

This report was produced by the Health Cluster in collaboration with humanitarian partners and members of the Humanitarian Coordination Task Team.

Highlights

- As of 15 April 2026, a total of 19,161 suspected cases and 2,973 confirmed cases have been reported, corresponding to an incidence of 22.4 cases per million population.
- Children under age 5 are disproportionately affected, accounting for about 79 per cent of reported cases as of 12 April. Infants under nine months, who are not yet eligible for routine immunisation, represent about 33 per cent of cases and remain at particularly high risk of severe outcomes.
- The ongoing measles outbreak is significantly affecting the delivery of routine health services, as health workers are being diverted to outbreak response activities, including case management, surveillance, and emergency vaccination campaigns.

Situation Overview

Bangladesh is facing a sustained increase in measles transmission with widespread geographic spread and increasing pressure on the health system. As of 15 April, a total of 19,161 suspected cases and 2,973 laboratory-confirmed cases have been reported nationwide, corresponding to an incidence of 22.4 cases per million population. At least 166 suspected measles-related deaths, including 32 laboratory-confirmed deaths, have been reported; however, the true mortality burden could be higher due to underreporting.

Children under age 5 are disproportionately affected, accounting for about 79 per cent of reported cases as of 12 April. Infants under nine months, who are not yet eligible for routine immunisation, represent about 33 per cent of cases and remain at particularly high risk of severe outcomes. The outbreak is primarily driven by immunisation gaps among children, including a high proportion of unvaccinated or partially vaccinated children. Disruptions to routine immunisation services in 2024 and 2025, including reduced coverage of measles-rubella (MR) vaccines, have contributed to the accumulation of susceptible children. In addition, only one round of Vitamin A supplementation was conducted in 2025, increasing vulnerability to severe disease.

According to the Directorate General of Health Services (DGHS) reports, measles hotspots have been identified in 18 of 64 districts: Barguna, Barishal, Chandpur, Chapai Nawabganj, Cox's Bazar, Dhaka, Gazipur, Jashore, Jhalokathi, Madaripur, Munshiganj, Mymensingh, Naogaon, Natore, Netrakona, Pabna, Rajshahi and Shariatpur. Of these hotspot districts, Barguna has recorded the highest incidence, while at least five hotspot districts have reported incidence rates exceeding 50 cases per million population. High-risk urban areas include Barishal, Dhaka North, Dhaka South and Mymensingh city corporations, of which three have also reported incidence rates above 50 cases per million population. Cases have been reported in 58 of 64 districts, indicating widespread transmission. Cases have also

been detected in remote and hard-to-reach areas, including Khagrachari District, highlighting the geographic spread of the outbreak. Transmission has also been reported in Rohingya refugee camps, with eight laboratory-confirmed cases, including seven in Cox's Bazar and one in Bhasan Char, and 214 suspected cases across camp settings, including 206 in Cox's Bazar and 8 in Bhasan Char. Overcrowded living conditions and limited health system capacity in these areas are increasing the risk of further spread.

Nationally, 2,973 laboratory-confirmed measles cases have been reported, with a national incidence rate of 16.76 cases per million population. Dhaka Division reported the highest caseload (1,767), followed by Rajshahi Division (809). Dhaka also recorded the highest incidence rate (38.95 cases per million population), followed closely by Rajshahi (38.74). Other divisions reported a lower relative burden, including Barishal (7.63) and Chattogram (5.25), while the lowest incidence was recorded in Rangpur (0.77)

The ongoing measles outbreak is significantly affecting the delivery of routine health services, as health workers are being diverted to outbreak response activities, including case management, surveillance, and emergency vaccination campaigns. This diversion is occurring within a system already experiencing a shortage of about 27¹ per cent in health assistants, which further amplifies service delivery gaps across routine health programs such as immunisation, maternal and child health, and primary care. At the same time, the rise in measles-related complications is increasing hospital admissions and driving higher demand for oxygen, antibiotics, and intensive care services, placing additional strain on already limited paediatric and critical care capacity.

Government Coordination and Response

In response, the Government of Bangladesh, with support from Global Alliance for Vaccines and Immunisation, UNICEF and WHO, launched an emergency MR vaccination campaign on 5 April targeting over 1.2 million children in 30 high-risk upazilas across 18 districts, the ones already identified as hotspots. The campaign is being scaled up in phases, with expansion to additional urban areas and nationwide coverage planned. The age of eligibility for the first vaccine dose has been temporarily lowered to six months as part of the emergency response.

The Ministry of Health and Family Welfare has prioritised available Vitamin A supplies for children with measles; however, additional procurement and distribution are required to protect an estimated 20 million children under age 5 who remain at risk.

Humanitarian Partners

BDRCS supported risk communication and community engagement in coordination with the Government, including community-based surveillance in Godagari, Dhaka South, and Sylhet

¹ DGHS Real time health information dashboard

City Corporation; volunteer outreach; dissemination of awareness materials; hospital needs follow-up; and coordination with health authorities and partners.

BRAC is conducting social mobilisation and awareness-raising to promote uptake of measles-rubella vaccination and is supporting campaign implementation through coordinated field-level activities, including vaccination services delivered through 11 BRAC primary health-care facilities integrated into government micro-plans.

Gender in Humanitarian Action partners have supported community awareness efforts in response to recurrent measles outbreaks across 11 districts. Partners conducted more than 100 awareness sessions with children, students, teachers and community members to strengthen awareness of measles risks and promote community engagement.

The International Centre for Diarrhoeal Disease Research, Bangladesh, has been supporting case management through the establishment of screening, treatment, and referral systems. In coordination with the Government, Bubble continuous positive airway pressure training was delivered in medical college hospitals and Thana health complexes in measles-prone areas, including Dhaka, Chattogram, Rajshahi and Mymensingh. Hospital-based vaccination was also provided in coordination with the Expanded Programme on Immunization

Jago Nari, with support from Bangladesh Health Watch, has established a help desk at Barguna General Hospital to support measles response efforts. Trained volunteers have been deployed to assist with crowd management and patient and caregiver support, and masks have been distributed to reduce infection risk, while parallel community awareness activities are underway across Barguna district to promote measles vaccination for children under five and prevent further transmission.

Jhpiego supported community engagement through immunisation information materials and facility-based health education, while also contributing to the training of Upazila Rapid Response Teams, targeted immunisation activities in low-performing areas, and logistical and volunteer support in high-priority locations.

PATH supported campaign monitoring, supervision, logistics and training in Dhaka North and Dhaka South city corporations.

Save the Children supported community engagement through around 700 community health workers and volunteers, including household outreach, school-based awareness and support to vaccination sites in priority districts and refugee and host community settings.

UNFPA, in collaboration with the DGHS, is prioritising pregnant women as a high-risk group and supporting the development of targeted Bangla IEC materials through DGHS-led technical consultations, with materials currently under finalisation for wider dissemination.

UNICEF is supporting the scale-up of MR vaccination through more than 5,000 trained community health workers, with priority given to children who are zero-dose or have missed doses. As of 15 April, around 829,500 children had been vaccinated, representing 68.9 per

cent of the 1.2 million target population. On 12 April, the campaign was expanded to high-risk city corporations, where a further 314,000 children had been vaccinated by 15 April, bringing the total to 25.7 per cent of the overall target. In total, approximately 1,142,400 children had been reached as of 15 April 2026, representing 47.1 per cent overall coverage. UNICEF is also strengthening cold chain systems and last-mile logistics to prevent stockouts. In priority districts, efforts are focused on reinforcing routine immunisation, service delivery, case management, and infection prevention and control, including through facility assessments, health worker training, surge support, and the emergency provision of essential medicines, equipment, and supplies. Surveillance and response are being strengthened through the integration of Vitamin A supplementation and nutrition support for suspected and confirmed measles cases, along with the activation of the Nutrition Cluster. Community-level activities are being expanded through risk communication and community engagement, education and child protection platforms to promote vaccination uptake, early care-seeking, case identification and referral, particularly among vulnerable and missed children.

WHO has supported the Government of Bangladesh's coordination and outbreak response efforts since mid-February and continues to provide nationwide technical support through a central team, eight divisional coordinators, 53 Surveillance and Immunisation Medical Officers, additional data personnel and surge support from the Regional Office. Support has included strengthening laboratory surveillance through the provision of measles test kits and reagents, specimen shipment and data analysis. Strategic decision-making has also been reinforced through four National Immunisation Technical Advisory Group meetings and two National Measles Verification Committee meetings, which informed key outbreak response measures, including vaccination activities in Rohingya camps. Capacity-building efforts included eight national training-of-trainers sessions, 64 district-level trainings and 12 city corporation-level trainings on MR surveillance, outbreak response and campaign implementation, as well as one batch of vaccine safety surveillance orientation in each district, city corporation and upazila. In addition, digital readiness assessment tools were rolled out nationwide to strengthen campaign planning and implementation.

Gaps and Challenges

Laboratory capacity remains overstretched, with high testing demand causing sample backlogs and intermittent reagent shortages at the National Polio and Measles Laboratory despite mitigation efforts. Staffing shortages and limited space are undermining effective triage and isolation, while severe overcrowding and the lack of adequately ventilated isolation areas are increasing the risk of nosocomial transmission. At the same time, shortages of essential medicines, pulse oximeters, paediatric ventilatory support and other basic supplies are weakening surge case management. In hard-to-reach areas, weak referral pathways continue to delay detection, referral and treatment. High levels of child malnutrition are worsening measles severity and increasing the risk of complications and mortality. Although Vitamin A supplementation has been prioritised for measles cases, limited supplies, procurement bottlenecks and uneven distribution continue to leave many children under five unreached, with an estimated 20 million at-risk children requiring coverage.