

Editorial

Measles in Bangladesh: From Immunity Gaps to Renewed Outbreak Risk in 2026

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Bangladesh has long been recognized as a public health success story in childhood immunization. Yet the recent measles situation suggests that this success is under strain. What once appeared to be a manageable problem of incomplete vaccine coverage has, in 2026, become a more urgent warning about outbreak vulnerability, health-system inequity and delayed protection among children. The current situation should not be interpreted as a failure of Bangladesh's immunization program alone, but rather as evidence that past gains are fragile when immunity gaps persist and outbreak detection is not matched by rapid preventive action.¹⁻⁴

The concern was already visible before the current surge. In 2025, UNICEF, WHO, and Gavi reported that full immunization coverage in Bangladesh had reached 81.6%, but approximately 400,000 children remained under-immunized and about 70,000 had received no vaccines at all. The same update emphasized that these missed children were concentrated disproportionately in urban poor settlements and other underserved communities. For measles, such clustering is epidemiologically dangerous. Because measles is among the most contagious human viral diseases, even relatively small pockets of susceptibility can sustain transmission and ignite outbreaks. WHO continues to note that measles can cause severe complications including pneumonia, encephalitis, blindness, and death, especially in malnourished children and in settings with delayed care.^{1,2}

The 2026 updates suggest that the risk has now become more concrete. Early in the year, WHO's epidemiological reporting from the Rohingya refugee response in Cox's Bazar showed no laboratory-confirmed measles cases in the first week of 2026, although one laboratory-confirmed rubella case and one suspected measles-rubella

case were recorded, illustrating that fever-rash surveillance remained active and necessary in a highly vulnerable population. The same report documented the continuing need for close monitoring in the camps, where overcrowding, mobility, and service disruption can rapidly change the outbreak picture.³ WHO also reported in March 2026 that digital outbreak-response tools such as Go.Data were being used in Cox's Bazar to strengthen real-time case investigation, contact tracing, and coordination, reflecting recognition that early detection capacity must be improved in high-risk settings.⁴

By late March and early April 2026, the national picture had worsened considerably. A recent BMJ report, citing official data from Bangladesh, stated that more than 2300 children had been admitted to hospital with suspected measles in 2026, of whom 684 had tested positive so far, with at least 38 child deaths reported. The same report noted that this represented a steep rise compared with 2025, when only 68 cases were recorded during the comparable period and 125 for the entire year. Importantly, the current outbreak wave was reported to have begun on 4 January with the first detected case in a Rohingya camp in Cox's Bazar before expanding more broadly.⁵ While journalistic reports should be interpreted cautiously, this account is clinically and epidemiologically consistent with the concern already signaled by surveillance data and immunity-gap estimates.

The response from Bangladeshi authorities in April 2026 indicates that the government now recognizes the seriousness of the situation. Reports from the state news agency BSS, citing Directorate General of Health Services statements, described emergency measures including nationwide vaccination efforts, emergency coordination meetings with frontline

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health workers, and cancellation of leave for DGHS staff until the outbreak is controlled. Another BSS report, citing a DGHS press release, stated that between 15 March and 3 April 2026, 771 measles cases had been confirmed and 5792 suspected cases had been recorded nationwide. These updates, although drawn from press reporting rather than peer-reviewed surveillance summaries, strongly suggest that Bangladesh has entered a period of active measles resurgence requiring immediate control measures.⁶⁻⁸

The implications are important. Bangladesh's challenge is no longer simply to improve national average vaccine coverage. The real task is to close the last-mile immunity gaps that permit measles to spread among children who are urban poor, mobile, displaced, or otherwise underserved. This requires more than routine messaging. It requires ward-level micro planning, timely second-dose delivery, catch-up vaccination, sensitive fever-rash surveillance and rapid local outbreak response. In addition, measles prevention must be integrated with nutrition support and pediatric case management, because severe outcomes are concentrated among children already made vulnerable by under nutrition and delayed access to care.^{1,2}

The timing is also politically and regionally significant. WHO South-East Asia has set 2026 as the target year for measles and rubella elimination in the region. For Bangladesh, the recent outbreak does not merely threaten short-term morbidity and mortality; it also tests whether elimination remains achievable under current service-delivery realities.⁹ The lesson is clear. Measles returns first where the health system reaches children last. Bangladesh still has the institutional capacity to reverse the present trend, but only if it treats the 2026 outbreak not as a temporary disturbance, but as a signal that equity, surveillance, and rapid vaccination response must now become the center of measles control policy.

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