Cox's Bazar District, Bangladesh
Emergency: Rohingya Refugee – Protracted Grade 2 Emergency
Reporting period: 1 - 31 July 2026

HEALTH SECTOR COX'S BAZAR

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

1,200,171 Rohingya Refugees
1.38 M Health Sector Target (JRP 2026)[1]

HIGHLIGHTS

- Routine healthcare service delivery and access remained uninterrupted throughout July 2026, without any major incidents or damage.
- Dengue transmission increased in July 2026, with a total of 750 RDT-positive cases, which is more than a four-fold increase compared to the previous month (171 cases).
- Following the emergency MR vaccination campaign in April-May 2026, in July 2026 both suspected measles cases and related health facility admissions have shown a declining trend.
- In July 2026, morbidity among refugees remained dominated by skin diseases (61,820+ cases; 17% of total consultations) and ARI (79,284+ non-pneumonial ARI cases; 21% of consultations), with both seeing significant increase from the previous month.

THE HEALTH SECTOR

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

REGISTERED HEALTH FACILITIES

43	HEALTH POSTS
46	PRIMARY HEALTH CENTRES
05	FACILITIES WITH CEmONC SERVICES
427	MEDICAL DOCTORS
397	NURSES
406	MIDWIVES

HEALTH ACTION

468K	OPD CONSULTATIONS
7,391	INPATIENT ADMISSIONS
3,010	FACILITY-BASED BIRTHS-Refugee & Host
98%	% LIVE BIRTHS
2%	% STILLBIRTHS
5	MATERNAL DEATHS
0%	COVID-19 CASE FATALITY RATIO

DISEASE SURVEILLANCE

1.00	CRUDE DEATHS/1,000 Pop (Jan-July 26)
12	COVID-19 SENTINEL SITES
33	AWD SENTINEL SITES
101	EWARS REPORTING SITES

HEALTH FUNDING $USD (JRP 2026)

RCP Financial Analysis for JRP 2026
(updated as of 30 June 2026)

USD	
49.9 M	Requested
37.1 M	Received/ Committed
12.8 M	Funding gap **26%**

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

Situation Update

General Situation

In July 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 July 2026, more than 468,008 outpatient (OPD) consultations were recorded (5,594 consultations per PHC and 2,982 consultations per HP), which is almost 10% higher (significant, P<0.05) than the number of consultations recorded last month and around 11% higher (significant, P<0.05) compared to the last 12 months' average monthly consultations. According to DHIS-2 data, OPD consultations are mainly contributed to by ARI and skin diseases, the same as the last 12 months.

In July 2026, more than 7,391 inpatient admissions were recorded, which is almost 13% higher (significant, P<0.05) than the last month but almost similar to the monthly average number of inpatient admissions of the last 12 months, and around 17% higher (significant, P<0.05) than the last six months' average, indicating more severe cases that require admission were recorded in this month. All other health service utilization indicators showed almost the similar increasing pattern compared to last month and the last six months' average.

According to DHIS-2 data, the morbidity distribution among refugees for July 2026 changed slightly compared to the previous months, but is still predominantly characterized by Acute Respiratory Infections (ARI) and skin diseases. After the significant reduction observed in the number of ARI cases reported in the last two months compared to the last 12-month average

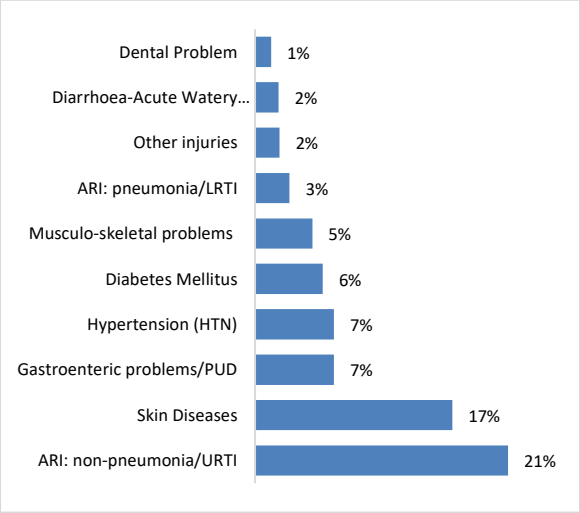

Figure 1: Top Morbidity Reported in DHIS-2 (July 2026)

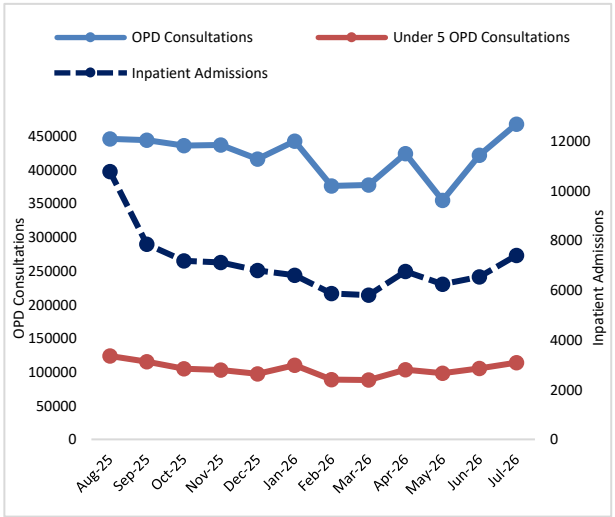

Figure 2: Trends of OPD consultations and Inpatient Admissions

number of cases, the number of non-pneumonial ARI cases was observed increasing again, with more than 79,284 cases reported this month, which is 33% higher than last month, contributing to 18% of the total consultations for diseases (Fig. 1) during the reporting period. Seasonal variations 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 over the last 12 months. More than 61,820 cases were reported this month, which is 17% higher than last month, contributing to around 17% 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 July 2026.
The top 10 reasons for consultations remained largely unchanged in the last 12 months.

Table 1: Selected Health System Performance Data

Indicator	July 2026	Cumulative 2026	Baseline-2025	Progress
Total number of OPD Consultations (Host and Rohingya)	468,008	**2,864,497**	**5,033,974**	**2.08 per person**
Total number of Inpatient Admissions (Host and Rohingya)	7,391	**45,174**	**104,324**	**43%**
Total number of patients referred out	4,528	**29,313**	**51,322**	**57%**
Total number of first-time users (Host and Rohingya)	7,343	**50,405**	**113,659**	**44%**
Total number of ANC 1 Visit - Rohingya	6,644	**43,336**	**81,087**	
Total number of Live births at the facility (Host and Rohingya)	2,946	**19,752**	**NA**	
Total number of Stillbirths at the facility (Host and Rohingya)	64	**393**	**NA**	
Of the births, the number of mothers who had ANC 4 or above visits (Rohingya)	2,366	**14,761**	**82%**	**98%**
Total number of C-sections at health facilities	346	**2,617**	**3,359**	
Total number of Post Abortion Care provided (Host and Rohingya)	211	**1,596**	**3,711**	
Total number of beneficiaries newly diagnosed with Hypertension (Host and Rohingya)	6,677	**49,188**	**NA**	

Total number of beneficiaries newly diagnosed with Diabetes Mellitus (Host and Rohingya)	1,022	**13,362**	**NA**	
Total Number of NEW clinical mental health consultations done by a psychiatrist and/or mhGAP doctor (Host and Rohingya)	1170	**6,104**	**NA**	
Number of NEW focused counselling done by a psychologist or a counsellor (Host & Rohingya)	4,244	**26,729**	**NA**	
Total number of Minor surgeries conducted (Host and Rohingya)	10,218	**58,396**	**83,852**	**70%**
Total number of Major surgeries conducted (Host and Rohingya)	564	**4,466**	**6,457**	**69%**
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)	4,540	**26,989**	**46,264**	
Number of Malnutrition cases referred: Total number of children 6-59 months referred for nutrition services	936	**5,178**	**9,001**	**58%**

Public health risks, priorities, needs, and gaps

1. Communicable Disease Control and Surveillance

Dengue

During July 2026, there was an increase in the number of Dengue Fever cases observed in the Rohingya camps at Cox's Bazar compared to the previous month, with a total of 750 RDT-positive cases, representing more than a four-fold increase compared to the previous month (171 cases). The cumulative number of RDT-positive dengue cases reached 1,364 in 2026. However, Weekly trends in RDT-positive cases remained lower than those observed during the same period in previous years, as observed in Figure 5. No confirmed deaths were reported so far

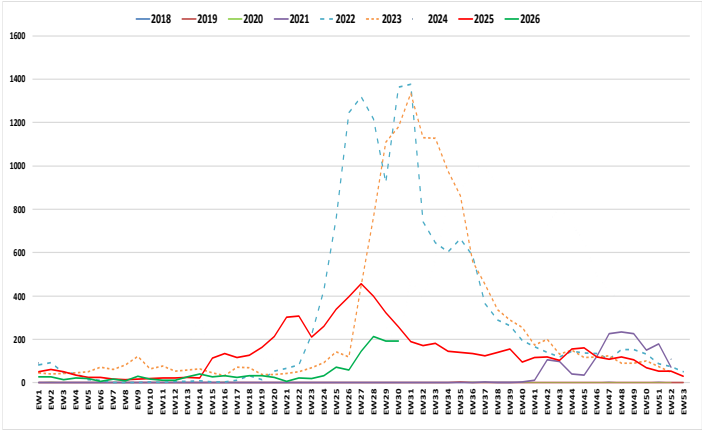

Figure 3: Dengue Trends among the Refugees (WHO, Cox's Bazar)

in 2026 (CFR 0%). The multi-sectoral response interventions continue to be scaled up by Health, WASH, and Camp and Site Management teams across all camps. Preparedness activities continued in anticipation of the monsoon season following a high-level multisectoral Dengue Preparedness and Readiness Meeting held on 8 July 2026.

AWD/Cholera

Cholera transmission remained limited, with one culture-confirmed case reported in July, similar to the one case reported in June 2026. A recent culture-confirmed but RDT-negative case was reported from Camp 11, involving a 55-year-old female. The cumulative number of culture-confirmed cholera cases in 2026 reached 10, including nine cases in the camps and one case in the host community. There is no confirmed cholera deaths were reported in the last twelve months (CFR-0%). Due to the campaign and cholera prevention efforts, transmission remained low. However, the sudden increase in cholera cases is an indication that the impact of the vaccine is waning.

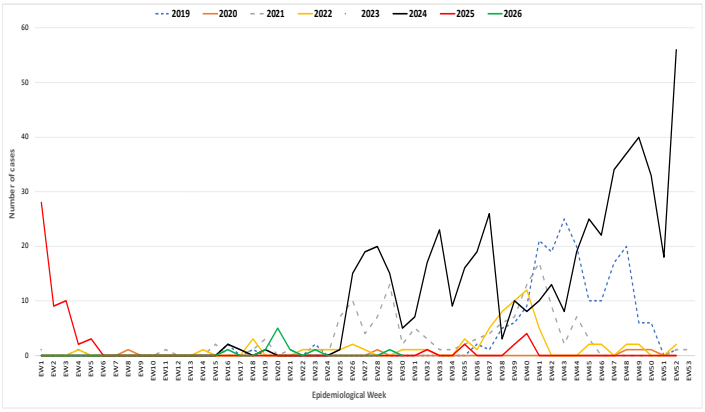

Figure 4: Trends of Culture-confirmed Cholera cases from 2018 - 2026

Weekly AWD consultations continued to decline. In July 2026, a total of 7,425 consultations were recorded, representing a 19% decrease compared to June (9,208 consultations).

Measles

As of July, a total of 1,824 suspected measles cases had been reported in 2026. Of these, 284 were laboratory-confirmed, and 970 were epidemiologically linked, bringing the total number of outbreak-related measles cases to 1,254. In addition, 14 laboratory-confirmed rubella cases were identified among the suspected cases. Ten (10) suspected measles deaths were reported, resulting in a case fatality rate (CFR) of 0.6%. Laboratory-confirmed measles outbreaks have been reported in all camps, including Bhasan Char Island, except Camp 25, based on the outbreak definition of two laboratory-confirmed cases occurring within 28 days of rash onset.

Despite the high cumulative disease burden and the increasing trend observed since April, both suspected measles cases and related health facility admissions have shown a declining trend following the mass measles vaccination campaign conducted from 26 April to 11 May 2026. The campaign targeted children aged 6 months to below 5 years across the camps and vaccinated 167,542 children, achieving 94.1% administrative coverage.

COVID-19

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

Diptheria

In July 2026, no lab-confirmed diphtheria case was reported in the Rohingya Camps at Cox's Bazar. The first diphtheria case this year was found in April 2026; however, zero cases were reported in the last three months, indicating that transmission remained controlled.

2. Routine Immunization and AFP & VPD surveillance

In July 2026, more than 38,000 doses of different antigens were administered, targeting children less than 2 years old. This includes 10,308 doses of the Polio vaccine (OPV 1st to 3rd doses, fIPV 1st and 2nd doses) and 7,032 doses of the Measles vaccine (MR 1st and 2nd doses).

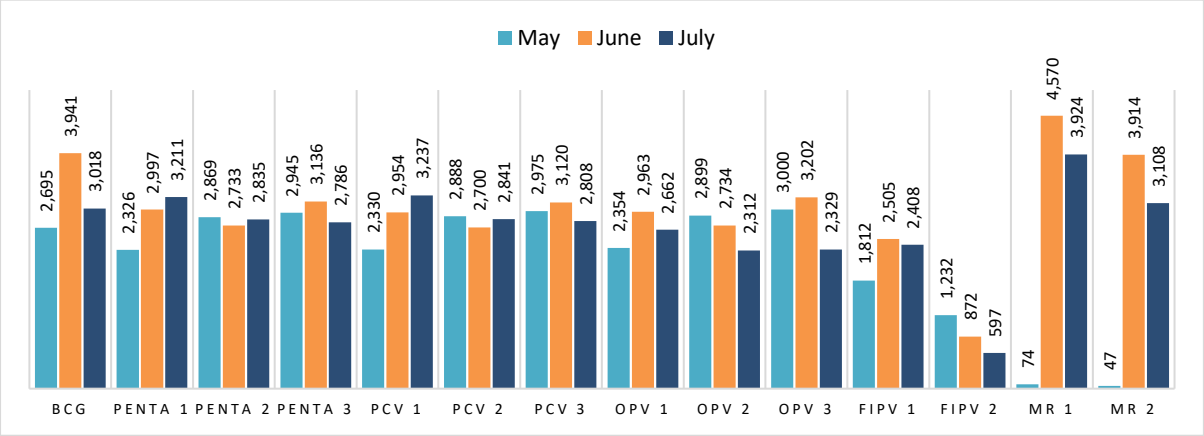

Figure 5: Number of doses administered through Routine Immunization in Rohingya Camps at Cox's Bazar (Source: DHIS-2)

Preventive bOPV campaign in the Rohingya camps

Since 2018, environmental surveillance has started in the Rohingya camps. In Jan 2026, Sabin-like-1 virus with seven nucleotide changes was found in samples from camps 21 and 24, posing an alarming situation for the Rohingya population as well as the national community.

Though two rounds of bOPV campaigns were conducted in 2024 with the support of WHO, following the continued influx from Rakhine State, low routine OPV3 and IPV2 coverage in multiple camps, and the recent detection of VDPV in Myanmar's Shan State, there is an increased risk of a vaccine-derived polio outbreak among both the Rohingya and the host population.

Epidemiologically, children under five years old are especially susceptible to polio transmission. In response, the Government of Bangladesh has planned two rounds of bOPV campaigns, with a minimum 28-day interval. Under the proactive leadership of the Bangladesh Government, the first-round campaign was started on July 26, 2026. The target is

to vaccinate 185,341 children under five in the Ukhia and Teknaf Rohingya camps to interrupt transmission and enhance immunity. The campaign will run 12 days in Ukhia and 7 days in Teknaf. As of 30 July 2026, a total of 124,942 children were vaccinated, representing 67.4% of the overall campaign target.

Health Sector Action

1. Coordination, Collaboration, and Strategic Guidance

Field Coordination

In July 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 Measles, 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)

Disease surveillance remained active across Rohingya camps and host communities through EWARS, indicator-based syndromic surveillance, sentinel surveillance, and laboratory networks, supporting the early detection and response to priority public health threats.

WHO-led Epi TWG Continued to Strengthen Disease Surveillance, Mortality Reporting, and Health Information Management.

A cascade of training sessions on the International Classification of Diseases, 11th Revision (ICD-11) and Medical Certification of Cause of Death (MCCOD) supported by WHO was conducted in July for health facility staff across the camps, including medical doctors, medical assistants, reporting officers, and CHW supervisors. This was undertaken to support the initiation of ICD-11 implementation and MCCOD reporting from 1 August 2026.

A laboratory capacity assessment was conducted to identify operational and resource gaps across a network of 51 health facilities and primary health centres (PHCs) to strengthen the newly launched Integrated Sentinel Surveillance (ISS) system. The surveillance system commenced implementation in July 2026, initially covering six priority diseases. As part of the integration process, a new reporting tool was deployed to capture weekly aggregated

laboratory testing data, enabling the calculation of testing denominators and improving the measurement of case detection rates.

Emergency Preparedness & Response Technical Committee (EPR TC)

In July 2026, the WHO-led Emergency Preparedness and Response Technical Committee (EPR TC) and WHO-technically supported Health Emergency Operation Center (HEOC) coordinated incident monitoring and emergency readiness across 33 Rohingya camps. Following the 8 July landslide in Camp 5, four Mobile Medical Teams (MMTs), four Medical Hubs, and 10 Dispatch and Response Unit (DRU) ambulances were activated under the Incident Command System for triage, stabilization, Psychological First Aid, and referral coordination. The integrated response managed 11 verified casualties, while all camp health facilities remained functional and essential services continued without interruption. The emergency network remained on heightened monsoon readiness.

During July, the EPR TC finalized, secured endorsement for, and disseminated the Mobile Medical Team Incident Commander Operational Concept and Terms of Reference. Seventeen Incident Commanders were formally designated, establishing clear responsibilities for readiness, deployment, Incident Command System implementation, METHANE reporting, referral coordination, joint needs assessment, and after-action review. The endorsed Medical Hub Focal Point framework was also operationalized across 13 designated hubs, standardizing casualty reception, surge management, stabilization, referral and continuity arrangements. Together, these governance mechanisms strengthened operational accountability and functional integration among 17 Mobile Medical Teams, 13 Medical Hubs and 33 Dispatch and Response Unit ambulances.

The EPR TC and HEOC also conducted two network-wide readiness reviews on 8 and 28 July in response to evolving monsoon risks and Bangladesh Meteorological Department advisories. Reviews verified staffing, emergency stocks, trauma capacity, ambulance functionality, communications, referral arrangements and activation thresholds across the emergency medical response network. The HEOC simultaneously consolidated incident information, issued the Camp 5 Emergency Response Update and Cox's Bazar District Disaster Situation Report No. 1, contributed to inter-sectoral flash updates, and finalized an integrated map linking MMTs, Medical Hubs and DRU ambulances across all 33 camps. These outputs strengthened anticipatory action and evidence-based operational decisions.

3. Health Sector Partners Update

HAEFA

In light of the increased monsoon-related emergencies, HAEFA organized an emergency preparedness session at its health posts on 21 July 2026. The session focused on flood and landslide early warning signs, safe evacuation practices, and household-level preparedness.

HAEFA distributed emergency preparedness packages containing oral rehydration salts, essential medicines, water purification tablets, a whistle, a torchlight, dry foods, and other lifesaving items to vulnerable community members to strengthen household-level readiness ahead of the peak monsoon period.

International Organization for Migration (IOM)

Figure 6: Bringing specialist surgical care closer to communities

IOM has initiated a special surgical campaign at Leda Field Hospital in Cox's Bazar. This is bringing essential surgical services closer to Rohingya communities and nearby Bangladeshi communities in remote Teknaf. The campaign offers access to specialist medical consultations, planned surgeries, care after surgery, and follow-up support through telemedicine, helping patients receive the care they need closer to home. It also provides practical training for health workers to strengthen their skills in surgical care. The campaign aims to support 180 surgical cases and train 15 health workers involved in surgical care. By bringing specialist care closer and strengthening the skills of local health workers, the initiative is helping improve access to quality healthcare for communities in remote areas.

IOM is supporting the first round of the Oral Polio Vaccine (OPV) campaign across the Rohingya refugee camps through the deployment of more than 200 community health workers, who are playing critical roles in community engagement and door-to-door administration of vaccines. As part of Risk Communication and Community Engagement (RCCE) efforts, IOM supported miking activities across all targeted camps to raise community awareness and encourage parents and caregivers to bring eligible children to receive the OPV.

Upcoming Events / Training Calendar

(***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 July 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 August 2026)*

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