risk of malaria. However, only 23% of UHC facilities reported having anti-malarial drugs in sufficient quantity. The availability of medications for NCDs was moderate among UHC facilities, with 49% reporting sufficient stocks of metformin, 68% reporting sufficient stocks of first-line anti-hypertensives, and 65% reporting sufficient stocks of anti-asthmatic drugs. Facility managers attributed these shortages to chronic stock depletion and insufficient monthly commodity allocations.

<sup>13</sup> World Health Organization. (10 October 2023). Human Papillomavirus (HPV) Vaccination Launching in Bangladesh: A single dose vaccine has potential to prevent cervical cancer! [https://www.who.int/bangladesh/news/detail/10-10-2023-human-papillomavirus-\(hpv\)-vaccination-launching-in-bangladesh--a-single-dose-vaccine-has-potential-to-prevent-cervical-cancer](https://www.who.int/bangladesh/news/detail/10-10-2023-human-papillomavirus-(hpv)-vaccination-launching-in-bangladesh--a-single-dose-vaccine-has-potential-to-prevent-cervical-cancer)

<sup>14</sup> National Malarial Elimination Program Directorate General of Health Services Ministry of Health & Family Welfare Government of Bangladesh. NATIONAL STRATEGIC PLAN FOR MALARIA ELIMINATION AND PREVENTION OF RE-ESTABLISHMENT OF MALARIA TRANSMISSION IN BANGLADESH 2024-2030.



Preventive measures for stock-outs can be explored, including re-evaluating appropriate drug allocations to facilities to better match patient needs, ensuring timely and complete deliveries, and providing targeted responses to UHFWC and UHC facilities which reported more considerable commodity shortages.

Objective	Action (Specific)	Indicators (Measurable)	Potential implementation barriers and mitigation approaches (Achievable)	Relevance	Timeline (Time-Bound)
<p><b>Accurate, timely demand forecasts are developed using consumption data and external variables, enabling proactive supply decisions that align with real needs.</b></p>	<p>Establish forecasting team within MoHFW. Develop standard operating procedures (SOPs) for integrating LMIS consumption data, DHIS2 service data, epidemiology trends, and climate forecasts into quarterly forecast cycles. Facilitate routine forecast review meetings at district level</p>	<p>Forecast accuracy (% deviation from actuals); % of districts submitting quarterly demand plans; reduction in stockout days of tracer commodities</p>	<p><b>Barrier:</b> Fragmented data streams → <b>Mitigation:</b> Start district pilots and gradually integrate systems. <b>Evidence:</b> Digital Health Strategy commits to interoperable forecasting platforms</p>	<p>Aligns with MoHFW strategy for evidence-based quantification, supports commodity availability for RMNCAH, urban &amp; rural service points.</p>	<p>SOPs and team in place within 4 months; cadence for planning established within 6 months; district-level reviews underway by month 7.</p>



<p><b>Procurement processes are efficient, transparent, and agile, ensuring timely acquisition of quality products and supply chain services, while fostering strategic partnerships with reliable suppliers.</b></p>	<p>Conduct mapping of licensed private pharmacies, social marketing outlets, wholesale &amp; logistics firms, and manufactures/suppliers; pilot contracts to supply essential tracers to patients during stockouts in 3 districts</p>	<p>% emergency orders fulfilled via private channels; reduction in stockout days (e.g. oxytocin, ORS)</p>	<p><b>Barrier:</b> Regulatory/quality risks → <b>Mitigation:</b> contract only accredited outlets/service providers, regular audits. Bangladesh has precedent for PPPs in health infrastructure (e.g. NIKDU dialysis center) via PPP Authority</p>	<p>Builds on Bangladesh’s licensed pharmaceutical sector (e.g. SMC) and aligns with GFF-endorsed private engagement strategies.  Improves local procurement &amp; contracting capacity</p>	<p>Mapping &amp; design: 3 months; pilot contracting active by month 6; evaluation at month 9; scale decision at month 12.</p>
<p><b>LMIS platforms provide accurate, real-time data that is routinely used for planning, performance monitoring, and continuous improvement across supply chain levels.</b></p>	<p>Utilize Target Software Standards to identify and deploy appropriate technology for last mile visibility and transaction digitization.</p>	<p>% Facilities reporting data into relevant planning teams on agreed schedule.  % Completeness of reporting on full medicine list (not just tracer)</p>	<p><b>Barrier:</b> Connectivity gaps → <b>Mitigation:</b> Offline-first design, SMS fallback. <b>Evidence:</b> DGHS eLMIS pilot during COVID-19 demonstrated feasibility.  Digital Health Strategy endorses mobile LMIS and dashboards</p>	<p>Complements forecasting process, improves real-time visibility of stock at rural UHFWCs and urban UHCs, builds resilience.</p>	<p>System configured and tested in 3 months; pilot launched by month 6; full dashboard operational by month 7; review and scaling plan at month 9.</p>



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**Other interventions that may be considered (both rely on improved supply chain planning, demand forecasting and ultimately supply planning capabilities):**

- Multi-month dispensing during seasons when weather disruptions are expected
- Stock piling is recommended in several documents, due to challenges in managing supply during times of external shock. This approach should be considered in parallel with contracting out to private sector logistics and warehousing companies where capacity exists.

**Recommendation #3: Addressing physical infrastructure deterioration and improving electricity access.**

**Assessment:** Critical infrastructure issues, including inconsistent electricity access, lack of improved separated latrines for staff, women, and people with limited mobility, as well as inadequate physical infrastructure were reported by facility managers. Only 3% of surveyed facilities reported consistent electricity access, and only half of UHFWCs reported an alternative power source during outages. Severe challenges related to lack of drinkable water (due to high iron content), destroyed or deteriorated buildings, and insufficient beds and rooms were also highlighted by many facility managers.

Exploring the availability of alternative generators (IPS or battery/fuel operated), as well as conducting renovations to repair and upgrade infrastructure, especially at facilities most affected by floods and monsoon rains, are potential follow-up actions.

Objective	Action (Specific)	Indicators (Measurable)	Potential implementation barriers and mitigation approaches (Achievable)	Relevance	Timeline (Time-Bound)



<p><b>Repair and upgrade damaged infrastructure to withstand floods and other emergencies.</b></p>	<ol style="list-style-type: none"> <li>1. Conduct infrastructure assessments and repair damaged buildings, roofs, and rooms.</li> <li>2. Renovate facilities most affected by floods and monsoon rains.</li> </ol>	<ol style="list-style-type: none"> <li>1. # of facilities repaired and upgraded.</li> <li>2. % of infrastructure damage repaired</li> </ol>	<p><b>Barriers:</b> Funding and technical challenges.</p> <p><b>Mitigation:</b> Secure funding, partner with technical experts, implement phased improvements.</p>	<p>Ensures safety and functionality of health facilities during disasters.</p>	<p>1-6 months for assessments and repairs; ongoing maintenance thereafter.</p>
<p><b>Provide consistent and reliable electricity to support health services.</b></p>	<ol style="list-style-type: none"> <li>1. Assess current power sources and install or upgrade alternative generators (IPS, batteries, fuel).</li> <li>2. Ensure backup power during outages.</li> </ol>	<ol style="list-style-type: none"> <li>1. % of facilities with functioning backup power.</li> <li>2. # of facilities with upgraded power sources.</li> </ol>	<p><b>Barriers:</b> Funding and technical installation challenges.</p> <p><b>Mitigation:</b> Seek external support, train staff on power management.</p>	<p>Critical for maintaining service delivery, especially in emergencies.</p>	<p>1-4 months for assessments and procurement; installations completed within 6 months.</p>

**Recommendation #4: Enhancing health care staff availability and training across UHFWC and UHC facilities.**



**Assessment:** Considerable staffing shortages of doctors, nurses, SACMOs/FWVs, and support staff (such as cleaners and security guards), were reported by facility managers. A majority of UHC (94%) and UHFWC (91%) facilities faced challenges with human resources, mainly due to unfilled positions, high work burdens, and staff shortages. Only 10 out of 198 surveyed UHFWC facilities had at least one nurse or midwife.

To address these issues, more detailed analyses of staffing needs are needed to identify roles most affected by shortages and address long-term and short-term needs. Alternative staffing options, such as hiring part-time or temporary workers, could be explored to respond to immediate staffing shortages. Task-shifting to alleviate the burden of administrative tasks on specialized personnel could also be considered.

Objective	Action (Specific)	Indicators (Measurable)	Potential implementation barriers and mitigation approaches (Achievable)	Relevance	Timeline (Time-Bound)
<b>Increase health care staff numbers and optimize their deployment to ensure adequate coverage in UHFWC and UHC facilities.</b>	<ol style="list-style-type: none"> <li>1. Conduct detailed staffing needs assessments to identify critical gaps.</li> <li>2. Hire part-time, temporary, or locum staff to address immediate shortages.</li> <li>3. Implement task-shifting strategies to reduce administrative</li> </ol>	<ol style="list-style-type: none"> <li>1. Number of additional staff hired or deployed.</li> <li>2. Reduction in staffing vacancies across facilities.</li> <li>3. Decrease in workload per staff member.</li> </ol>	<p><b>Barriers:</b> Budget constraints; resistance to task-shifting.</p> <p><b>Mitigation:</b> through advocacy for increased funding, clear training, protocols, and stakeholder engagement on task-shifting benefits.</p>	Ensuring adequate staffing improves service quality, reduces burnout, and increases facility capacity.	<ol style="list-style-type: none"> <li>1. 1-2 months for staffing needs assessment.</li> <li>2. 3-6 months for hiring and task-shifting implementation.</li> </ol>



	burdens on specialized personnel.				
<b>Strengthen staff skills and knowledge through targeted training programs to improve service quality.</b>	<ol style="list-style-type: none"> <li>1. Develop and implement training programs focusing on emergency response, infection control, and patient management.</li> <li>2. Conduct refresher courses and cross-training to improve versatility.</li> <li>3. Utilize e-learning platforms for ongoing capacity development</li> </ol>	<ol style="list-style-type: none"> <li>1. Number of staff trained per quarter</li> <li>2. Improvement in staff competence scores pre- and post-training. Increased staff confidence in handling emergencies.</li> </ol>	<p><b>Barriers:</b> Limited training resources; technological gaps.</p> <p><b>Mitigation:</b> Partner with training institutions, leverage e-learning, and seek funding support.</p>	Well-trained staff are critical for delivering quality care, especially in resource-limited settings.	<ol style="list-style-type: none"> <li>1. 2-4 months for training needs assessment and program development.</li> <li>2. Ongoing quarterly training sessions.</li> </ol>



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## NEXT STEPS

Three additional rounds of the FASTR rapid-cycle health facility survey are planned for 2025. Round two will provide an updated set of results on quarterly indicators featured in this report – external shocks, the availability of basic utilities, and the availability of supplies – and will capture new insights on facility-level financing and community engagement.

# ANNEX



Cover photo: Mother with children outside of Dhaka, Bangladesh. © Alex Robinson for CHMI.



## Annex Table 1: External shocks

% facilities	UHC	UFWC	Bangladesh
	N=194	N=198	N=392
Percentage of facilities facing at least one shock affecting the communities it serves	21%	15%	15%
Percentage of facilities facing at least one shock affecting their ability to provide services	21%	15%	15%
Natural disasters	16%	14%	14%
Violence or security threats	4%	1%	1%
Outbreaks, epidemics, or pandemics	1%	0%	0%
Major changes in population	0%	0%	0%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Percentage of facilities facing at least one shock affecting the communities it serves	22%	24%	3%	15%	0%	9%	19%	37%
Percentage of facilities facing at least one shock affecting their ability to provide services	22%	24%	3%	15%	0%	9%	19%	37%
Natural disasters	22%	22%	3%	14%	0%	7%	18%	37%
Violence or security threats	0%	4%	0%	0%	0%	1%	1%	0%
Outbreaks, epidemics, or pandemics	0%	0%	0%	0%	0%	0%	0%	0%
Major changes in population	0%	0%	0%	0%	0%	0%	0%	0%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 2: Impact of shocks on services

% facilities	UHC	UHFWC	Bangladesh
	N=41	N=29	N=70
Service use has decreased overall because of the shock	49%	76%	73%
Service use has increased overall because of the shock	24%	3%	6%
Infrastructure	71%	93%	91%
Quality of care	71%	76%	75%
Human resources	54%	62%	61%
Leadership and coordination	44%	59%	57%
Financing	54%	55%	55%
Medical supplies and equipment	39%	55%	53%
Community engagement and trust	39%	52%	50%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=8	N=21	N=5	N=5	N=1	N=7	N=11	N=12
Service use has decreased overall because of the shock	92%	60%	20%	76%	100%	82%	73%	94%
Service use has increased overall because of the shock	0%	12%	0%	0%	0%	4%	6%	5%
Infrastructure	92%	89%	100%	100%	100%	85%	75%	98%
Quality of care	61%	60%	13%	100%	100%	93%	78%	100%
Human resources	61%	50%	87%	76%	100%	44%	51%	81%
Leadership and coordination	61%	50%	7%	76%	100%	41%	49%	79%
Financing	63%	41%	13%	100%	100%	41%	73%	45%
Medical supplies and equipment	61%	57%	7%	76%	100%	41%	27%	63%
Community engagement and trust	61%	50%	0%	98%	100%	44%	25%	45%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



### Annex Table 3: Adequate infrastructure

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Average share of key infrastructures available at health facilities (%)	88%	66%	68%
Percentage of facilities with all key infrastructures available (%)	37%	7%	9%
Availability of power (any source)	99%	96%	97%
Availability of communications (continual access to telephone and/or internet)	78%	78%	78%
Availability of emergency transportation, with driver and fuel available 24h a day	88%	-	88%
Availability of basic WASH	55%	7%	11%
Improved water source on the facility premises	96%	77%	79%
Functional hand hygiene facility (water with soap or sanitizer) at all points of care and within 5m of toilets	96%	73%	75%
Safe disposal of non-sharps infectious waste	75%	68%	69%
Guidelines or protocols for cleaning	86%	46%	50%
Improved latrines, with one separated toilet for staff and for women (with a menstrual hygiene bin in the female-only toilet)	87%	22%	27%



% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Average share of key infrastructures available at health facilities (%)	66%	69%	63%	71%	59%	72%	69%	70%
Percentage of facilities with all key infrastructures available (%)	6%	12%	7%	9%	9%	3%	16%	6%
Availability of power (any source)	100%	98%	95%	96%	89%	96%	100%	100%
Availability of communications (continual access to telephone and/or internet)	86%	80%	72%	88%	67%	75%	71%	87%
Availability of emergency transportation, with driver and fuel available 24h a day	94%	83%	83%	82%	86%	100%	91%	86%
Availability of basic WASH	7%	14%	10%	10%	9%	4%	22%	7%
Improved water source on the facility premises	68%	76%	77%	77%	67%	86%	92%	87%
Functional hand hygiene facility (water with soap or sanitizer) at all points of care and within 5m of toilets	68%	80%	69%	78%	67%	79%	75%	80%
Safe disposal of non-sharps infectious waste	79%	72%	60%	64%	72%	79%	61%	73%
Guidelines or protocols for cleaning	41%	53%	40%	67%	38%	65%	44%	34%
Improved latrines, with one separated toilet for staff and for women (with a menstrual hygiene bin in the female-only toilet)	21%	26%	31%	28%	12%	25%	41%	28%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 4: Routine utilities and communications

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Percentage of facilities that had continual access to power, water, and telephone or internet service in the past 7 days	3%	3%	3%
Continual availability of water	82%	80%	80%
Continual availability of telephone service	76%	77%	77%
Continual availability of internet	58%	56%	56%
Continual availability of electricity	5%	3%	3%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Percentage of facilities that had continual access to power, water, and telephone or internet service in the past 7 days	0%	0%	3%	8%	0%	4%	4%	0%
Continual availability of water	73%	74%	86%	80%	84%	88%	74%	80%
Continual availability of telephone service	86%	78%	72%	88%	67%	75%	66%	87%
Continual availability of internet	59%	55%	62%	65%	36%	52%	50%	61%
Continual availability of electricity	0%	0%	4%	8%	0%	4%	4%	0%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 5: Latrine availability for designated groups

% facilities	UHC	UHFWC	Bangladesh
	N=191	N=189	N=380
Improved functional and accessible latrine available for staff only	94%	53%	57%
Improved functional and accessible latrine available for people with limited mobility	28%	2%	4%
Improved functional and accessible latrine available for women only	97%	40%	45%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=29	N=81	N=71	N=46	N=28	N=53	N=44	N=28
Improved functional and accessible latrine available for staff only	65%	52%	48%	69%	67%	47%	70%	54%
Improved functional and accessible latrine available for people with limited mobility	9%	7%	4%	3%	2%	1%	1%	1%
Improved functional and accessible latrine available for women only	43%	42%	47%	42%	34%	54%	46%	48%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 6: Female-only toilets water availability and cleaning frequencies

% facilities	UHC	UHFWC	Bangladesh
	N=186	N=76	N=262
<b>Water availability</b>			
All the time	79%	71%	72%
Most of the time	19%	18%	19%
Some of the time	1%	8%	7%
Never	1%	3%	2%
<b>Cleaning frequency</b>			
More than once every day	45%	4%	11%
Once every day	42%	49%	48%
Every 2-3 days	12%	37%	32%
Once a week or less frequently	1%	11%	9%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=19	N=55	N=50	N=31	N=17	N=39	N=31	N=20
<b>Water availability</b>								
All the time	57%	68%	78%	88%	56%	66%	81%	72%
Most of the time	27%	21%	21%	11%	25%	20%	19%	0%
Some of the time	0%	5%	0%	0%	19%	14%	0%	28%
Never	16%	5%	0%	1%	0%	0%	0%	0%
<b>Cleaning frequency</b>								
More than once every day	10%	8%	5%	1%	30%	14%	21%	17%
Once every day	25%	62%	46%	59%	28%	46%	42%	41%
Every 2-3 days	49%	24%	27%	40%	42%	33%	27%	41%
Once a week or less frequently	16%	5%	23%	0%	0%	7%	9%	0%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 7: Gender-friendly accommodations

% facilities	<b>UHC</b>	<b>UHFWC</b>	<b>Bangladesh</b>
	N=194	N=198	N=392
Facility has a room with auditory and/or visual privacy for patient consultations	87%	59%	61%
Facility has spaces and equipment for childcare while women are waiting to see a provider	11%	1%	2%
Facility has a separate waiting room for men and women	44%	20%	22%

% facilities	<b>BAR</b>	<b>CHA</b>	<b>DHA</b>	<b>KHU</b>	<b>MYM</b>	<b>RAJ</b>	<b>RAN</b>	<b>SYL</b>
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Facility has a room with auditory and/or visual privacy for patient consultations	61%	62%	59%	67%	59%	52%	71%	61%
Facility has spaces and equipment for childcare while women are waiting to see a provider	0%	2%	1%	0%	0%	2%	6%	0%
Facility has a separate waiting room for men and women	30%	20%	25%	17%	35%	14%	23%	15%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



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## Annex Table 8: Accessibility for persons with disabilities

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Facility has steps to access or enter parts of it	25%	34%	33%
Facility has a ramp or lift available wherever there are stairs for access of people with limited mobility (among facilities that have stairs)	90%	0%	5%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Facility has steps to access or enter parts of it	21%	33%	29%	29%	35%	37%	51%	27%
Facility has a ramp or lift available wherever there are stairs for access of people with limited mobility (among facilities that have stairs)	8%	5%	7%	11%	4%	5%	1%	2%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 9: Availability of medical supplies and equipment

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Average share of tracer medical supplies available at facilities (%)	77%	53%	55%
Percentage of facilities with all tracer medical supplies available (%)	1%	0%	0%
Average percentage of tracer medical equipment available (%)	86%	71%	72%
Average percentage of tracer essential medicines available (%)	69%	39%	42%
Average percentage of tracer vaccines available (%)	77%	-	77%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Average share of tracer medical supplies available at facilities (%)	52%	61%	54%	57%	50%	52%	52%	56%
Percentage of facilities with all tracer medical supplies available (%)	0%	0%	0%	0%	0%	0%	0%	0%
Average percentage of tracer medical equipment available (%)	66%	83%	69%	73%	64%	70%	69%	72%
Average percentage of tracer essential medicines available (%)	41%	45%	42%	44%	39%	38%	38%	43%
Average percentage of tracer vaccines available (%)	69%	40%	83%	95%	76%	90%	92%	100%



## Annex Table 10: Vaccine availability

% facilities	UHC	UHFWC*	Bangladesh
	N=194	N=193	N=392
Average percentage of tracer vaccines available (%)	77%	-	77%
Percentage of facilities with all tracer vaccines (%)	60%	-	60%
Measles and rubella vaccine	83%	-	83%
Polio vaccine	80%	-	80%
BCG vaccine	80%	-	80%
Penta vaccine (DPT + HiB + HepB)	70%	-	70%
Pneumococcal vaccine (PCV)	71%	-	71%
Human papilloma vaccine injection (HPV)	25%	-	25%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Average percentage of tracer vaccines available (%)	69%	40%	83%	95%	76%	90%	92%	100%
Percentage of facilities with all tracer vaccines (%)	63%	29%	44%	86%	50%	78%	74%	100%
Measles and rubella vaccine	69%	49%	94%	95%	79%	100%	96%	100%
Polio vaccine	75%	40%	94%	100%	71%	89%	100%	100%
BCG vaccine	69%	43%	86%	95%	93%	93%	96%	100%
Penta vaccine (DPT + HiB + HepB)	69%	36%	67%	86%	64%	89%	87%	100%
Pneumococcal vaccine (PCV)	63%	36%	75%	95%	71%	81%	83%	100%
Human papilloma vaccine injection (HPV)	44%	10%	31%	59%	43%	15%	13%	0%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.

\*UHFWCs were removed from the calculation of vaccine availability indices, as vaccines are not expected to be available in those facilities.



## Annex Table 11: Essential medicines availability

<i>% facilities</i>	<b>UHC</b> N=194	<b>UHFWC</b> N=198	<b>Bangladesh</b> N=392
Average percentage of tracer essential medicines available (%)	69%	39%	42%
Percentage of facilities with all tracer essential medicines (%)	7%	1%	1%
Iron folic acid	96%	72%	74%
Short-acting reversible contraception methods	73%	65%	65%
Amoxicillin or gentamicin	88%	55%	57%
Long-acting reversible contraception methods	60%	50%	51%
Chlorohexidine	78%	37%	41%
Zinc sulphate	86%	31%	36%
Oral rehydration salts	88%	16%	22%
Magnesium sulphate	70%	16%	20%
Oxytocin or other uterotonic	70%	10%	15%
Vitamin A	58%	-	58%
Anti-asthmatics	65%	-	65%
First-line anti-hypertensives	68%	-	68%
Metformin, insulin injection, other hypoglycemics	49%	-	49%
Anti-malarials	23%	-	23%



% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Average percentage of tracer essential medicines available (%)	41%	45%	42%	44%	39%	38%	38%	43%
Percentage of facilities with all tracer essential medicines (%)	0%	0%	0%	4%	0%	0%	0%	4%
Iron folic acid	67%	65%	82%	78%	78%	75%	66%	87%
Short-acting reversible contraception methods	72%	70%	65%	81%	47%	50%	57%	80%
Amoxicillin or gentamicin	68%	59%	49%	48%	61%	57%	58%	74%
Long-acting reversible contraception methods	50%	60%	55%	56%	30%	47%	40%	54%
Chlorohexidine	33%	42%	42%	41%	38%	39%	44%	41%
Zinc sulphate	41%	46%	32%	31%	50%	28%	33%	21%
Oral rehydration salts	16%	24%	23%	17%	33%	25%	24%	8%
Magnesium sulphate	22%	26%	20%	26%	11%	16%	21%	8%
Oxytocin or other uterotonic	13%	21%	17%	20%	5%	10%	7%	20%
Vitamin A	69%	50%	58%	64%	71%	41%	48%	100%
Anti-asthmatics	50%	48%	69%	77%	79%	67%	65%	86%
First-line anti-hypertensives	56%	50%	72%	82%	71%	81%	65%	79%
Metformin, insulin injection, other hypoglycaemic	31%	31%	53%	77%	71%	63%	26%	64%
Anti-malarials	19%	29%	8%	14%	36%	7%	22%	79%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 12: Medical equipment availability

% facilities	<b>UHC</b>	<b>UHFWC</b>	<b>Bangladesh</b>
	N=194	N=198	N=392
Average percentage of tracer medical equipment available (%)	86%	71%	72%
Percentage of facilities with all tracer medical equipments (%)	9%	22%	21%
Functional thermometer	100%	81%	82%
Functional child weighing scale	99%	82%	83%
Functional height board	98%	68%	71%
Functional blood pressure apparatus	100%	89%	90%
Oxygen delivery apparatus	97%	51%	55%
Speculum	94%	74%	75%
Equipment to collect pap smear specimen	78%	-	78%
Refrigerator continuous temperature monitoring	96%	51%	55%
Cold box or vaccine carrier with ice packs	91%	-	91%
Ventilator	16%	-	16%
X-Ray machine	79%	-	79%

% facilities	<b>BAR</b>	<b>CHA</b>	<b>DHA</b>	<b>KHU</b>	<b>MYM</b>	<b>RAJ</b>	<b>RAN</b>	<b>SYL</b>
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Average percentage of tracer medical equipment available (%)	66%	83%	69%	73%	64%	70%	69%	72%
Percentage of facilities with all tracer medical equipments (%)	13%	33%	19%	15%	17%	19%	18%	26%
Functional thermometer	74%	91%	85%	82%	67%	89%	67%	87%
Functional child weighing scale	74%	98%	88%	79%	78%	82%	71%	74%
Functional height board	42%	91%	65%	71%	56%	68%	79%	61%



% facilities	<b>BAR</b>	<b>CHA</b>	<b>DHA</b>	<b>KHU</b>	<b>MYM</b>	<b>RAJ</b>	<b>RAN</b>	<b>SYL</b>
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Functional blood pressure apparatus	100%	89%	88%	96%	95%	89%	88%	80%
Oxygen delivery apparatus	55%	69%	45%	64%	45%	47%	50%	54%
Speculum	81%	84%	70%	74%	59%	75%	75%	80%
Equipment to collect pap smear specimen	75%	81%	86%	77%	71%	63%	70%	100%
Refrigerator continuous temperature monitoring	47%	64%	50%	46%	51%	44%	62%	74%
Cold box or vaccine carrier with ice packs	81%	69%	97%	100%	100%	100%	100%	100%
Ventilator	0%	19%	14%	32%	29%	11%	17%	0%
X-Ray machine	69%	69%	92%	77%	79%	89%	74%	79%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



### Annex Table 13: Contraceptive methods availability

% facilities	UHC	UHFWC	Bangladesh
	N=156	N=191	N=347
Average share of tracer reversible contraceptive methods available (%)	68%	59%	60%
Percentage of facilities with all tracer reversible contraceptive methods (%)	39%	21%	22%
Male condom	75%	77%	77%
Oral contraceptive	76%	65%	66%
Intrauterine contraceptive device (IUCD)	61%	47%	49%
Injectable contraceptive	73%	56%	57%
Emergency contraceptive pill	53%	52%	52%
Implant	68%	-	68%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=29	N=79	N=60	N=34	N=23	N=51	N=43	N=28
Average share of tracer reversible contraceptive methods available (%)	59%	62%	61%	70%	50%	57%	52%	65%
Percentage of facilities with all tracer reversible contraceptive methods (%)	9%	22%	29%	42%	13%	17%	16%	14%
Male condom	78%	79%	75%	88%	70%	71%	62%	93%
Oral contraceptive	74%	73%	63%	78%	53%	57%	65%	61%
Intrauterine contraceptive device (IUCD)	52%	48%	62%	49%	30%	52%	36%	48%
Injectable contraceptive	48%	65%	55%	63%	53%	46%	61%	61%
Emergency contraceptive pill	44%	45%	50%	70%	46%	61%	37%	60%
Implant	63%	81%	61%	32%	57%	67%	82%	100%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 14: Strategies used when a medicine is unavailable

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Use or prescribe a less suitable medicine	53%	41%	42%
Instruct the patient to purchase the medicine elsewhere	96%	84%	85%
Refer or transfer the patient to another health facility	84%	96%	95%
Delay treatment until the medicine is in stock	12%	12%	12%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Use or prescribe a less suitable medicine	48%	43%	42%	58%	19%	43%	29%	48%
Instruct the patient to purchase the medicine elsewhere	81%	80%	82%	89%	84%	86%	92%	93%
Refer or transfer the patient to another health facility	91%	95%	91%	95%	100%	96%	96%	100%
Delay treatment until the medicine is in stock	19%	14%	1%	15%	11%	19%	6%	15%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



**Annex Table 15: Frequency of medicines orders and deliveries receipt**

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
<b>Medicines orders</b>			
Monthly	9%	81%	75%
Every other month	7%	14%	13%
Less than quarterly	60%	1%	6%
Quarterly	15%	5%	5%
Weekly	7%	0%	1%
Every two weeks	2%	0%	0%
<b>Deliveries receipt</b>			
Monthly	10%	86%	80%
Every other month	4%	10%	9%
Less than quarterly	64%	0%	5%
Quarterly	12%	5%	5%
Weekly	7%	0%	1%
Every two weeks	2%	0%	0%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
<b>Medicines orders</b>								
Monthly	52%	77%	80%	83%	72%	67%	79%	79%
Every other month	19%	18%	6%	4%	16%	18%	12%	13%
Less than quarterly	9%	4%	9%	4%	3%	8%	3%	7%
Quarterly	19%	1%	5%	8%	8%	7%	3%	0%
Weekly	0%	0%	0%	1%	0%	0%	2%	1%
Every two weeks	0%	0%	0%	0%	0%	0%	0%	0%
<b>Deliveries receipt</b>								
Monthly	65%	88%	82%	86%	67%	67%	83%	85%



% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Every other month	6%	7%	6%	4%	22%	18%	8%	7%
Less than quarterly	9%	5%	6%	4%	3%	5%	3%	7%
Quarterly	20%	0%	5%	5%	8%	9%	2%	0%
Weekly	0%	0%	0%	1%	0%	0%	2%	1%
Every two weeks	0%	0%	0%	0%	0%	0%	0%	0%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 16: Methods for recording the receipt, inventory, and dispensing of medicines

<i>% facilities</i>	<b>UHC</b> N=194	<b>UHFWC</b> N=198	<b>Bangladesh</b> N=392
Paper records only	81%	94%	93%
Paper records and one or more IT systems (including mobile phone applications)	19%	6%	7%

<i>% facilities</i>	<b>BAR</b> N=30	<b>CHA</b> N=84	<b>DHA</b> N=73	<b>KHU</b> N=48	<b>MYM</b> N=31	<b>RAJ</b> N=53	<b>RAN</b> N=45	<b>SYL</b> N=28
Paper records only	95%	90%	97%	92%	100%	87%	94%	92%
Paper records and one or more IT systems (including mobile phone applications)	5%	10%	3%	8%	0%	13%	6%	8%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 17: Medical supplies challenges

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Percentage of facilities reporting at least one challenge related to medical supplies (%)	72%	87%	86%
Percentage of facilities reporting that challenges limited or prevented service delivery (%)	53%	66%	65%
Patient numbers were greater than expected	60%	56%	56%
Lack of space for storage	38%	23%	24%
No delivery (or pickup) vehicle available	19%	24%	24%
Lack of funds to order additional supplies	26%	20%	21%
Shortages at the district- or higher-level	13%	18%	18%
Other challenges	13%	18%	18%
Some supplies are available, but unusable/expired	7%	4%	4%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Percentage of facilities reporting at least one challenge related to medical supplies (%)	78%	84%	80%	92%	83%	92%	90%	86%
Percentage of facilities reporting that challenges limited or prevented service delivery (%)	58%	67%	56%	76%	64%	68%	69%	53%
Patient numbers were greater than expected	58%	52%	47%	73%	61%	70%	48%	40%
Lack of space for storage	26%	16%	18%	22%	32%	37%	26%	33%
No delivery (or pickup) vehicle available	8%	27%	20%	48%	19%	19%	12%	26%
Lack of funds to order additional supplies	20%	20%	10%	39%	7%	23%	22%	29%
Shortages at the district- or higher-level	33%	15%	16%	30%	21%	11%	11%	10%



% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Other challenges	21%	14%	13%	14%	16%	35%	22%	7%
Some supplies are available, but unusable/expired	1%	5%	1%	4%	6%	11%	5%	0%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



**Annex Table 18: Availability of staff cadres**

Average number of staff cadres	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Number of health care providers	51	2	6
Number of medical doctors	11	0	1
Number of nursing and midwifery personnel	29	0	2
Number of community health workers	49	2	5
Number of women health care providers	34	1	4
Number of women medical doctors	4	0	0
Number of women nurses/midwives	27	0	2
Number of women community health workers	25	1	3

Average number of staff cadres	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Number of health care providers	5	5	6	5	5	7	6	4
Number of medical doctors	0	1	1	1	1	1	1	1
Number of nursing and midwifery personnel	3	2	2	2	2	3	3	2
Number of community health workers	6	5	5	4	6	7	5	6
Number of women health care providers	4	3	4	3	3	5	4	3
Number of women medical doctors	0	0	1	0	0	1	1	0
Number of women nurses/midwives	3	2	2	2	2	3	3	2
Number of women community health workers	3	3	3	3	3	4	3	3

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 19: Staff training availability

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Average share of key trainings received in past 2 years in facilities (%)	54%	23%	26%
Percentage of facilities that received all adequate training in past 2 years (%)	1%	0%	0%
Family planning services	41%	37%	38%
Intrauterine contraceptive device (IUCD) insertion	44%	32%	33%
Adolescent friendly health services	63%	31%	34%
Antenatal care (ANC) services	86%	29%	34%
Postnatal care (PNC) services	84%	30%	34%
Newborn resuscitation using newborn bag/mask	68%	22%	26%
Child immunization	61%	-	61%
Growth monitoring services for children	53%	14%	17%
Diagnosis and treatment of sick children/IMCI	81%	23%	28%
Gender-based violence screening	50%	-	50%
Cervical cancer screening by Pap Smear	69%	-	69%
STI diagnosis and treatment	38%	9%	11%
Malaria diagnosis	20%	-	20%
Malaria treatment	19%	-	19%
Providing services to older adults	28%	-	28%
Mental Health and Psychosocial Support (MHPSS)	52%	-	52%



% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Average share of key trainings received in past 2 years in facilities (%)	24%	32%	29%	18%	20%	25%	24%	26%
Percentage of facilities that received all adequate training in past 2 years (%)	0%	0%	0%	0%	0%	0%	0%	0%
Family planning services	37%	45%	36%	36%	18%	31%	40%	54%
Intrauterine contraceptive device (IUCD) insertion	35%	45%	39%	8%	29%	26%	35%	41%
Adolescent friendly health services	53%	47%	39%	10%	38%	27%	24%	26%
Antenatal care (ANC) services	22%	43%	41%	27%	22%	36%	28%	28%
Postnatal care (PNC) services	22%	42%	45%	27%	22%	40%	23%	28%
Newborn resuscitation using newborn bag/mask	25%	30%	25%	22%	20%	22%	23%	41%
Child immunization	69%	74%	39%	50%	86%	52%	70%	64%
Growth monitoring services for children	17%	14%	21%	14%	20%	22%	11%	21%
Diagnosis and treatment of sick children/IMCI	13%	34%	23%	27%	23%	33%	28%	28%
Gender-based violence screening	50%	48%	19%	23%	64%	70%	74%	86%
Cervical cancer screening by Pap Smear	81%	64%	69%	73%	57%	70%	57%	93%
STI diagnosis and treatment	11%	14%	7%	9%	10%	10%	15%	10%
Malaria diagnosis	0%	29%	14%	9%	50%	26%	22%	0%
Malaria treatment	0%	29%	11%	9%	50%	26%	22%	0%
Providing services to older adults	44%	19%	17%	5%	29%	44%	48%	36%
Mental Health and Psychosocial Support (MHPSS)	44%	21%	42%	32%	71%	81%	70%	100%

\*BAR: Barishal; CHA: Chattogram; DHA: Dhaka; KHU: Khulna; MYM: Mymensingh; RAJ: Rajshahi; RAN: Rangpur; SYL: Sylhet.



## Annex Table 20: Human resources challenges

% facilities	UHC	UHFWC	Bangladesh
	N=194	N=198	N=392
Percentage of facilities that report at least one challenge related to human resources	93%	91%	91%
Percentage of facilities reporting that challenges limited or prevented service delivery (%)	71%	68%	68%
Absenteeism	24%	10%	11%
Unfilled positions or staff shortage	88%	76%	77%
High work burden	87%	81%	81%
Some services are dependent on unpaid volunteers	8%	9%	9%
Lack of training	77%	83%	83%
Lack of satisfaction with job condition	9%	14%	14%

% facilities	BAR	CHA	DHA	KHU	MYM	RAJ	RAN	SYL
	N=30	N=84	N=73	N=48	N=31	N=53	N=45	N=28
Percentage of facilities that report at least one challenge related to human resources	99%	98%	89%	74%	89%	88%	100%	93%
Percentage of facilities reporting that challenges limited or prevented service delivery (%)	72%	75%	65%	51%	73%	57%	83%	74%
Absenteeism	2%	13%	13%	4%	7%	12%	8%	28%
Unfilled positions or staff shortage	86%	89%	74%	60%	66%	70%	91%	80%
High work burden	98%	89%	75%	70%	83%	74%	79%	93%
Some services are dependent on unpaid volunteers	7%	10%	5%	4%	0%	16%	18%	13%
Lack of training	92%	86%	81%	69%	84%	84%	91%	80%
Lack of satisfaction with job condition	21%	15%	18%	8%	11%	18%	9%	7%



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