Cox's Bazar District, Bangladesh
Emergency: Rohingya Refugee – Protracted Grade 2 Emergency
Reporting period: 1 - 28 February 2026

HEALTH SECTOR COX'S BAZAR

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

1,182,755 Rohingya Refugees
1.18 M Health Sector Target (JRP 2025)[1]

HIGHLIGHTS

- In February 2026, Routine service delivery and access to essential healthcare services remained widely uninterrupted.
- The trend in skin diseases continued to increase at an alarming rate, with an upsurge observed over the last six months, with 47,639 cases reported this month (around 15% of total consultations for diseases).
- The declining trend in dengue cases continued in the Rohingya community, with stable case numbers over the past 31 weeks and significantly lower transmission compared with 2023–2024.
- Cholera, Diphtheria, and COVID-19 remain under control, with zero cases reported in February 2026.
- 199 suspected Measles with two confirmed Measles cases were reported in February 2026. Outbreak Response Immunization (ORI) is underway.

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
407	MEDICAL DOCTOR
402	NURSES
460	MIDWIVES

HEALTH ACTION

374K	OPD CONSULTATIONS
5,866	INPATIENT ADMISSIONS
2,508	FACILITY-BASED BIRTHS-Refugee & Host
98%	% LIVE BIRTHS
2%	% STILLBIRTHS
1	MATERNAL DEATHS
0%	COVID-19 CASE FATALITY RATIO

DISEASE SURVEILLANCE

0.41	CRUDE DEATHS/1,000 Pop (Up to Feb 26)
12	COVID-19 SENTINEL SITES
35	AWD SENTINEL SITES
105	EWARS REPORTING SITES

HEALTH FUNDING $USD (JRP 2025)

RCP Financial Analysis, JRP 2025

USD	
92.3 M	Requested
55.2 M	Received/ Committed
37.1 M	Funding gap **40.3 %**

[1] *100% of the Rohingya Refugees living in camps and 25% of the Host Community have been targeted in JRP 2025*

Situation Update

General Situation

In February 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 February 2026, more than 375,949 outpatient (OPD) consultations were recorded (4,877 consultations per PHC and 2,196 consultations per HP), which is slightly lower (6%) than the number of consultations recorded/ day last month. According to DHIS-2 data, the OPD consultations are mainly contributed to by ARI and skin diseases, the same as last year.

In February 2026, more than 5,866 inpatient admissions were recorded, which is around 25% lower (significant, $P<0.05$) than the monthly average number of inpatient admissions of the last year, but similar to the last two months, indicating less severity of cases in the last three 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 February 2026 changed slightly compared to the previous months, but is still predominantly characterized by Acute Respiratory Infections (ARI) and skin diseases. ARI cases contributed 23% of the consultations for diseases (Fig. 1) during the reporting period, with around 72,724 consultations for non-pneumonia infections, which was 9% lower than last month. Seasonal

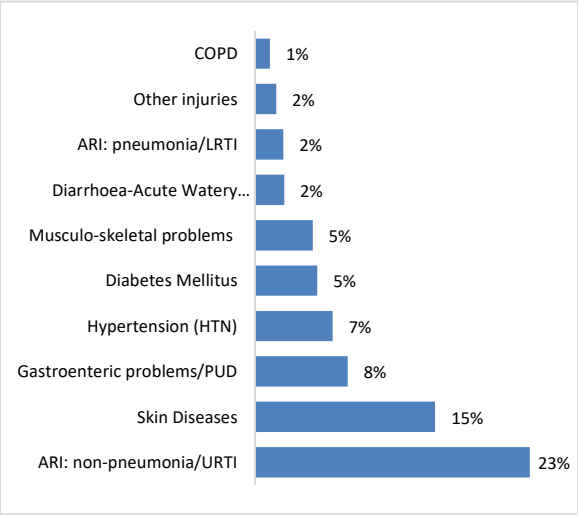

Figure 1: Top Morbidity Reported in DHIS-2 (Feb 2026)

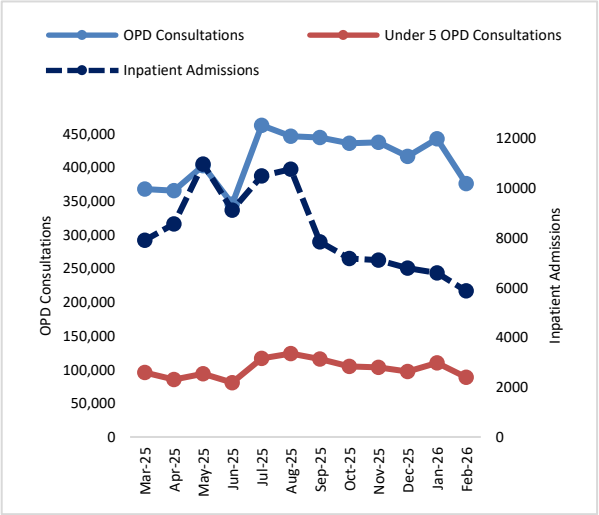

Figure 2: Trends of OPD consultations and Inpatient Admissions

variations and shifts in weather patterns may contribute to the changes in ARI consultations. The trend in skin diseases continued to increase at an alarming rate, with an upsurge observed since the last six months, with more than 47,639 cases reported this month, contributing to

around 15% 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 February 2026.
The top 10 reasons for consultations remained largely unchanged in the last 12 months.

Table 1: Selected Health System Performance Data

Indicator	February 2026	Cumulative 2026	Baseline-2025	Progress
Total number of OPD Consultations (Host and Rohingya)	375,949	**818,489**	**5,033,974**	**0.69 per person**
Total number of Inpatient Admissions (Host and Rohingya)	5,866	**12,461**	**104,324**	**12%**
Total number of patients referred out	3,725	**8,173**	**51,322**	**16%**
Total number of first-time users (Host and Rohingya)	7,081	**14,726**	**113,659**	**13%**
Total number of ANC 1 Visit - Rohingya	5,078	**10,993**	**81,087**	
Total number of Live births at the facility (Host and Rohingya)	2,456	**5,589**	**NA**	
Total number of Stillbirths at the facility (Host and Rohingya)	52	**98**	**NA**	
Of the births, the number of mothers who had ANC 4 or above visits (Rohingya)	1,531	**3,774**	**82%**	**86%**
Total number of C-sections at health facilities	366	**779**	**3,359**	
Total number of Post Abortion Care provided (Host and Rohingya)	227	**519**	**3,711**	
Total number of beneficiaries newly diagnosed with Hypertension (Host and Rohingya)	6,271	**15,345**	**NA**	
Total number of beneficiaries newly diagnosed with Diabetes Mellitus (Host and Rohingya)	1,271	**4,952**	**NA**	
Total Number of NEW clinical mental health consultations done by a psychiatrist and/or mhGAP doctor (Host and Rohingya)	650	**1,495**	**NA**	

Number of NEW focused counselling done by a psychologist or a counsellor (Host & Rohingya)	3,768	**7,527**	**NA**	
Total number of Minor surgeries conducted (Host and Rohingya)	6,850	**14,510**	**83,852**	**17%**
Total number of Major surgeries conducted (Host and Rohingya)	653	**1,308**	**6,457**	**20%**
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)	3,531	**7,853**	**46,264**	
Number of Malnutrition cases referred: Total number of children 6-59 months referred for nutrition services	608	**1,989**	**9,001**	**22%**

Public health risks, priorities, needs, and gaps

1. Communicable Disease Control and Surveillance

Dengue

During the reporting month, there was a steady decline in the number of Dengue Fever cases observed in the Rohingya camps at Cox's Bazar compared to the previous months, with more than 45 cases (37 Rohingya, 8 Host) reported in February 2026, which is 50% lower than last month. 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.

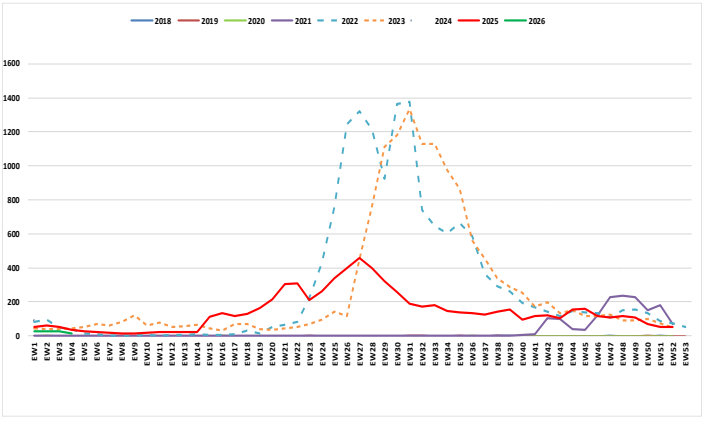

Figure 3: Dengue Trends among the Refugees (WHO, Cox's Bazar)

AWD/Cholera

Cholera remains under control, with zero cases reported in February 2026. 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, transmission remained low. No cholera-related deaths were confirmed in the last twelve months (CFR-0%).

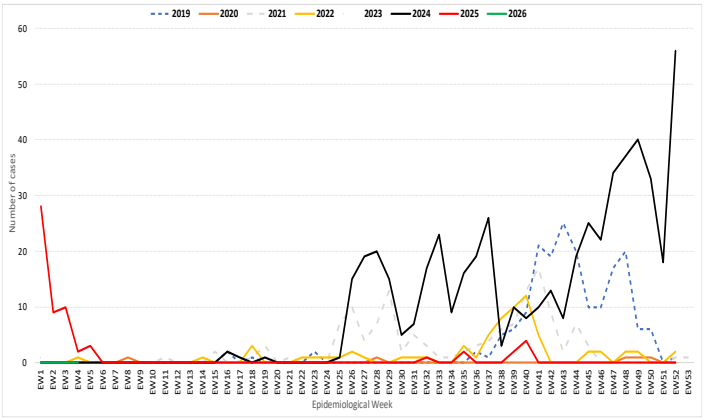

Figure 4: Trends of Culture-confirmed Cholera cases from 2018 - 2026

COVID-19

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

Diptheria

In February 2026, no new confirmed diphtheria case was reported in the Rohingya Camps at Cox's Bazar.

2. Routine Immunization and AFP & VPD surveillance

In February 2026, more than 40,157 doses of different antigens were administered, targeting children less than 2 years old. This includes 13,457 doses of the Polio vaccine (OPV 1st to 3rd doses, fIPV 1st and 2nd doses) and 5,136 doses of the Measles vaccine (MR 1st and 2nd doses).

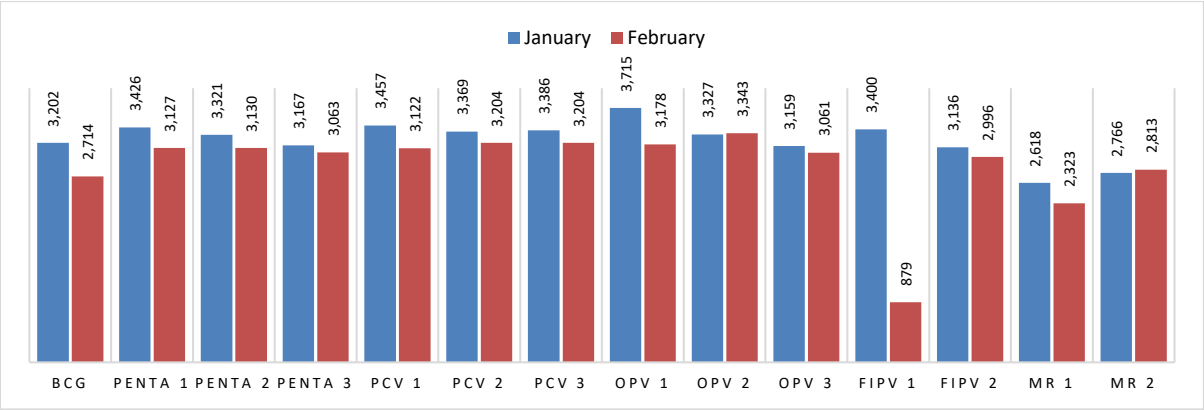

Figure 5: Number of doses administered through Routine Immunization in Rohingya Camps at Cox's Bazar (Source: DHIS-2)

Measles Surveillance: In January 2026, a total of 19 suspected measles cases were reported from Ukhia and Teknaf camps. Of these, two cases became lab-confirmed measles.

Health Sector Action

1. Coordination, Collaboration, and Strategic Guidance

Technical and Strategic Guidance

Field Coordination

In February 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)

The draft of Acute Watery Diarrhoea (AWD)/Cholera Preparedness and Response Plan (January 2026–December 2027) has been finalized for circulation to implementing partners for review and operational alignment.

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 has been finalized. 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.

Emergency Preparedness & Response Technical Committee (EPR TC)

In February 2026, the WHO-led Emergency Preparedness & Response Technical Committee (EPR TC), in close coordination with the Health Emergency Operation Center (HEOC), advanced operational readiness, emergency governance, and logistics preparedness across Rohingya camps and host communities. Priority efforts focused on institutionalizing supportive supervision systems, strengthening cyclone and monsoon preparedness, consolidating HEOC coordination mechanisms, and completing the Emergency Health Logistics Gap Analysis to inform 2026 surge readiness.

Through integrated EPR TC strategic leadership and HEOC operational coordination, February 2026 marked a shift from planning to system institutionalization—embedding supportive supervision, strengthening cyclone/monsoon preparedness, and completing logistics gap analyses critical for surge readiness. These actions further consolidated an ICS-aligned, data-driven emergency health architecture, strengthening Health Sector preparedness for anticipated seasonal risks and sudden-onset emergencies.

3. Health Sector Partners Update

HAEFA

In February 2026, HAEFA conducted a strategic awareness session with the community and local leaders to enhance preparedness for the cyclone and monsoon season in Cox's Bazar. The discussions focused on health risks associated with heavy rains, including waterborne diseases, injuries, and potential disruption of essential health services. Community-based early warning systems and emergency referral pathways were established to ensure rapid response. The initiative strengthened local capacity to prevent disease outbreaks and maintain timely access to health services, enabling communities to protect health and well-being during seasonal emergencies.

International Organization for Migration (IOM)

There was a fire incident at Camp 11, Ukhiya in the early morning of 13 February 2026, affecting 31 shelters. IOM responded to the incident immediately with the deployment of one mobile medical team (IOM MMT-2), providing emergency medical response and coordination in close collaboration with the health sector, EPR technical committee, and camp-level stakeholders. MHPSS remained integrated with the response. A total of 127 patients were screened, of which 34 individuals (10 female, 24 male) received medical treatment and 12 (05 Female, 07 Male) received Psychological First Aid (PFA). The medical cases include six burns, 23 injuries, and 1 acute watery diarrhoea. IOM provided two ambulances on standby through the Dispatch and Referral Unit (DRU) to ensure timely continuity of care.

As part of IOM's commitment to integrate palliative care services in the primary healthcare service for patients with chronic and terminal illness, IOM piloted a new palliative care patient recording system at Camp 24 to improve documentation, continuity of care, and follow-up for patients with life-limiting illness.

United Nations Children's Fund (UNICEF)

In February 2026, the Open Smart Register Platform (OpenSRP) was rolled out for full-scale field implementation across all 33 Rohingya camps in Cox's Bazar with technical support from UNICEF. This marked a significant step in operationalizing a digital, individual-level immunization tracking system.

Implementation commenced following an official directive in early February, enabling vaccinators to use the platform from 25 February 2026 for real-time recording of vaccination services at both fixed and outreach sites. Household-level registration was conducted during integrated outreach activities, with vaccination teams registering children aged 0–23 months for routine immunization, adolescent girls for human papillomavirus (HPV) vaccination, and pregnant women for tetanus-diphtheria (Td) vaccination. Each beneficiary was assigned a unique digital identifier supported by QR-coded immunization cards to ensure tracking, verification, and continuity of care.

The platform's offline functionality enabled uninterrupted use in low-connectivity settings, with data synchronized to the national Management Information System (MIS), Directorate General of Health Services (DGHS) server once connectivity was restored. Collectively, this transition from the capacity-building trainings conducted in December 2025 to field implementation represents a significant advancement toward a digitally enabled, accountable, and equitable immunization system, ensuring that no child, adolescent girl, or pregnant woman is left unvaccinated.

World Health Organization (WHO)

Non-Communicable Diseases (NCD) and Mental Health: In February 2026, WHO provided 13 sessions of supportive supervision for mhGAP for 61 healthcare providers working in Rohingya camps. These supportive supervision sessions will help them retain their knowledge gained in training and will enable them to implement mhGAP in PHCs. Along with these sessions, 13 monitoring visits for NCD services in the PHCs were conducted. The objective of these monitoring visits is to assess the progress and quality of NCD service integration within primary health care facilities, identify gaps, and provide technical guidance to strengthen effective and sustainable NCD care delivery.

Gap filling in essential medicines and IEC material supply in all the healthcare facilities in the Rohingya camps were continued. The objective of gap filling in essential medicines and IEC material supply is to ensure uninterrupted availability of key NCD and mental health supplies and information materials across all healthcare facilities in the Rohingya camps, supporting consistent service delivery and improved patient care.

Essential Lab Services: In February 2026, five diphtheria tests were performed, and no positive cases were detected. In addition, 124 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 14 blood, 84 urine, 18 stool, and 8 wound swabs. Of the 124 specimens, 20 (16.1%) yielded bacterial growth on culture and were identified with corresponding AST (antibiogram) results.

Among the 20 culture-positive isolates, Escherichia coli was the most frequently identified organism (16/20; 80%). The remaining isolates comprised one each of Proteus spp., Enterococcus spp., Staphylococcus aureus, and Pseudomonas spp. Among the E. coli isolates, around 90% resistance to ampicillin was the most common finding from twenty culture-positive isolates.

To support ongoing Hepatitis C surveillance, 1,168 pre-test samples were tested, among which 879 were HCV RNA detectable, resulting in a detection rate of 75.25%. Additionally, 1,242 post-treatment samples were tested; of these, 1,164 were HCV RNA undetectable at SVR12, indicating sustained virologic response and successful treatment outcomes, while 78 samples remained HCV RNA detectable.

In February 2026, 14 HIV confirmatory tests were performed from HIV determine-positive samples collected from camp health facilities; of these, 12 were positive.

Upcoming Events / Training Calendar

Title of Training	Start date	End date	Organizer	Target Participant
Social Autopsy meeting in the camp with community stakeholders	24/Feb/26	24/Feb/26	RTMI-UNFPA	Community Stakeholder
Workshop for Collaboration with different stakeholders regarding ERTS service through SRG WG	12/Feb/26	12/Feb/26	RTMI-UNFPA	Stakeholder
Training on OBLSS for Doctors and Midwives	16/Feb/26	18/Feb/26	RTMI-UNFPA	Doctor,Midwife

(***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 January 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 March 2026)*

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