



1.61 M people in need (PiN)
(ISCG JRP 2025)



1,189,213 Rohingya Refugees
1.38 M Health Sector Target (JRP 2026)¹

HIGHLIGHTS

- In March 2026, Routine service delivery and access to essential healthcare services remained widely uninterrupted.
- Skin diseases continued to maintain its position among the top 3 morbidities with a high number of cases, with an upsurge observed since the last 10 months, with more than 42,638 (around 14% of total consultations for diseases).
- Cholera, Diphtheria, and COVID-19 remain under control, with zero cases reported in March 2026. Dengue cases also remain minimal compared to previous year trends.
- Nationwide devastating Measles outbreak is ongoing. Followed by the nation wide outbreak, the increasing number of measles cases were observed in Rohingya camps, with 76 suspected cases and 8 lab-confirmed measles cases reported so far.

THE HEALTH SECTOR



49 ACTIVE HEALTH SECTOR (HS) PARTNERS
 17 APPEALING PARTNERS – JRP 2026

REGISTERED HEALTH FACILITIES



45 HEALTH POSTS
 46 PRIMARY HEALTH CENTRES
 05 FACILITIES WITH CEmONC SERVICES
 448 MEDICAL DOCTOR
 405 NURSES
 453 MIDWIVES

HEALTH ACTION



370K OPD CONSULTATIONS
 5,797 INPATIENT ADMISSIONS
 2,585 FACILITY-BASED BIRTHS-Refugee & Host
 97.4% % LIVE BIRTHS
 2.6% % STILLBIRTHS
 1 MATERNAL DEATHS
 0% COVID-19 CASE FATALITY RATIO

DISEASE SURVEILLANCE



0.57 CRUDE DEATHS/1,000 Pop (Up to Mar 26)
 12 COVID-19 SENTINEL SITES
 33 AWD SENTINEL SITES
 102 EWARS REPORTING SITES

HEALTH FUNDING \$USD (JRP 2026)



RCP Financial Analysis for JRP 2026
(updated as of February 2026)
 USD **49.9 M** Requested
25.9 M Received/ Committed
23.9 M Funding gap **48 %**

¹ 100% of the Rohingya Refugees living in camps and 25% of the Host Community have been targeted in JRP 2026

General Situation

In March 2026, routine service delivery and access to essential healthcare services remained uninterrupted without any major incident. Health facilities continued to operate without damage or disruption.

Health Services Delivery

In March 2026, more than 370,686 outpatient (OPD) consultations were recorded (4,865 consultations per PHC and 2,188 consultations per HP), which is almost similar to the number of consultations recorded/ day last month but around 10% lower than last 12 months average monthly consultations. The decrease is seasonal, as observed every year during the Eid season due to the month of Ramadan and Eid holidays. According to DHIS-2 data, OPD consultations are mainly contributed to by ARI and skin diseases, the same as last year.

In March 2026, more than 5,797 inpatient admissions were recorded, which is almost similar to the last month but around 30% lower (significant, $P < 0.05$) than the monthly average number of inpatient admissions of the last year, but similar to the last three months, indicating less severity of cases in the last four months compared to the previous months. All other health service utilization indicators showed almost the same decreasing pattern compared to last month and the last six months' average.

According to DHIS-2 data, the morbidity distribution among refugees for March 2026 changed slightly compared to the previous months, but is still predominantly characterized by Acute Respiratory Infections (ARI) and skin diseases. ARI cases contributed 25% of the consultations for diseases (Fig. 1) during the reporting period, with around 75,714 consultations for non-pneumonia infections, which was slightly higher (4%) than last month. Seasonal variations

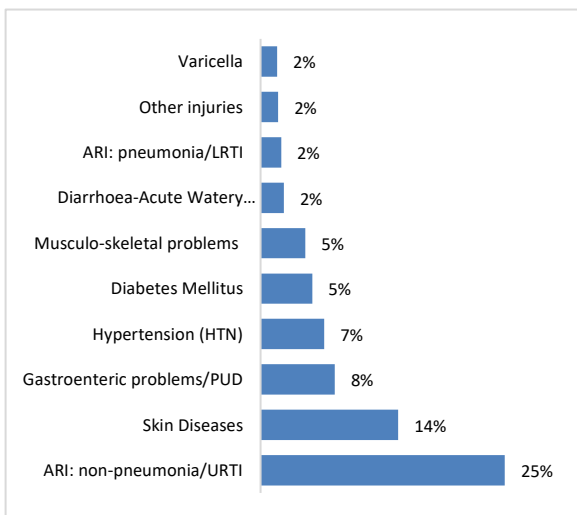


Figure 1: Top Morbidity Reported in DHIS-2 (Mar 2026)

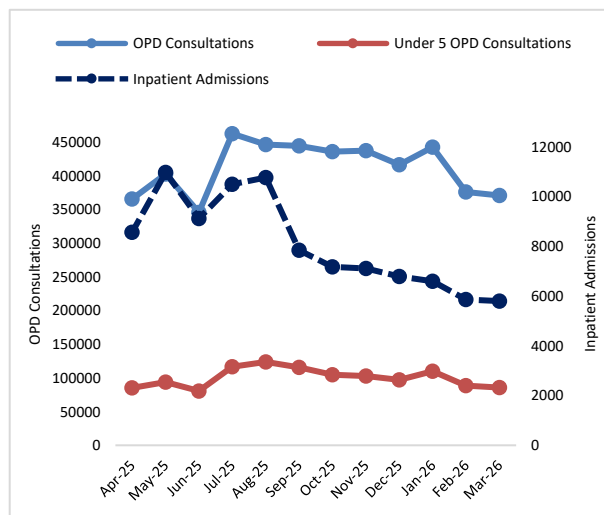


Figure 2: Trends of OPD consultations and Inpatient Admissions

and shifts in weather patterns may contribute to the changes in ARI consultations. The trend in skin diseases continued to maintain its position among the top 3 morbidities with a high

number of cases, with an upsurge observed since the last 10 months, with more than 42,638 cases reported this month, contributing to around 14% of the total consultations for diseases during the reporting period. Scabies contact management was initiated in all 33 camps through community health workers (CHWs), involving identification of close contacts, treatment, health promotion, environmental interventions, and follow-up. WHO supported the provision of medication starting in October 2025, and this support was sustained through March 2026.

The top 10 reasons for consultations remained largely unchanged in the last 12 months.

Table 1: Selected Health System Performance Data

| Indicator | March 2026 | Cumulative 2026 | Baseline-2025 | Progress |
|--|------------|-----------------|---------------|-----------------|
| Total number of OPD Consultations (Host and Rohingya) | 370,686 | 1,189,175 | 5,033,974 | 1.00 per person |
| Total number of Inpatient Admissions (Host and Rohingya) | 5,797 | 18,258 | 104,324 | 18% |
| Total number of patients referred out | 3,385 | 11,558 | 51,322 | 23% |
| Total number of first-time users (Host and Rohingya) | 5,522 | 20,248 | 113,659 | 18% |
| Total number of ANC 1 Visit - Rohingya | 4,749 | 15,742 | 81,087 | |
| Total number of Live births at the facility (Host and Rohingya) | 2,519 | 8,108 | NA | |
| Total number of Stillbirths at the facility (Host and Rohingya) | 66 | 164 | NA | |
| Of the births, the number of mothers who had ANC 4 or above visits (Rohingya) | 1,730 | 6,278 | 82% | 98% |
| Total number of C-sections at health facilities | 353 | 1,132 | 3,359 | |
| Total number of Post Abortion Care provided (Host and Rohingya) | 168 | 687 | 3,711 | |
| Total number of beneficiaries newly diagnosed with Hypertension (Host and Rohingya) | 5,902 | 21,247 | NA | |
| Total number of beneficiaries newly diagnosed with Diabetes Mellitus (Host and Rohingya) | 963 | 5,915 | NA | |
| Total Number of NEW clinical mental health consultations done by a psychiatrist and/or | 623 | 2,118 | NA | |

| | | | | |
|---|-------|---------------|---------------|------------|
| mhGAP doctor (Host and Rohingya) | | | | |
| Number of NEW focused counselling done by a psychologist or a counsellor (Host & Rohingya) | 3,961 | 11,488 | NA | |
| Total number of Minor surgeries conducted (Host and Rohingya) | 6,594 | 21,104 | 83,852 | 25% |
| Total number of Major surgeries conducted (Host and Rohingya) | 607 | 1,915 | 6,457 | 30% |
| Total number of Post Natal Care (PNC) visits after discharge from health facility following birth/delivery or first visit after home delivery (Host and Rohingya) | 3,250 | 11,103 | 46,264 | |
| Number of Malnutrition cases referred: Total number of children 6-59 months referred for nutrition services | 588 | 2,577 | 9,001 | 29% |

Public health risks, priorities, needs, and gaps

1. Communicable Disease Control and Surveillance

Dengue

During the reporting month, there was a slight increase in the number of Dengue Fever cases observed in the Rohingya camps at Cox's Bazar compared to the previous month, with more than 82 cases (68 Rohingya, 14 Host) reported in March 2026, which is 82% higher than last month. However, the trend of dengue is still much lower than previous year's trends, as observed

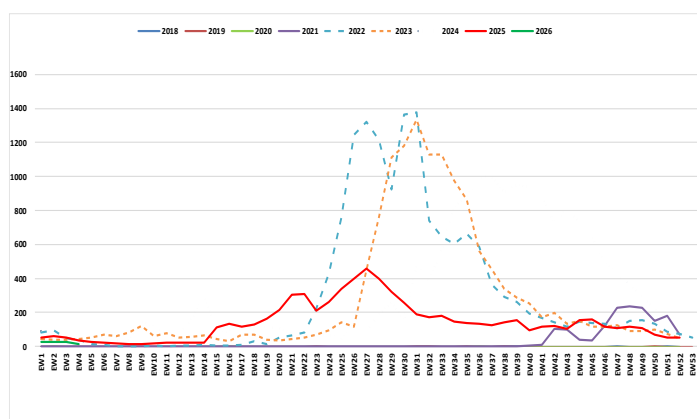


Figure 3: Dengue Trends among the Refugees (WHO, Cox's Bazar)

in Figure 5. No confirmed deaths were reported during the reporting period (CFR 0%). The multi-sectoral response interventions continue to be scaled up by Health, WASH, and Camp and Site Management teams across all camps.

AWD/Cholera

Cholera remains under control, with zero cases reported in March 2026, with no cases reported in the last six months. Since the Oral Cholera Vaccine (OCV) campaign in January 2025, a total of seven confirmed cases have been recorded so far. Due to the campaign and cholera prevention efforts, transmission remained low. No cholera-related deaths were confirmed in the last twelve months (CFR-0%).

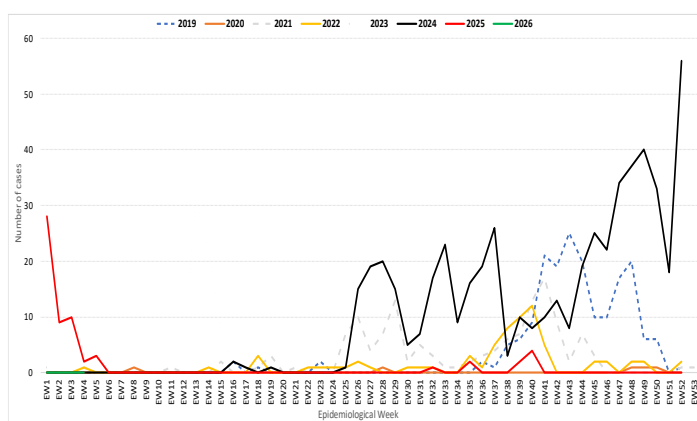


Figure 4: Trends of Culture-confirmed Cholera cases from 2018 - 2026

Measles

Country-wide Measles situation:

As of 2 April 2026, Bangladesh reported 2,310 suspected and 751 confirmed measles cases (incidence: 17.2/million), with ~80% among children under five, indicating high burden in young age groups. A total of 41 suspected deaths were reported, mainly among unvaccinated children under two years. Transmission is widespread, with the highest case numbers in Dhaka Division and the highest incidence in Barishal, Mymensingh, and Rajshahi. Cox's Bazar has the highest district incidence. Multiple district and urban hotspots identified, with 30 upazilas contributing a significant proportion of cases. A phased nationwide MR campaign targeting children 6–59 months is ongoing, starting from hotspot areas and expanding nationwide.

Rohingya camps with measles situation:

As of March 2026, a total of 76 suspected cases were reported from Rohingya response, among them 8 lab-confirmed positive measles cases, including 1 case from Bhasan Char island and 1 case from Teknaf Upazila. Two suspected outbreaks were reported in Camp 3 and Camp 15, based on the definition of at least five suspected cases within a camp occurring within 28 days of rash onset. However, no laboratory-confirmed outbreaks have been reported in the camps so far. The annualized measles incidence per million population in the camps in 2026 up to March stands at 29.44, compared to 5.10 in the previous year.

The annualized discarded (non-measles, non-rubella) rate was 23.92/100,000 population in 2026 and 47.13/100,000 population in 2025 against a global target of 2/100,000 annually. This indicates adequate case investigation and laboratory surveillance sensitivity.

COVID-19

COVID-19 transmission is also under control, with 0 cases reported in March 2026.

Diphtheria

In March 2026, no new confirmed diphtheria case was reported in the Rohingya Camps at Cox's Bazar, similar to the last four months.

2. Routine Immunization and AFP & VPD surveillance

In March 2026, more than 33,000 doses of different antigens were administered, targeting children less than 2 years old. This includes 10,968 doses of the Polio vaccine (OPV 1st to 3rd doses, fIPV 1st and 2nd doses) and 4,120 doses of the Measles vaccine (MR 1st and 2nd doses).

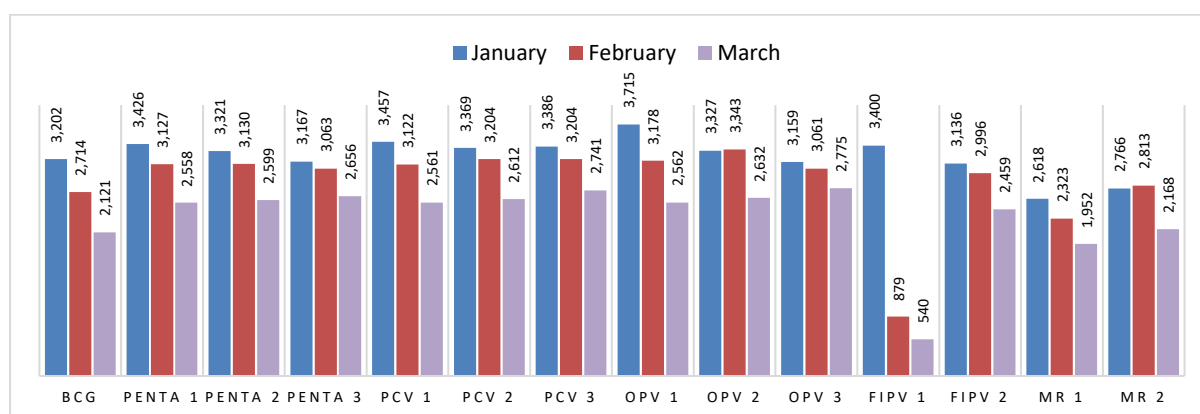


Figure 5: Number of doses administered through Routine Immunization in Rohingya Camps at Cox's Bazar (Source: DHIS-2)

Health Sector Action

1. Coordination, Collaboration, and Strategic Guidance

Technical and Strategic Guidance

Field Coordination

In March 2026, 33 camp-level health partner coordination meetings were held across all camps. One Camp Health Focal Point meeting was held as well. These meetings focused on updates regarding available health services, epidemiological trends, and public health programs. Key discussions included strategies for community health outreach support and public health promotion efforts targeting communicable diseases like Dengue, Chikungunya, COVID-19, and Cholera/AWD, etc. Critical updates were shared with partners, and emerging issues were addressed collaboratively.

2. Technical Working Groups (TWGs)

Epidemiology, Case management, and IPC Technical Working Group (Epi TWG)

Routine supportive supervision is being implemented to ensure functionality, data quality, and timeliness of EWARS reporting, and to strengthen end-to-end surveillance performance across all health facilities. To address immediate capacity gaps, targeted on-the-job training is being delivered to facility staff, complemented by a phased short- and long-term capacity development plan to institutionalize competencies and mitigate current gaps.

Guidance for the integrated sentinel surveillance system was finalized and printed and will be distributed to the Health Sector partners. A structured capacity assessment is going on in the camps, and findings were subsequently disseminated through a workshop convened with all health-sector partners to support harmonized implementation and coordinated follow-up actions.

Mortality surveillance and ICD-11 training are planned for the coming month to introduce the ICD-11 classification system in the current context. Implementation is planned for the second quarter of this year.

3. Health Sector Partners Update

HAEFA

During March 2026, Health and Education for All (HAEFA) conducted targeted awareness sessions on measles outbreaks and prevention at HAEFA's two health posts in FDMN camps. The initiative emphasized early symptom recognition, timely healthcare seeking, and the importance of vaccination.

To support infection prevention efforts, protective masks were distributed among community members to reduce transmission risk. The intervention strengthened community awareness and promoted preventive practices, contributing to ongoing efforts to control the measles outbreak in alignment with Health Sector priorities.

International Organization for Migration (IOM)

WHO, IOM and the Health Sector Emergency Preparedness and Response Technical Committee jointly organized a training on integrated pre-hospital emergency response, engaging 187 frontline responders from 17 partner organizations.

World Health Organization (WHO)

Essential Lab Services: In March 2026, two diphtheria tests were performed, and no positive cases were detected. In addition, 77 AMR surveillance specimens were collected from health

facilities across the camp sites and processed for culture and antimicrobial susceptibility testing (AST) in line with the AMR surveillance protocol. Specimens included 17 blood, 40 urine, 12 stools, and 8 wound swabs. Of the 77 specimens, 07 (9.1%) yielded bacterial growth on culture and were identified with corresponding AST (antibiogram) results.

Among the 07 culture-positive isolates, Escherichia coli was the most frequently identified organism (05/07; 71.4%). The remaining isolates comprised one each of Klebsiella spp., Staphylococcus aureus. Among the E. coli isolates, 100% resistance to ampicillin, Cefazolin, Ceftriaxone, and around 80% resistance to Ceftazidime were the most common findings from five E. coli culture-positive isolates.

To support ongoing Hepatitis C surveillance, 893 pre-test samples were tested, among which 687 were HCV RNA detectable, resulting in a detection rate of 76.93%. Additionally, 1,303 post-treatment samples were tested; of these, 1,238 were HCV RNA undetectable at SVR12, indicating sustained virologic response and successful treatment outcomes, while 65 samples remained HCV RNA detectable.

In March, 06 HIV confirmatory tests were performed from HIV determine-positive samples collected from camp health facilities; of these, 05 tests were positive.

Upcoming Events / Training Calendar

| Title of Training | Start date | End date | Organizer | Target Participant |
|---|------------|-----------|------------|---|
| Expert review meeting on maternal & newborn death for Rohingya community with CSH | 16-Mar-26 | 16-Mar-26 | RTMI-UNFPA | Representative of partner organization with specialist |
| Strengthening Pre-Hospital Emergency Response through Integrated Clinical BLS, DRU Management, and ICS-Aligned Referral Systems for Emergency Responders Operating in the Rohingya Camps and Surrounding Host Communities of Cox's Bazar District | 9-Mar-26 | 11-Mar-26 | WHO & IOM | Drivers and attendants integral to the DRU ambulance fleet, Medical Assistants, Registered Nurses, Midwives, and Paramedics/Clinical Officers, Pharmacists/Dispensers |
| Training on Essential Newborn Care(ENC NOW!) 1 & 2 | 6-Apr-26 | 15-Apr-26 | MedGlobal | Doctor, Nurse, Midwife |
| Refresher of the Hep C surveillance for HCWs | 5-Apr-26 | 8-Apr-26 | WHO | Physicians, MATS, Nurses, CHWs, CHDSO |
| Dissemination workshop to introduce the "Guidelines for Hepatitis C Surveillance Linked with Care Cascade in Refugee Settings, Cox's Bazar, Bangladesh." | 9-Apr-26 | 9-Apr-26 | WHO | Coordinators of the Organizations and Government personnel |
| Training on Advanced Life Support (ALS) and Emergency Trauma Management for Medical Hub and Mobile Medical Team (MMT) Health Care Workers in the Rohingya Camps of Cox's Bazar | 27-Apr-26 | 29-Apr-26 | WHO & IOM | Healthcare Workers working in the Medical Hubs and Mobile Medical Teams (MMTs) |

| | | | | |
|---|-----------|-----------|-----|------------------------------|
| Training on Clinical Management of Rape and Intimate Partner Violence with Health Service Providers (Batch 1) | 12-Apr-26 | 13-Apr-26 | WHO | Doctors, Nurses and Midwives |
| Training on Clinical Management of Rape and Intimate Partner Violence with Health Service Providers (Batch 2) | 15-Apr-26 | 16-Apr-26 | WHO | Doctors, Nurses and Midwives |
| Training on Clinical Management of Rape and Intimate Partner Violence with Health Service Providers (Batch 3-4) | | | | |

[\(LINK TO TRAINING CALENDAR\)](#)

References:

1. *Emergency response framework – 2nd ed. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO.*
2. *Joint Government of Bangladesh - UNHCR Population Factsheet as of March 2026. [UNHCR Operational Data Portal \(ODP\)](#).*
3. <https://healthcluster.who.int/publications/m/item/health-cluster-dashboard-q1-march-2023>
4. *Please visit the Health Sector Webpage available [here](#) to access the following: Health Sector HeRAMS, Health Sector 4W, Health Sector Training Planner, and Sector strategic documents.*
5. *Health Service Performance Indicators Data Source: Health Sector Monthly 4W report and HeRAMS (Data extracted on 20 April 2026)*

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