



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



**1,204,492 Rohingya Refugees
1.38 M Health Sector Target (JRP 2026)¹**

HIGHLIGHTS

- Routine healthcare service delivery and access remained uninterrupted throughout August 2026, without any major incidents or damage.
- August 2026 marked the inclusion of the Typhoid Conjugate Vaccine (TCV) into the routine immunization schedule for 15-month-olds in camps.
- Dengue transmission increased in August 2026, with 1,114 cases reported from camps (up >65% from July) along with 104 host cases and 6 confirmed deaths, pushing 2026 cumulative cases to 2,620 (10 deaths, CFR 0.4%).
- Cholera transmission increased significantly in August 2026, with six (6) culture-confirmed cholera cases.
- In August 2026, morbidity among refugees remained dominated by skin diseases (71,747+ cases; 18% of total consultations) and ARI (77,872+ non-pneumonial ARI cases; 20% of consultations).

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
421 MEDICAL DOCTORS
399 NURSES
424 MIDWIVES

HEALTH ACTION



469K OPD CONSULTATIONS
7,536 INPATIENT ADMISSIONS
3,026 FACILITY-BASED BIRTHS-Refugee & Host
98.2% % LIVE BIRTHS
1.8% % STILLBIRTHS
3 MATERNAL DEATHS
0% COVID-19 CASE FATALITY RATIO

DISEASE SURVEILLANCE



1.17 CRUDE DEATHS/1,000 Pop (Jan-Aug 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 August 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 August 2026, more than 469,126 outpatient (OPD) consultations were recorded (5,962 consultations per PHC and 2,904 consultations per HP), which is almost similar to 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 in the last 12 months.

In August 2026, more than 7,536 inpatient admissions were recorded, which is almost similar to the last month but around 7% higher than 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 August 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 May and June compared to the last 12-month

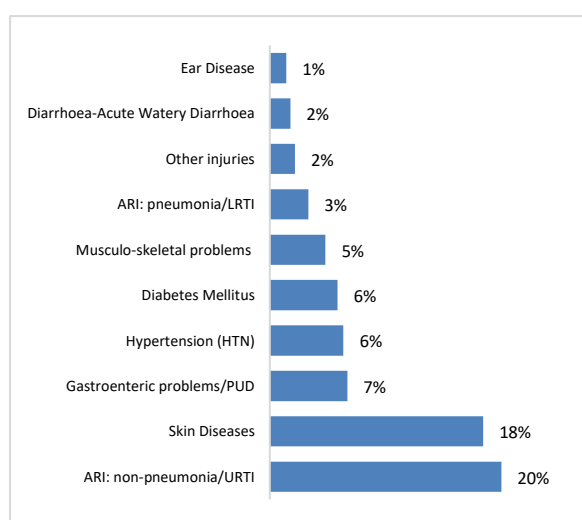


Figure 1: Top Morbidity Reported in DHIS-2 (Aug 2026)

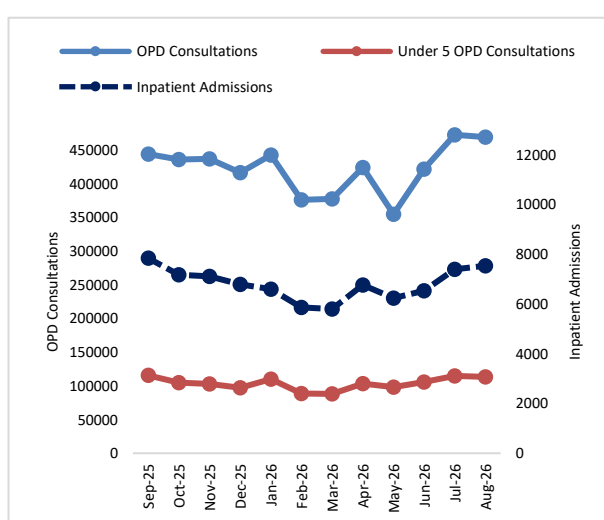


Figure 2: Trends of OPD Consultations and Inpatient Admissions

average number of cases, the number of non-pneumonial ARI cases was observed increasing again from July, which continued in August, with more than 77,872 cases reported this month, which is similar to the previous month, contributing to 20% 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 71,747 cases were reported this month, which is 12% higher than last month and the highest in this year, contributing to around 18% 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 August 2026. The top 10 reasons for consultations remained largely unchanged in the last 12 months.

Table 1: Selected Health System Performance Data

Indicator	August 2026	Cumulative 2026	Baseline- 2025	Progress
Total number of OPD Consultations (Host and Rohingya)	469,126	3,338,150	5,033,974	2.42 per person
Total number of Inpatient Admissions (Host and Rohingya)	7,536	52,710	104,324	51%
Total number of patients referred out	4,692	34,025	51,322	66%
Total number of first-time users (Host and Rohingya)	6,760	57,227	113,659	50%
Total number of ANC 1 Visit - Rohingya	6,895	50,277	81,087	
Total number of Live births at the facility (Host and Rohingya)	2,966	22,718	NA	
Total number of Stillbirths at the facility (Host and Rohingya)	60	453	NA	
Of the births, the number of mothers who had ANC 4 or above visits (Rohingya)	2,474	17,235	82%	98%
Total number of C-sections at health facilities	402	3,019	3,359	
Total number of Post Abortion Care provided (Host and Rohingya)	513	2,109	3,711	
Total number of beneficiaries newly diagnosed with	7,034	56,527	NA	

Hypertension (Host and Rohingya)				
Total number of beneficiaries newly diagnosed with Diabetes Mellitus (Host and Rohingya)	1,538	15,119	NA	
Total Number of NEW clinical mental health consultations done by a psychiatrist and/or mhGAP doctor (Host and Rohingya)	1108	7,229	NA	
Number of NEW focused counselling done by a psychologist or a counsellor (Host & Rohingya)	3,829	30,569	NA	
Total number of Minor surgeries conducted (Host and Rohingya)	9,704	68,107	83,852	81%
Total number of Major surgeries conducted (Host and Rohingya)	492	4,958	6,457	77%
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)	4,418	31,435	46,264	
Number of Malnutrition cases referred: Total number of children 6-59 months referred for nutrition services	941	6,134	9,001	

Public health risks, priorities, needs, and gaps

1. Communicable Disease Control and Surveillance

Dengue

During August 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 1114 RDT-positive cases in camps and 104 cases in the host, representing more than a 65% increase compared to the previous month (781 cases). The cumulative number of RDT-positive dengue

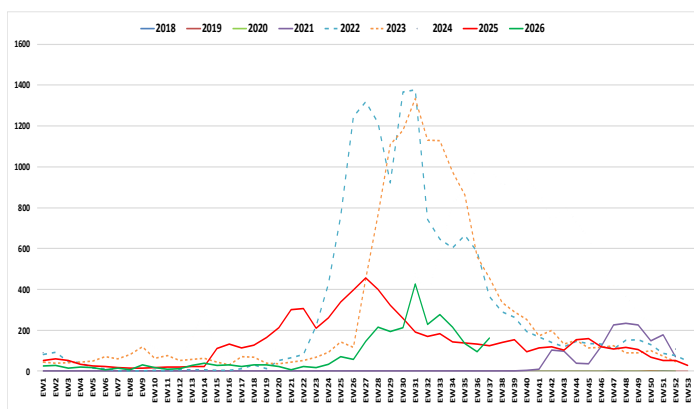


Figure 3: Dengue Trends among the Refugees (WHO, Cox's Bazar)

cases reached 2,620 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. In August 2026, six (6) dengue-confirmed deaths were reported from the camps, up from two deaths reported in July 2026. So far in 2026, 10 confirmed Dengue deaths have been reported (CFR 0.4%), which is comparatively higher than the previous year. 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 transmission increased significantly in August 2026, with six (6) culture-confirmed cholera cases (Four cases in Rohingya refugee camps and two in the host population) reported, an increase from one culture-confirmed case reported the previous month. The cumulative number of culture-confirmed cholera cases in 2026 reached 16. There is no confirmed

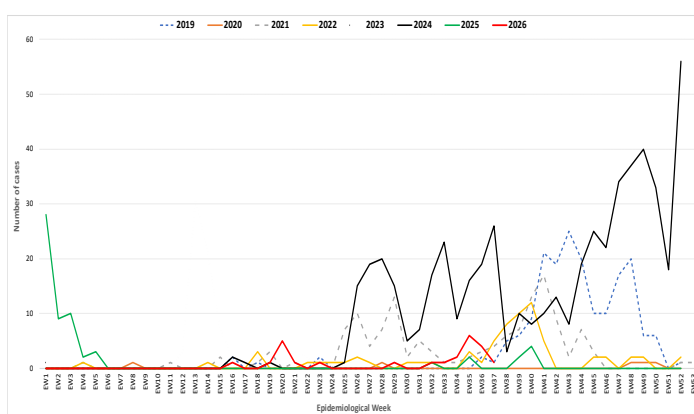


Figure 4: Trends of Culture-confirmed Cholera cases from 2018 - 2026

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.

AWD consultations continued to decline. In August 2026, a total of 6,923 consultations were recorded, representing a 6% decrease compared to July.

Measles

The trends in suspected measles cases have remained unstable in the Rohingya camps based on indicator-based syndromic surveillance data and health facility admission data. As of 31 August 2026, a total of 2,273 suspected cases, of which 322 were lab-confirmed and 1,286 were epidemiologically confirmed, 10 suspected measles deaths, and 29 laboratory-confirmed rubella cases were reported from Ukhiya, Teknaf, and Bhasan Char-based camps.

In August 2026, the WHO epidemiology unit, in collaboration with the WHO IVD unit and the Health Sector, assessed the measles situation in camps and noted a rising burden among children between 5-10 years and 10-15 years, who are now being prioritized for the second round of the MR vaccination campaign.

Diphtheria

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

2. Routine Immunization and AFP & VPD surveillance

In August 2026, more than 30,000 doses of different antigens were administered, targeting children less than 2 years old. This includes 6,199 doses of the Measles vaccine (MR 1st and 2nd doses). August 2026 marked the inclusion of the Typhoid Conjugate Vaccine (TCV) into the routine immunization schedule for 15-month-olds in camps; 2,786 TCV doses were administered.

Preventive bOPV campaign in the Rohingya camps

Since 2018, environmental surveillance has been conducted 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 target is to vaccinate 185,341 children under five in the Ukhia and Teknaf Rohingya camps to interrupt transmission and enhance immunity. A total of 198,772 children were vaccinated, achieving 107.2% cumulative coverage against the overall target. Coverage reached 107.0% in Ukhia (164,145 children) and 108.4% in Teknaf (34,627 children), demonstrating high campaign reach across both Upazilas. The second round of the campaign has been planned in September 2026.

Measles Surveillance

From January to August 2026, 2,114 suspected Measles cases were reported, including 1,615 laboratory-confirmed and epidemiologically linked cases (76.4%), corresponding to an

annualized incidence of approximately 202 per 100,000 population. In August, 17 specimens were investigated, of which 7 were measles-positive, and 1 was rubella-positive.

Acute Flaccid Paralysis (AFP) surveillance

As of August 2026, 09 AFP cases were reported from Ukhia and Teknaf, of which 7 were classified as non-polio AFP (Ukhia 5 and Teknaf 2), corresponding to an annualized AFP rate of 3.66 and a non-polio AFP rate of 2.93 per 100,000 children aged <15 years. During the 1st round of the bOPV campaign, 17 suspected AFP cases were identified through house-to-house visits, of which 4 met the AFP case definition following verification and reinvestigation, with samples collected for laboratory investigation.

Health Sector Action

1. Coordination, Collaboration, and Strategic Guidance

Field Coordination

In August 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)

WHO, the lead of the Epi TWG, initiated monitoring of the implementation of the International Classification of Diseases 11th revision (ICD-11) in relevant designated health facilities. More than 50% of health facilities have so far commenced reporting as planned. The feedback from initial implementation of ICD-11 has been shared with Health Sector Partners to guide appropriate responses.

Similarly, the WHO epidemiology and surveillance team continued to monitor the rollout of integrated sentinel surveillance in all 46 PHC, 5 field hospitals, and gaps noted have been highlighted and discussed during the TWG meeting.

This month, WHO, in collaboration with icddr,b, concluded a cholera risk assessment, post-oral cholera vaccine evaluation, and outbreak prediction study whose findings will add great

value to the cholera preparedness and response plan. The draft report on this assessment has been finalized, and policy briefs are also being drafted on the same.

Emergency Preparedness & Response Technical Committee (EPR TC)

In August 2026, the WHO-led Emergency Preparedness and Response Technical Committee (EPR TC), through the WHO-technically supported Health Emergency Operation Center (HEOC) at the Civil Surgeon Office, sustained coordinated readiness of 17 Mobile Medical Teams, 13 Medical Hubs and 33 Dispatch and Response Unit ambulances across all 33 Rohingya camps. The mechanism enabled rapid verification and referral tracking following a fire in Camp 4 Extension that injured five people. Targeted distribution of emergency medicines, burn-care supplies and blood-glucose monitoring commodities strengthened frontline stabilization and referral capacity, while the monthly HEOC meeting assigned time-bound corrective actions.

Enhanced readiness was maintained across 17 MMTs, 13 Medical Hubs and 33 DRU ambulances serving all 33 camps. Following a gas-cylinder-related fire in Camp 4 Extension, rapid verification, facility notification, and referral tracking were supported. Five injured people received initial care at the GK Primary Health Care Centre; four were referred to Ukhia Upazila Health Complex, and one continued care at the initial facility.

Needs-based distribution positioned International Emergency Health Kit 2024 medicines and renewables, Trauma and Emergency Surgery Kit 2019 burn and dressing materials, blood-glucose monitoring devices and test strips across MMTs, Medical Hubs, DRU services, Ukhia and Teknaf Upazila Health Complexes, and the 250-bed District Sadar Hospital. The allocation strengthened frontline stabilization, wound and burn care, basic diagnostics, and referral continuity.

Preliminary technical assessments of two proposed Terre des Hommes MMTs for Camps 26 and 27 reviewed staffing, equipment, supplies, deployment arrangements, and alignment with the MMT Operational Plan 2025. Preparations were also finalized for the Health Sector-coordinated Integrated Fire Emergency Response and Burn Management Training on 8-9 September, while planning advanced for the next DRU, MMT and Medical Hub review cycles.

3. Health Sector Partners Update

World Health Organization (WHO)

Essential Lab Services: The WHO-supported IEDCR field laboratory at Cox's Bazar Medical College continued to deliver diagnostic support across critical surveillance programs: in Diphtheria testing, all 3 processed samples returned negative; under antimicrobial resistance (AMR) surveillance, 245 specimens yielded 54 culture-positive isolates (22%), dominated by *Escherichia coli* (37%) and *Staphylococcus aureus* (24%), followed by *Pseudomonas* spp. and

Klebsiella spp., with notable sensitivity observed for Pseudomonas spp. (tobramycin, ceftazidime-avibactam, imipenem), E. coli (ceftazidime-avibactam, fosfomycin, tobramycin, meropenem, gentamicin), and S. aureus (gentamicin, doxycycline, linezolid, sulfamethoxazole-trimethoprim), alongside high resistance to ampicillin in Klebsiella spp. and emerging resistance to ampicillin, cefazolin, cefuroxime, and ceftriaxone; and in Hepatitis C monitoring, 66.63% of 739 pre-treatment samples (from 1,109 tested) had detectable HCV RNA, while post-treatment evaluations demonstrated a 94.6% SVR12 non-detectable rate among 975 samples, leaving 52 cases with detectable HCV RNA.

Laboratory at Camp site: 07 supportive supervision visits were conducted to health facility laboratories, focusing on the review and updating of Standard Operating Procedures (SOPs). During the reporting period, laboratory supplies (equipment's, reagents, and consumables) were provided to the health sector partners and government facilities to support the restoration of essential laboratory services around 124,312 USD.

Blood Transfusion Services: A total of 384 units of blood were transfused through ten WHO-supported Blood Transfusion Centres (BTCs) located in camp health facilities, ensuring timely access to lifesaving transfusion services for both refugee and host populations.

Non-Communicable Diseases (NCD) and Mental Health: In August 2026, WHO provided 12 sessions of supportive supervision for mhGAP for 43 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, 20 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 was 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.

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 August 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 24 September 2026)

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