

BANGLADESH

DISEASE OUTBREAKS AND CLIMATIC SHOCKS HEIGHTEN ACUTE MALNUTRITION RISKS

IPC ACUTE MALNUTRITION ANALYSIS JANUARY – DECEMBER 2026

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KEY FIGURES

JANUARY - DECEMBER 2026



3,628,749

cases of children aged
6-59 months acutely
malnourished

IN NEED OF TREATMENT

Severe Acute
Malnutrition (SAM)

710,907

Moderate Acute
Malnutrition (MAM)

2,917,842

Overview

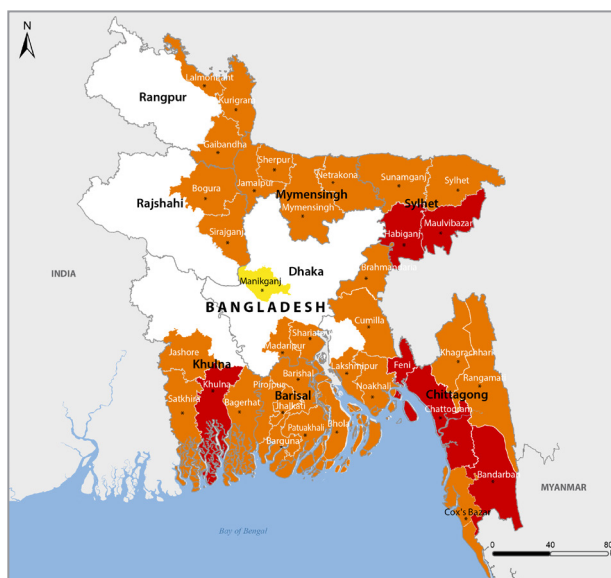
Nearly 3.7 million cases of acute malnutrition are expected among children aged 6–59 months between January and December 2026 across 37 disaster prone districts affected by acute malnutrition and food insecurity. This caseload includes close to 711,000 children with severe acute malnutrition (SAM) and about 2.9 million with moderate acute malnutrition (MAM). Across the 37 analysed districts, Global Acute Malnutrition (GAM) prevalence ranges from 15.0–19.9 percent in the six districts classified in Critical (IPC AMN Phase 4), 10.0–14.9 percent in the 30 districts in Serious (IPC AMN Phase 3), and 5.0–9.9 percent in Manikganj, the single district in Alert (IPC AMN Phase 2).

During the current period (January–August 2026), six districts were classified in Phase 4: Habiganj and Maulvibazar in Sylhet Division; Chattogram, Bandarban and Feni in Chattogram Division; and Khulna in Khulna Division. Flash floods, a measles outbreak, inadequate feeding practices, and poor water, sanitation and hygiene (WASH) conditions are driving the deterioration. A further 30 districts were classified in Phase 3, while Manikganj was the only district in Phase 2.

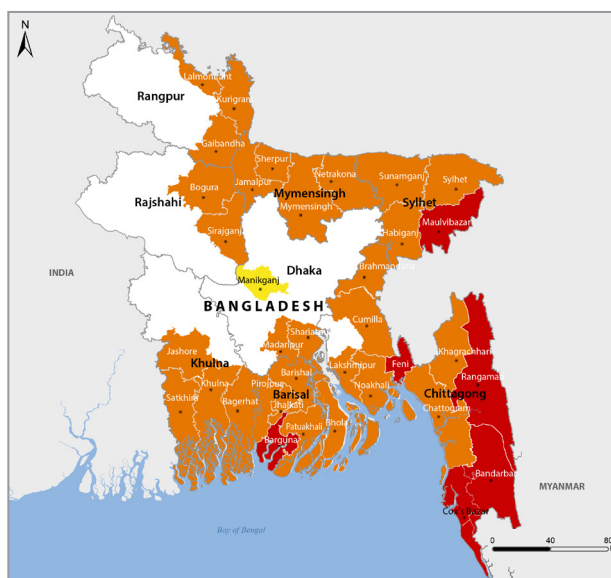
During the projection period (September–December 2026), the nutrition situation is expected to deteriorate slightly. Maulvibazar (Sylhet), Bandarban and Feni (Chattogram) will remain in Phase 4 (Critical), while Barguna (Barishal), Cox's Bazar and Rangamati (Chattogram) will worsen from Phase 3 to Phase 4. Chattogram, Khulna and Habiganj (Sylhet) will improve from Phase 4 to Phase 3, joining 27 districts that will remain in Phase 3. Manikganj (Dhaka) will remain in Phase 2 across both periods. Persistent impacts of the measles outbreak, seasonal hazards such as cyclones and flooding, seasonal morbidity—including acute respiratory infection (ARI) and diarrhoea—and the effects of the lean season on food access and feeding practices will continue to drive acute malnutrition through the projection period.



Current Acute Malnutrition Jan - Aug 2026



Projection Acute Malnutrition Sep - Dec 2026



Map Key

IPC Acute Malnutrition Phase Classification

1 - Acceptable	5 - Extremely critical	Evidence Level
2 - Alert	Phase classification based on MUAC	* Acceptable
3 - Serious	Areas with inadequate evidence	** Medium
4 - Critical	Areas not analysed	*** High

Contributing factors



Measles outbreak

The impact of the measles outbreak on the acute malnutrition situation cannot be reliably assessed, as nutrition outcome data were collected before the outbreak began in March 2026. Nevertheless, measles remains a significant risk factor for acute malnutrition and mortality among young children.

Bangladesh experienced a nationwide measles outbreak beginning in March 2026, with transmission reported across all 64 districts. By 25 June 2026, more than 95,760 suspected cases, 11,390 confirmed cases, and 596 suspected measles-related deaths (including 93 confirmed deaths) had been reported. Children under five years accounted for 81 percent of reported cases, highlighting the high vulnerability of young children. Given the bidirectional relationship between measles and acute malnutrition, the outbreak may increase nutritional vulnerability and mortality risks, although its impact is not reflected in available nutrition outcome data.

The outbreak response included emergency measles-rubella (MR) vaccination, strengthened surveillance, case management support, and Vitamin A supplementation. By late June, more than 18.4 million children had been vaccinated through the nationwide MR campaign, exceeding the initial target. A total of 22.6 million children received vitamin A capsules, while vaccination and Vitamin A campaigns in Rohingya refugee camps reached 94 percent of targeted children. Despite declining trends in reported cases, ongoing transmission among under-five children continues to pose risks of increased morbidity, mortality, and nutritional vulnerability.



Inadequate food consumption

Limited access to diversified foods remains a major driver of acute malnutrition. On average, only 33 percent of children aged 6–23 months meet the Minimum Dietary Diversity (MDD) standard, which is lower than the national estimate of 35.2 percent reported by the Multiple Indicator Cluster Surveys (MICS) 2025. Across the 37 assessed districts, 81 percent were classified as being at medium risk, with MDD levels ranging between 20 and 39.9 percent. Poor dietary diversity during this critical period of growth and development increases the risk of nutrient deficiencies, weakens immunity, and contributes significantly to acute malnutrition.



Poor sanitation and hygiene conditions

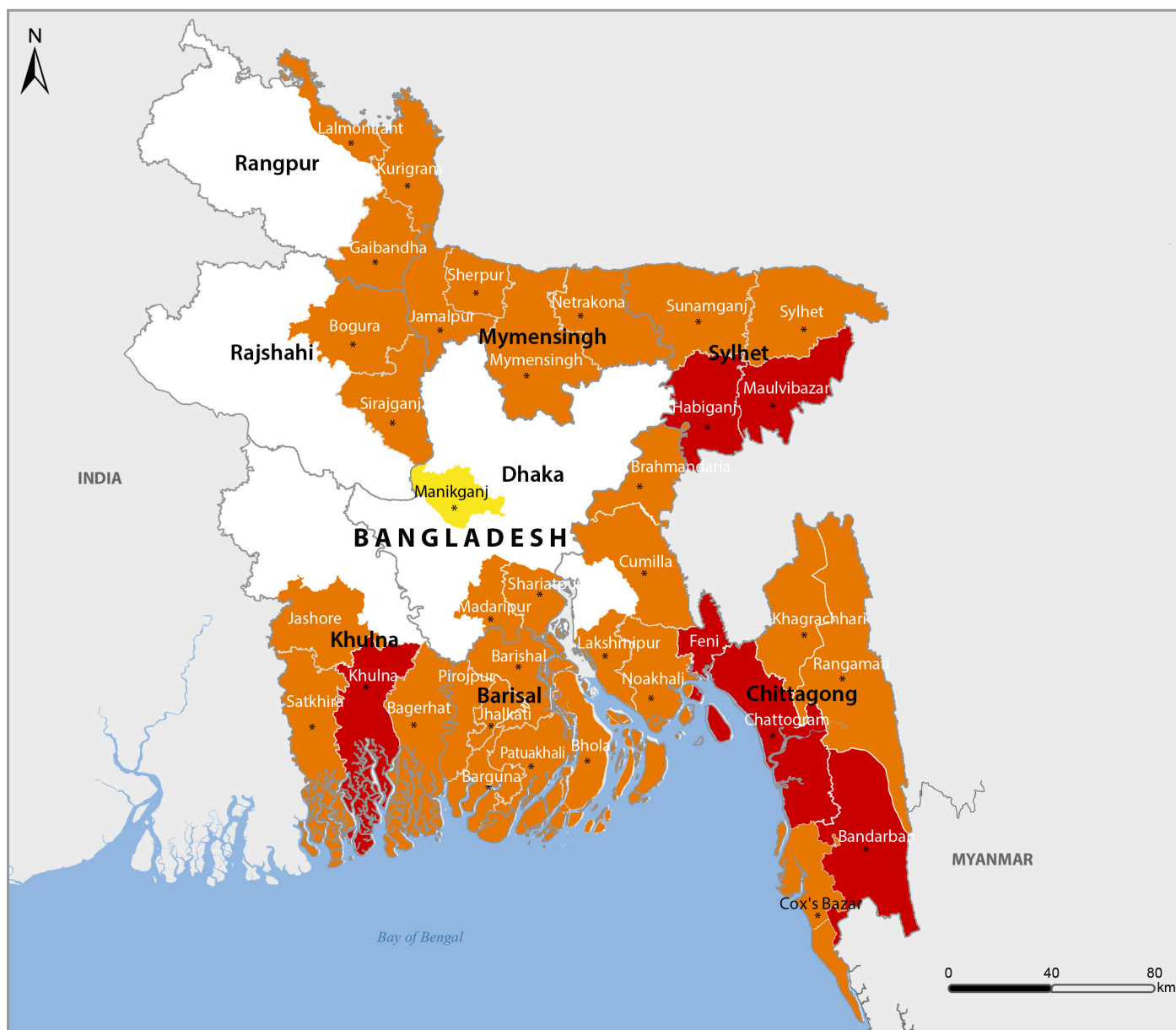
Poor access to sanitation and handwashing facilities with water and soap remains a significant contributing factor to acute malnutrition. Across the assessed districts, poor hygiene and sanitation conditions were identified as a medium-risk factor for acute malnutrition in more than half of the districts. Inadequate access to handwashing facilities increases the incidence of diarrhoea and other infectious diseases, which reduces nutrient absorption and utilisation, thereby heightening children's susceptibility to acute malnutrition.



High levels of food insecurity

Acute food insecurity remains one of the key contributing factors to the current malnutrition burden. The IPC Acute Food Insecurity (AFI) analysis for May–August 2026 estimates that 15.3 million people (15 percent of analysed population) are experiencing IPC AFI Phase 3 or above (Crisis or worse) food insecurity. Conditions are expected to worsen between September and December 2026, with the affected population projected to increase to 18.1 million people (18 percent of analysed population).

CURRENT ACUTE MALNUTRITION SITUATION OVERVIEW (JANUARY - AUGUST 2026)



Key for the Map

IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical

- Phase classification based on MUAC
- Areas with inadequate evidence
- Areas not analysed

Evidence level:

- * Acceptable
- ** Medium
- * High

CURRENT ACUTE MALNUTRITION SITUATION OVERVIEW (JANUARY - AUGUST 2026)

The MICS 2025 survey, published in November 2025, indicates a national global acute malnutrition (GAM) prevalence of 12.9 percent, placing Bangladesh in Serious (IPC AMN Phase 3). Across the 37 analysed districts, the six districts in Critical (IPC AMN Phase 4) show a GAM prevalence of 15.0–19.9 percent, the 30 districts in Serious a prevalence of 10.0–14.9 percent, and Manikganj, the single district in Alert (IPC AMN Phase 2), a prevalence of 5.0–9.9 percent.

Between January and December 2025, high levels of acute malnutrition were largely associated with the impacts of the food insecurity situation driven by the lingering effects of the 2024 climatic shocks, particularly lasting effects of widespread flooding, and Cyclone Remal. Persistent macroeconomic challenges and political instability were also driving the food insecurity situation. In the current period of analysis, the inadequate care and feeding practices and poor food consumption have contributed to elevated levels of acute malnutrition, alongside persistent challenges related to an ongoing measles outbreak, flash floods, and cyclones. The analysis team developed a composite scoring matrix to assess the convergence of key contributing factors associated with acute malnutrition across the 37 analysed districts. The scoring draws on the eight indicators most consistently classified as medium to high risk—covering child feeding and caring practices, poor WASH conditions and acute food insecurity—selected for their discriminatory value in identifying hotspots. The current analysis shows that four districts (Bandarban, Barguna, Bhola and Kurigram) had the highest score of 6, reflecting the convergence of multiple risk factors. Several districts, including Jamalpur, Lakshmipur, Madaripur, Mymensingh, Noakhali, Patuakhali, Shariatpur, Sherpur and Sunamganj, scored 5 and were also identified as highly vulnerable. These findings suggest that acute malnutrition in these districts is likely driven by the combined effects of inadequate child feeding practices, poor dietary diversity, disease burden, suboptimal WASH conditions and food insecurity.

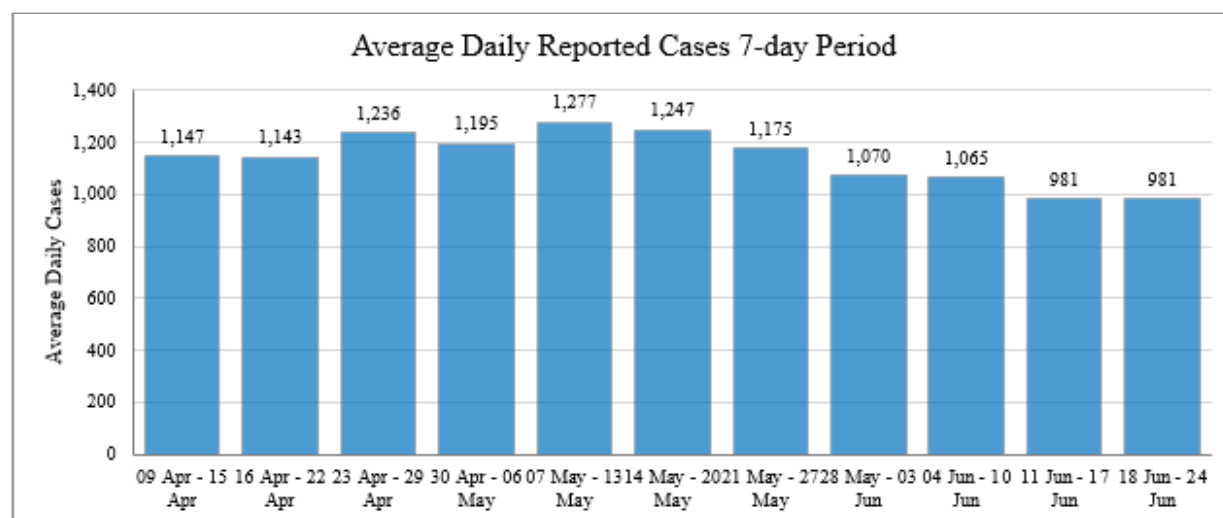
Main Contributing Factors

Impact of the measles outbreak on the acute malnutrition

The impact of the measles outbreak on the acute malnutrition situation cannot be reliably assessed, as nutrition outcome data were collected before the outbreak began in March 2026. However, measles is a well-established risk factor for acute malnutrition, as infection can reduce appetite, impair nutrient absorption, increase metabolic demands, and exacerbate existing nutritional deficiencies, while children with acute malnutrition are also at increased risk of severe measles and related mortality.

Bangladesh has been experiencing a large-scale measles outbreak since early 2026, with a rapid increase in cases reported from March onwards. By mid-April 2026, transmission had spread to 58 of the 64 districts across all eight divisions, indicating widespread nationwide circulation. By 25 June 2026, more than 95,760 suspected cases, 11,390 confirmed cases, and 596 suspected measles-related deaths (including 93 confirmed deaths) had been reported.

Figure 1: Average daily reported cases by 7-day period. Weekly averages 980 cases per day, ICCG, Situation report 5, 25 June 2026 ([here](#))



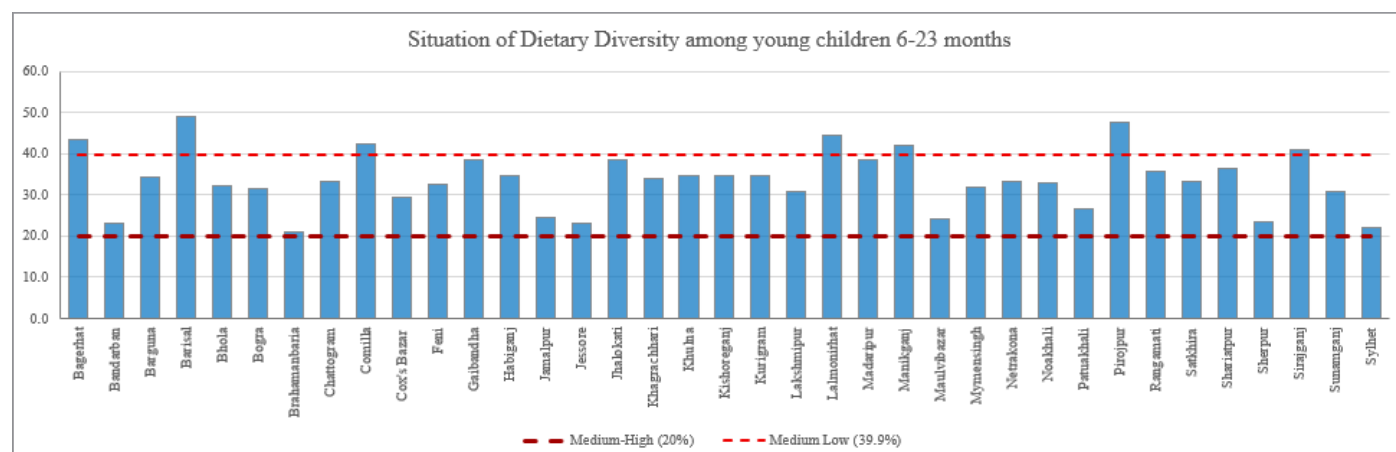
The highest concentration of cases was reported in Dhaka Division, followed by Rajshahi, Chattogram, and Khulna divisions, with major urban hotspots identified in densely populated informal settlements of Dhaka, including Demra, Jatrabari, Kamrangirchar, Korail, Mirpur, and Tejgaon. The outbreak predominantly affected young children, with around 81 percent of reported cases occurring among children under five years of age, particularly infants and children under two years who are at higher risk of severe complications. Given the bidirectional relationship between measles and malnutrition, the outbreak may contribute to increased nutritional vulnerability and mortality risks among young children, particularly in areas already affected by food insecurity, poor health access, or high levels of acute malnutrition.

The measles outbreak triggered a nationwide response including emergency MR vaccination, enhanced surveillance, case management strengthening, and vitamin A supplementation. The MR campaign launched in April 2026 and expanded nationwide by May, vaccinating more than 18.4 million children by late June. The MR vaccination and Vitamin A supplementation campaign reached 99.4 percent of the 22,706,314 targeted children. However, localised and scattered low-level transmission continues, with new cases still reported mainly among children under five. This sustains the risk of increased morbidity and mortality and of deteriorating acute malnutrition outcomes, although available nutrition data does not capture this impact.

Inadequate food intake drives acute malnutrition

The situation of Minimum Dietary Diversity (MDD) among children aged 6–23 months is presented in Figure 2. MDD measures the proportion of children who consumed foods from at least five out of eight recommended food groups during the previous 24 hours and serves as a key proxy indicator of the quality and diversity of complementary feeding. Adequate dietary diversity is essential to ensure that young children receive a broad range of nutrients required for optimal growth, development, and immune function, while poor dietary diversity increases the risk of micronutrient deficiencies and undernutrition.

Figure 2: Dietary diversity by districts (quality of the children diet) among children 6-23 month, MICS 2025, BBS (Nov 2025)

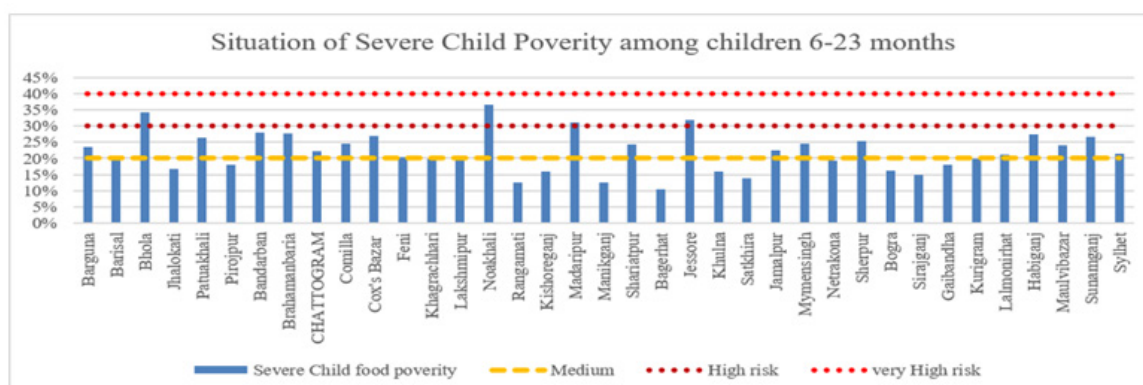


As shown in the graph above, the proportion of children aged 6–23 months achieving MDD across the 37 districts averaged 33 percent, which is below the national estimate of 35.2 percent reported by MICS in 2025. This indicates that only one in three young children consumed food from at least five of the eight recommended food groups during the previous 24 hours, reflecting inadequate dietary diversity and suboptimal complementary feeding practices. The prevalence ranged from 21 percent in the lowest-performing district to 49 percent in the highest-performing district, highlighting considerable geographical disparities in diet quality, while remaining below desirable levels in all districts.

According to the IPC AMN contributing-factor reference thresholds, 81 percent of districts were classified as medium risk (20–39.9 percent), while the remaining 19 percent were classified as low risk (≥ 40 percent), suggesting that inadequate dietary diversity is a widespread contributor to acute malnutrition risk across the analysed districts. Insufficient dietary diversity limits children's intake of essential vitamins, minerals, and other nutrients required for healthy growth, development, and immune function. Consequently, children are more vulnerable to micronutrient deficiencies and infections, which can compromise nutritional status and increase the risk of acute malnutrition.

Poor dietary diversity therefore remains an important underlying factor contributing to the persistence of child wasting and other forms of undernutrition. Similarly, severe child food poverty was identified as an important contributing factor to acute malnutrition in the IPC AMN analysis. Severe child food poverty refers to the situation where a child consumes foods from two or fewer of the eight recommended food groups in a day, reflecting extreme dietary deprivation and a heightened risk of malnutrition. According to the analysis, the average prevalence of severe child food poverty among children aged 6–23 months across the 37 analysed districts was 23 percent, exceeding the national estimate of 21.1 percent reported in MICS 2025. The prevalence ranged from 10 percent to 36 percent, indicating substantial geographical disparities in the quality and diversity of young children's diets.

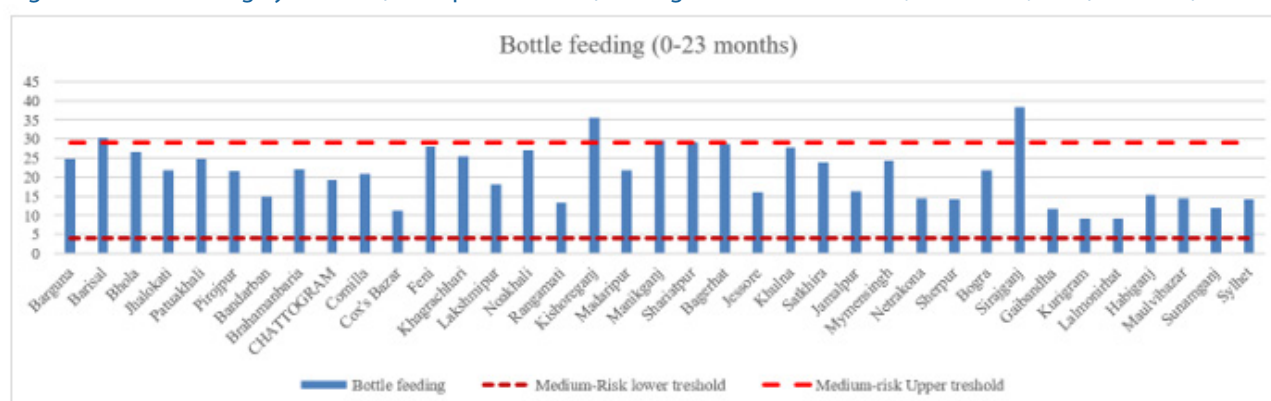
Figure 3: Severe child food poverty by districts (children consuming 0 to 2 Food groups in the past 24 hours) among children 6-23 month, MICS 2025, BBS (Nov 2025)



The analysis further shows that more than two-thirds of the assessed districts were classified as either medium or high risk based on the IPC AMN contributing-factor reference thresholds. Specifically, 57 percent of districts fell into the medium-risk category (20.0–29.9 percent), while 11 percent were classified as high risk (30.0–39.9 percent). The districts with the highest levels of severe child food poverty were Noakhali, Bhola, Jashore and Madaripur, where approximately one-third or more of children aged 6–23 months consumed foods from two or fewer food groups during the previous day. Children experiencing severe food poverty are more likely to consume monotonous diets dominated by staple foods, limiting their intake of essential nutrients. As a result, they face an increased risk of micronutrient deficiencies, impaired growth, and acute malnutrition.

Bottle feeding was identified as one of the most consistently elevated risk factors across the analysed districts. As identified in the risk-rating analysis, 89 percent (33 of the 37) of the analysed districts were classified as medium-risk category (4.1–29 percent), while 11 percent were classified as high risk (greater than or equal to 29.1 percent), indicating that bottle feeding is a common practice across nearly all analysed districts. The highest levels of bottle feeding were observed in Sunamganj, Mymensingh, Bhola and Maulvibazar. This pattern is of concern because bottle feeding is often associated with reduced breastfeeding, increased exposure to contaminated food and water, and a higher risk of diarrhoeal diseases and other infections, particularly in areas with poor WASH conditions. These pathways can contribute to inadequate nutrient intake, recurrent illness and an increased risk of acute malnutrition among young children.

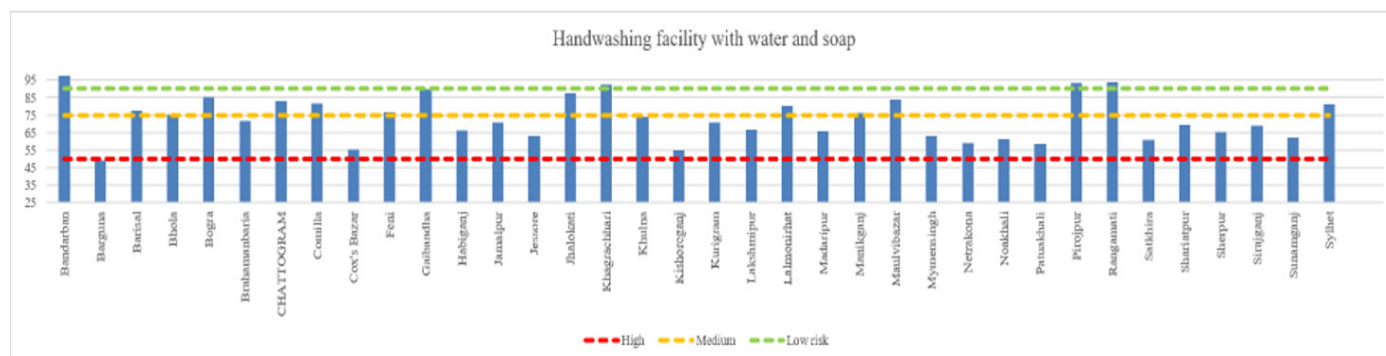
Figure 4: Bottle feeding by districts (in the past 24 hours) among children 6-23 month, MICS 2025, BBS (Nov 2025)



Poor hygiene and sanitation

Poor access to handwashing facilities with water and soap remains an important contributing factor to the current acute malnutrition analysis. Across the analysed districts, 54 percent (20 of the 37) were classified as medium risk with a prevalence of 50.1–75 percent, while 32 percent (12 of the 37) were classified as low risk with a prevalence of 75.1–89.9 percent, and 3 percent (1 of the 37) classified as high risk with a prevalence less than or equal to 50 percent. The predominance of medium-risk classifications suggests persistent gaps in hygiene conditions across many analysed districts. Poor access to handwashing facilities can increase the incidence of diarrhoeal and other infectious diseases, which negatively affect nutrient utilisation and increase children’s vulnerability to acute malnutrition.

Figure 5: Presence of basic hygiene by districts (household with handwashing facility with water & soap), MICS 2025, BBS (Nov 2025)

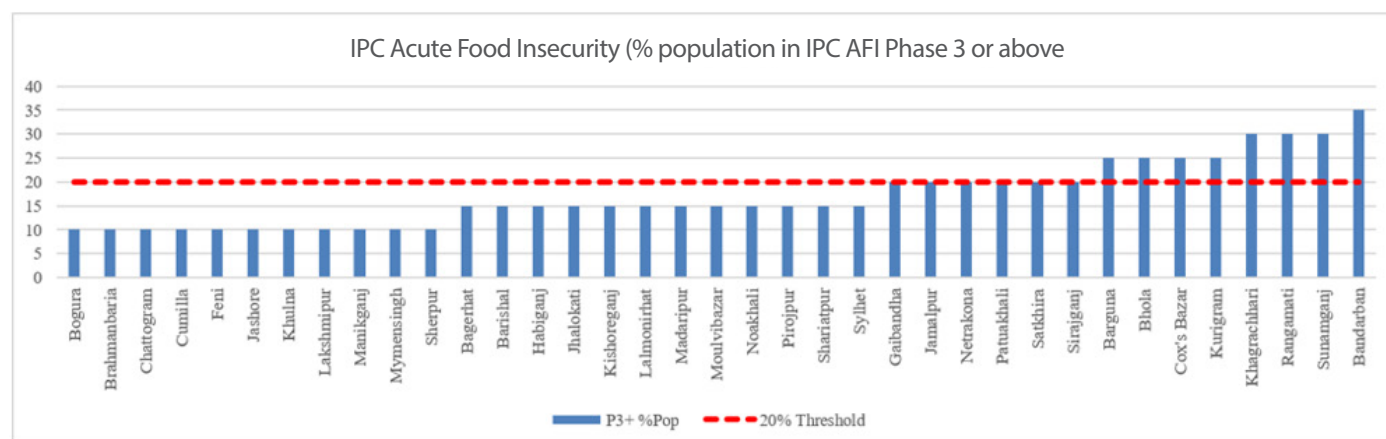


Food insecurity

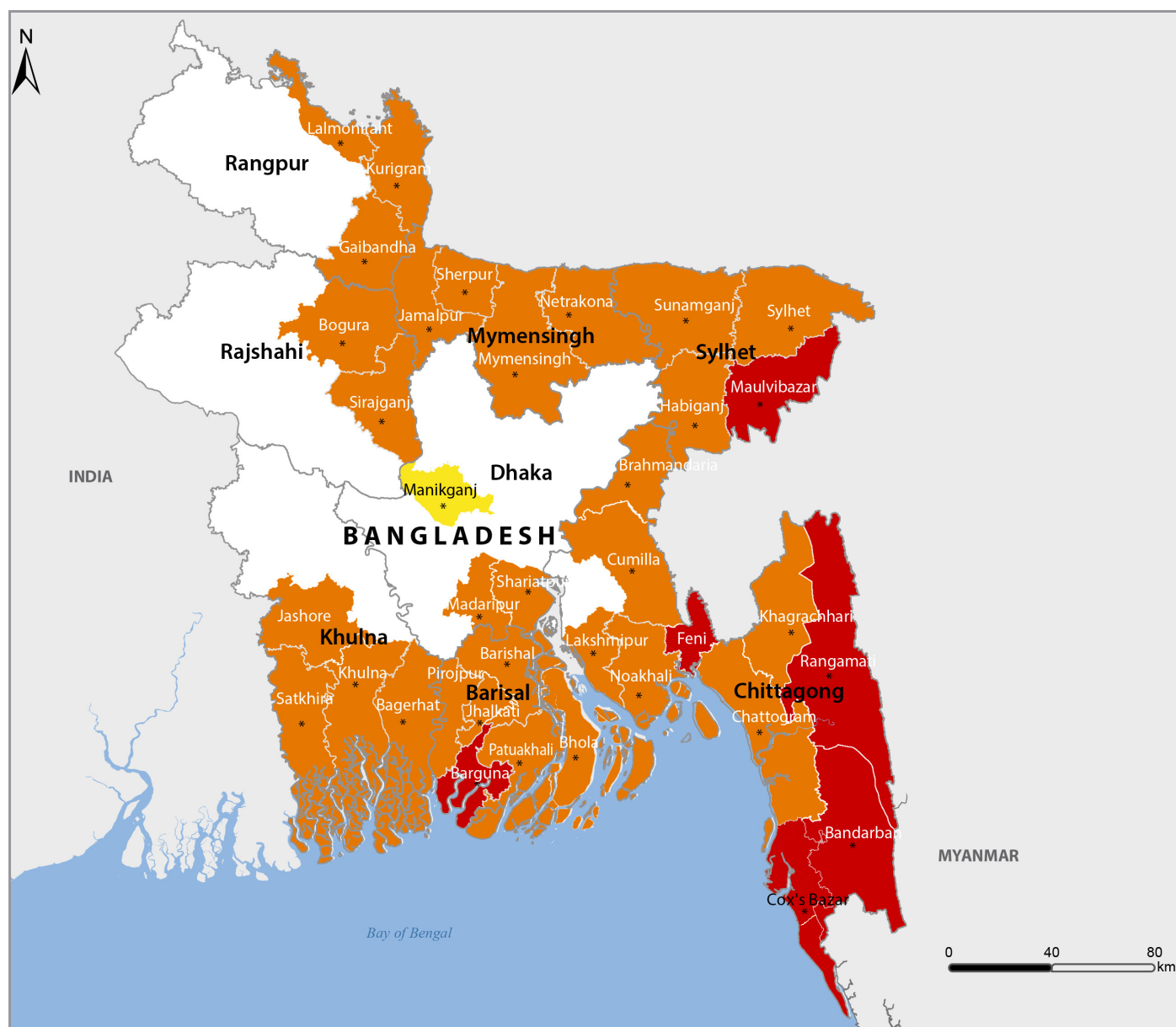
Acute food insecurity remains an important contributing factor to the current acute malnutrition situation. According to the IPC Acute Food Insecurity (AFI) analysis for May–August 2026, approximately 15.3 million people, representing 15 percent of the analysed population, were classified in IPC AFI Phase 3 or above (Crisis or worse). Across the IPC AMN (January – December 2026) analysed districts, 38 percent (14 of 37) exceeded the threshold of 20 percent of the population in IPC AFI Phase 3 or above, indicating elevated levels of acute food insecurity.

The highest proportions of the population facing Crisis or worse food insecurity were recorded in Bandarban, Khagrachhari, Rangamati, Sunamganj, and Kurigram, Barguna, Cox’s Bazar and Bhola. This pattern indicates that a substantial proportion of households continue to face constraints in accessing adequate food, particularly in geographically isolated and shock-prone areas such as the Chattogram Hill Tracts, Haor basin and coastal districts. The IPC AFI analysis identifies constrained economic access to food, recurrent climatic shocks, inflationary pressure, and livelihood disruptions as the primary drivers of food insecurity in these areas. The analysis also suggests that acute malnutrition is not solely driven by food insecurity. Across the IPC AMN analysed districts, elevated levels of acute malnutrition frequently coincide with poor child feeding practices, inadequate dietary diversity, severe child food poverty and poor WASH conditions. The convergence of these factors can further compromise nutrient intake, increase susceptibility to illness and impair nutrient absorption, thereby increasing the risk of acute malnutrition among young children.

Figure 6: Proportion of household in IPC AFI Phase 3 or above (May-Aug 2026), IPC AFI 2026, (May 2026)



MAP OF PROJECTED ACUTE MALNUTRITION SITUATION (SEPTEMBER - DECEMBER 2026)



Key for the Map

IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical

- Phase classification based on MUAC
- Areas with inadequate evidence
- Areas not analysed

Evidence level:

- * Acceptable
- ** Medium
- * High

PROJECTION ACUTE MALNUTRITION SITUATION OVERVIEW (SEPTEMBER – DECEMBER 2026)

Between September and December 2026, the overall nutrition situation is expected to remain largely unchanged in most districts, although localised deterioration is anticipated in several high-risk areas. Of the 37 districts analysed, 31 districts (84 percent) are expected to remain in the same phase as the current period (January–August 2026), indicating continued persistence of acute malnutrition at concerning levels. The majority of these districts will remain classified in AMN Phase 3 (Serious), while Bandarban, Feni, and Maulvibazar are projected to remain in AMN Phase 4 (Critical). Manikganj is the only district projected to remain in AMN Phase 2 (Alert).

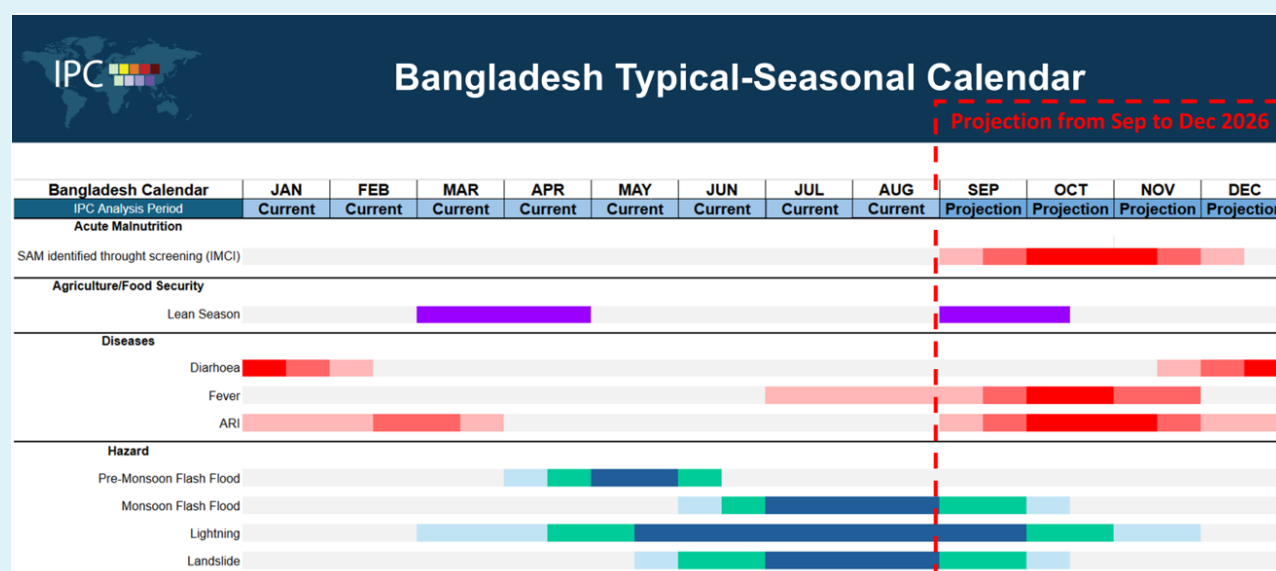
A modest improvement is projected in three districts. Chattogram, Khulna, and Habiganj are expected to improve from Phase 4 to Phase 3 during the projection period. While this represents a positive shift, these districts will continue to face a serious acute malnutrition burden, requiring sustained efforts to address the underlying causes of malnutrition and prevent a reversal of gains.

Conversely, Barguna, Cox's Bazar, and Rangamati are likely to deteriorate, moving from Phase 3 to Phase 4. The deterioration indicates a worsening nutritional situation, with an increasing proportion of children expected to face acute malnutrition and elevated nutrition-related health risks. Barguna is projected to shift to Phase 4 due to continued cyclone and tidal-flood exposure converging with an existing measles hotspot, where the district recorded the highest early rate nationally. Cox's Bazar is expected to shift to Phase 4, driven by monsoon-related flooding and landslides, seasonal and disease related shift, market disruptions, and reduced humanitarian response capacity due to declining humanitarian funding, compounded by the protracted Rohingya refugee crisis. Rangamati is projected to shift to Phase 4 due to flash floods and landslides alongside weak WASH access and ongoing measles transmission. The shift to Phase 4 highlights the need for intensified preventive and treatment interventions, particularly among vulnerable populations.

The expected deterioration is likely to be driven by a combination of interrelated factors. These include a high burden of childhood illnesses, particularly diarrhoeal diseases and other infections, sub-optimal breastfeeding practices, and limited access to diversified and nutritious complementary foods for young children. Poor hygiene and sanitation conditions are expected to further increase the risk of disease and malnutrition. In addition, food insecurity, compounded by high poverty levels and rising food prices, is likely to constrain household purchasing power and reduce access to nutritious diets. Together, these factors are expected to continue driving persistently high levels of acute malnutrition across many districts and contribute to the projected deterioration in the most vulnerable areas.

Key assumptions and seasonal variation for the projected period

Figure 7: Acute malnutrition and nutrition drivers seasonal variation during a typical year in Bangladesh, (Source: Adapted from DHIS-2 data, HEA and OCHA/ACLED calendar)



The overall situation across most analysed factors is expected to remain largely stable, with a few critical seasonal and disease-related shifts during the projection period. Conflict, political and economic conditions, population displacement, access to health and nutrition services, vaccination coverage, and baseline WASH conditions (water, sanitation, and hygiene) are all highly unlikely to change, while breastfeeding and health-seeking behaviors will also remain steady. However, child dietary indicators—including dietary diversity, minimum meal frequency, and overall access to a diverse diet—are expected to slightly deteriorate during the lean season across most districts, with the exception of Habiganj. Additionally, seasonal health shifts will likely cause a slight increase in diarrhoea and ARI/fever during peak seasons. Conversely, the current measles outbreak situation is projected to improve significantly as families feel more comfortable visiting healthcare centers following the government's newly initiated measles campaign, while acute watery diarrhoea (AWD) and cholera rates are expected to see no change.

TOTAL NUMBER OF CHILDREN (CURRENT & PROJECTION) AFFECTED BY ACUTE MALNUTRITION AND IN NEED OF TREATMENT (JANUARY - DECEMBER 2026)

Division	District	Under 5 population	GAM prevalence (only WFH)	MAM prevalence (only WFH)	SAM prevalence	Estimated number of SAM	Estimated number of MAM	Total SAM & MAM cases
Barishal	Barishal	250,410	14.0%	11.9%	2.1%	15,776	89,396	105,172
	Barguna	98,444	13.6%	11.8%	1.8%	5,316	34,849	40,165
	Bhola	188,263	11.6%	8.9%	2.7%	15,249	50,266	65,515
	Jhalokati	64,409	12.7%	11.3%	1.4%	2,705	21,835	24,540
	Patuakhali	168,267	14.1%	11.3%	2.8%	14,134	57,042	71,177
	Pirojpur	116,726	11.0%	8.5%	2.5%	8,754	29,765	38,520
Barishal Total		886,519				61,934	283,153	345,089
Chattogram	Bandarban	47,995	16.3%	13.1%	3.2%	4,619	18,912	23,531
	Brahmanbaria	329,859	11.4%	8.5%	3.0%	29,391	83,760	113,150
	Cox's Bazar	286,930	13.9%	11.6%	2.3%	20,079	99,757	119,837
	Chattogram	914,737	17.2%	12.8%	4.5%	122,308	350,593	472,901
	Cumilla	619,725	12.0%	7.8%	4.2%	78,653	145,345	223,998
	Feni	164,492	15.2%	12.1%	3.1%	15,408	59,537	74,945
	Khagrachhari	71,240	10.3%	7.7%	2.6%	5,649	16,394	22,044
	Lakshmipur	193,344	10.5%	8.6%	1.9%	11,016	49,661	60,677
	Noakhali	361,652	10.9%	9.4%	1.4%	15,660	102,519	118,179
	Rangamati	64,603	14.0%	11.5%	2.4%	4,708	22,373	27,081
Chattogram Total		3,054,577				307,491	948,851	1,256,343
Dhaka	Madaripur	130,782	12.3%	9.2%	3.1%	12,167	36,213	48,380
	Manikganj	157,584	6.3%	5.9%	0.4%	1,786	28,086	29,872
	Kishoreganj	330,500	12.7%	10.6%	2.0%	20,313	105,348	125,661
	Shariatpur	130,937	14.2%	11.4%	2.8%	11,169	44,802	55,971
Dhaka Total		749,803				45,435	214,449	259,884
Khulna	Bagerhat	158,019	14.4%	12.1%	2.3%	10,970	57,191	68,162
	Jashore	301,411	13.9%	11.2%	2.7%	24,346	101,288	125,634
	Khulna	256,010	15.0%	13.3%	1.7%	13,076	102,096	115,172
	Satkhira	215,179	10.4%	8.8%	1.7%	10,807	56,569	67,376
Khulna total		930,619				59,199	317,144	376,344

Division	District	Under 5 population	GAM prevalence (only WFH)	MAM prevalence (only WFH)	SAM prevalence	Estimated number of SAM	Estimated number of MAM	Total SAM & MAM cases
Mymensingh	Jamalpur	252,833	11.9%	8.8%	3.1%	23,344	66,832	90,176
	Mymensingh	596,652	11.1%	8.9%	2.2%	39,024	159,054	198,079
	Netrokona	235,145	12.4%	10.2%	2.2%	15,545	72,071	87,616
	Sherpur	151,903	14.8%	11.6%	3.2%	14,527	52,753	67,280
Mymensingh Total		1,236,533				92,440	350,710	443,151
Rajshahi	Bogura	364,802	11.7%	10.9%	0.9%	9,698	118,852	128,550
	Sirajganj	328,013	13.6%	11.4%	2.2%	22,097	111,801	133,898
Rajshahi Total		692,815				31,795	230,653	262,448
Rangpur	Gaibandha	251,497	13.8%	12.3%	1.5%	11,424	92,553	103,977
	Kurigram	228,619	13.1%	10.7%	2.4%	16,278	73,636	89,914
	Lalmonirhat	140,206	12.3%	10.1%	2.2%	9,411	42,336	51,746
Rangpur Total		620,322				37,113	208,525	245,637
Sylhet	Habiganj	231,354	15.6%	13.4%	2.2%	14,948	93,126	108,074
	Maulvibazar	208,262	16.1%	12.7%	3.4%	21,416	79,215	100,630
	Sunamganj	264,367	12.0%	10.6%	1.4%	11,377	83,893	95,270
	Sylhet	378,289	12.0%	9.5%	2.4%	27,759	108,123	135,881
Sylhet Total		1,082,272				75,500	364,357	439,855
Grand Total		9,253,460				710,907	2,917,842	3,628,749

The expected number of cases of acute malnutrition was calculated using the global standard using the following formula: $N \times P \times K$ where N is population of children 6 to 59 months in the area, P is the estimated prevalence of SAM or MAM, and K is the correction factor is correction factor to account for new or incident cases over 12 months, which for South Asia is 3.

PROFILE OF THE MOST AFFECTED AREAS - ACUTE MALNUTRITION HOTSPOTS SOUTH/CENTRAL CHATTOGRAM DIVISION (BANDARBAN, CHATTOGRAM, COX'S BAZAR, FENI DISTRICTS)

Current Acute Malnutrition
(January - August 2026)



Projection Acute Malnutrition
(September - December 2026)



Key for the Map

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- ** Medium
- *** High

Within Chattogram Division, the measles outbreak particularly affected Bandarban, Chattogram, Cox's Bazar, Rangamati and Feni districts. By 25 June 2026, Chattogram Division remained among the most affected areas, with 2,514 suspected cases reported (as of the latest available division-level breakdown), while Cox's Bazar refugee camps reported 865 suspected cases, including 105 laboratory-confirmed cases and 5 deaths. Within Chattogram City, nine urban wards were identified as measles hotspots, with a high concentration of cases reported in densely populated areas and significant pressure on referral hospitals. The high proportion of cases among children under five raises concerns potential impacts on child morbidity, mortality, and acute malnutrition vulnerability, particularly in areas already facing elevated nutritional risks.

Between June and July 2026, flash floods and landslides affected Chattogram, Cox's Bazar, Rangamati and Bandar districts following intense monsoon rainfall. The impact was particularly severe in Bandarban due to its mountainous terrain and in Cox's Bazar due to the vulnerability of densely populated refugee and host communities. The floods disrupted livelihoods, WASH infrastructure, and access to essential services, increasing risks of disease transmission and nutritional deterioration among vulnerable populations, including young children and pregnant and breastfeeding women.

Districts		IPC AMN Current (Jan-Aug 2026)	IPC AMN Projection (Sep-Dec 2026)	Children acutely malnourished and in need of treatment	GAM%	SAM%	MAM%
Bandarban	Magnitude & prevalence	AMN Phase 4 (Critical)	AMN Phase 4 (Critical)	23,531	16.3%	3.2%	13.1%
	Main drivers	 Flash floods	 Measles outbreak	 Poor WASH	 Poor access to healthcare services	 Acute diarrhoea	 Food insecurity
Chattogram District	Magnitude & prevalence	AMN Phase 4 (Critical)	AMN Phase 3 (Serious)	472,901	17.2%	4.5%	12.8%
	Main drivers	 Measles outbreak	 Flash floods	 Landslides	 Poor childcare practices	 Poor feeding	 Acute diarrhoea
Feni	Magnitude & prevalence	AMN Phase 4 (Critical)	AMN Phase 4 (Critical)	74,945	15.2%	3.1%	12.1%
	Main drivers	 Measles outbreak	 Flash floods	 Poor feeding	 Poor childcare practices	 Poor access to healthcare services	 Acute diarrhoea
Cox's Bazar District	Magnitude & prevalence	AMN Phase 3 (Serious)	AMN Phase 4 (Critical)	119,837	13.9%	2.3%	11.6%
	Main drivers	 Measles outbreak	 Poor WASH	 Poor childcare practices	 Poor access to healthcare services	 Poor feeding	 Food insecurity
Rangamati	Magnitude & prevalence	AMN Phase 3 (Serious)	AMN Phase 4 (Critical)	27,081	14%	2.4%	11.5%
	Main drivers	 Flash floods	 Landslides	 Poor WASH	 Poor feeding	 Acute diarrhoea	

Bandarban District

Bandarban District is classified in IPC Acute Malnutrition Phase 4 (Critical) and is expected to remain in Phase 4 during the projection period, with an estimated 23,531 children aged 6–59 months affected, including 4,619 severe cases requiring urgent treatment. The critical nutrition situation is driven by recurrent disease outbreaks, including the 2026 measles outbreak, inadequate dietary intake, limited access to health and nutrition services, and persistent socioeconomic vulnerabilities, particularly in remote hill areas. Recent flash floods and monsoon-related disruptions have further increased vulnerability by affecting livelihoods, food access, WASH conditions, and access to essential services. The situation is expected to remain fragile due to seasonal increases in ARI and diarrhoea, continued disease risks, and potential disruptions during the monsoon period. Priority actions should focus on strengthening Community-Based Management of Acute Malnutrition (CMAM) services, improving access to health and nutrition interventions, enhancing disease prevention and outbreak response, and expanding food security and livelihood support for the most vulnerable households.

Chattogram District

Chattogram District is currently classified in Phase 4 and is projected to improve to Phase 3 during the projection period. An estimated 472,901 children aged 6–59 months are affected by acute malnutrition, including around 122,308 severe cases requiring urgent treatment.

Despite relatively better access to services in urban areas, significant nutrition vulnerabilities persist among poor households, informal settlements, hard-to-reach coastal communities, and populations affected by economic shocks and limited livelihood opportunities. The nutrition situation is influenced by disease outbreaks, monsoon-related disruptions, fluctuations in food prices and caring and feeding practices, especially lack of early initiation of breastfeeding.

The nutrition situation is expected to improve during the projected period due to reduced outbreak risk of measles and AWD, along with a relatively stable food security situation with only 15 percent of households at Phase 3. The burden is particularly pronounced in underserved rural, informal settlement and coastal areas where poverty and service gaps remain significant. Priority interventions should include scale-up of nutrition screening and treatment services, improved disease prevention and management, strengthened WASH interventions, and targeted support to vulnerable communities with elevated nutrition risks.

Feni District (Chattogram)

Feni District (Chattogram) is classified in Phase 4 and is projected to remain in Phase 4 through the projection period. An estimated 74,945 children aged 6–59 months are affected, including around 15,408 severe cases requiring urgent treatment. The nutritional situation is primarily driven by disease outbreak, delayed initiation of breastfeeding, health seeking behaviour and inadequate dietary intake.

The most affected populations are concentrated in vulnerable rural communities and areas prone to seasonal flooding and waterlogging, where livelihoods and access to services are frequently disrupted. Seasonal rainfall, increased incidence of waterborne diseases, and periodic shocks affecting household income are likely to continue influencing nutrition outcomes during the projection period. Priority actions should focus on strengthening caring and feeding practices through behaviour change activities, acute malnutrition treatment services, expanding community-level screening and referral mechanisms, and providing targeted food and nutrition support to vulnerable households and children at greatest risk.

Cox's Bazar District (Chattogram)

Cox's Bazar District (Chattogram) is currently classified in Phase 3 and is likely to deteriorate to Phase 4 during the outlook period, highlighting a worsening nutrition situation requiring urgent and scaled-up action. An estimated 119,837 children aged 6–59 months are affected by acute malnutrition, including approximately 20,079 children suffering from SAM requiring immediate lifesaving treatment.

The nutrition situation is driven by a combination of acute shocks and underlying vulnerabilities, including poor dietary diversity, inadequate Infant and Young Child Feeding (IYCF) practices, limited access to nutrient-rich foods, sub-optimal WASH conditions, recurrent diarrhoeal diseases and acute respiratory infections, and constrained access to quality health and nutrition services.

Cox's Bazar's vulnerability is further amplified by the presence of approximately 1.2 million Rohingya refugees, placing significant pressure on local services, livelihoods, natural resources, and social infrastructure. High population density, limited livelihood opportunities, poverty, exposure to climate-related hazards, and dependence on humanitarian assistance continue to affect both refugee and host communities. During the projection period, the nutrition situation is expected to deteriorate further due to monsoon-related flooding and landslides, seasonal disease peaks, market disruptions, and reductions in humanitarian funding affecting nutrition-specific and nutrition-sensitive interventions.

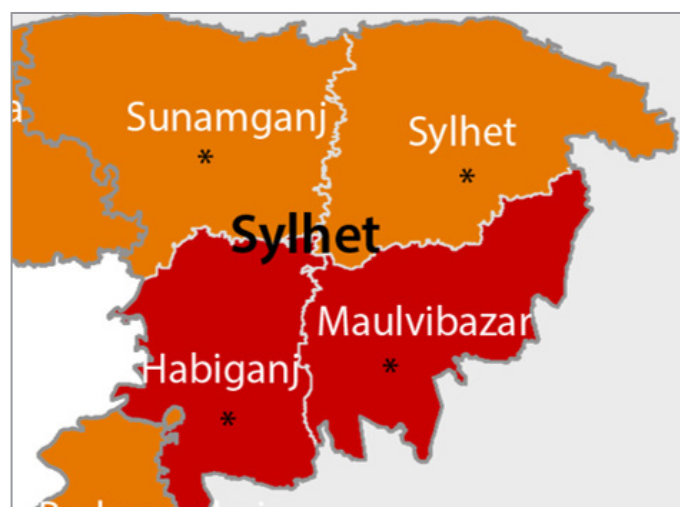
Priority actions should focus on expanding access to quality CMAM services, strengthening preventive nutrition interventions, improving maternal and child nutrition and IYCF practices, enhancing immunization and disease prevention, and maintaining adequate WASH services. Strengthening nutrition surveillance, early warning systems, climate-resilient preparedness, and livelihood and social protection support will be critical to prevent further deterioration and reduce excess morbidity and mortality among vulnerable populations.

Rangamati District (Chattogram)

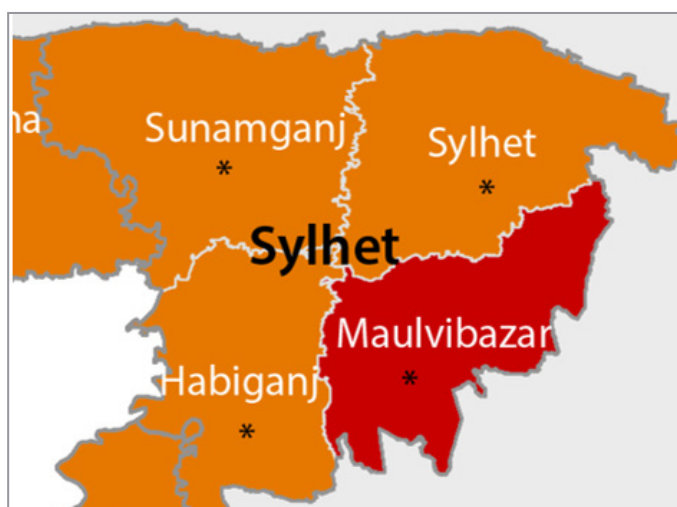
Rangamati District (Chattogram) is currently classified in Phase 3 and is projected to deteriorate to Phase 4 during the outlook period, highlighting a worsening nutrition situation requiring urgent and scaled-up action. An estimated 27,081 children aged 6–59 months are affected by acute malnutrition, including approximately 4,708 children suffering from SAM requiring immediate lifesaving treatment. The nutrition situation is driven by a combination of acute shocks and underlying vulnerabilities, including flash floods and landslides, measles outbreak and food insecurity, inadequate feeding practices and poor access to basic water and sanitation conditions.

PROFILE OF THE MOST AFFECTED AREAS - ACUTE MALNUTRITION HOTSPOTS SYLHET DIVISION (HABIGANJ & MAULVIBAZAR DISTRICTS)

Current Acute Malnutrition (January - August 2026)

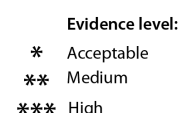
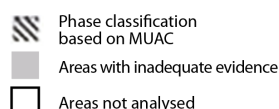


Projection Acute Malnutrition (September - December 2026)



Key for the Map

IPC Acute Malnutrition Phase Classification



Between June and July 2026, flash floods affected Sylhet Division, including Habiganj and Maulvibazar districts, following intense monsoon rainfall and upstream runoff. Flooding particularly affected low-lying haor communities, disrupting livelihoods, WASH services, and access to essential health and nutrition services, thereby increasing vulnerability to disease and potential nutritional deterioration among already vulnerable households.

Districts		IPC AMN Current (Jan-Aug 2026)	IPC AMN Projection (Sep-Dec 2026)	Children acutely malnourished and in need of treatment	GAM%	SAM%	MAM%
Maulvibazar	Magnitude & prevalence	AMN Phase 4 (Critical)	AMN Phase 4 (Critical)	100,630	16.1%	3.4%	12.7%
	Main drivers	 Flash floods	 Landslides	 Measles outbreak	 Poor childcare practices	 Poor feeding	 Poor access to healthcare services
Habiganj	Magnitude & prevalence	AMN Phase 4 (Critical)	AMN Phase 3 (Serious)	108,074	15.6%	2.2%	13.4%
	Main drivers	 Flash floods	 Landslides	 Measles outbreak	 Poor feeding	 Poor access to healthcare services	 Acute diarrhoea

Maulvibazar District

Maulvibazar District is currently facing a severe public health crisis and is classified in Phase 4. The situation is expected to remain at this level throughout the projection period, requiring immediate life-saving interventions. The GAM prevalence reached 16.1 percent according to the 2025 MICS, exceeding the international emergency threshold of 15 percent, meaning that more than one in six children under five is affected by wasting. An estimated 100,630 children under five years of age are experiencing acute malnutrition and require urgent therapeutic and supplementary nutrition support.

The nutrition crisis is driven by a combination of acute shocks and underlying vulnerabilities. Recurrent flash floods continue to disrupt livelihoods, markets, access to safe drinking water, and essential services. Poor IYCF practices—including a high prevalence of unsafe bottle feeding and inadequate dietary diversity—further contribute to poor nutritional outcomes. At the same time, recurrent diarrhoeal diseases, poor health-seeking behaviour, and the 2026 measles outbreak have increased the risk of acute malnutrition among young children. The situation is expected to remain fragile during the projection period due to the convergence of the lean agricultural season, monsoon-related flooding, and recurring disease outbreaks.

The entire district is affected, although vulnerability is particularly concentrated in rural communities, low-lying haor basins, and marginalised tea garden (Cha Bagan) communities. The nutritional situation has remained volatile over recent years, with no sustained improvement, as reflected by the GAM prevalence falling from 12.2 percent (BDHS 2022) to 10.8 percent (SMART 2024), before rising sharply to 16.1 percent (MICS 2025).

To reduce GAM below the emergency threshold and prevent excess morbidity and mortality, priority actions should focus on rapidly expanding CMAM services and ensuring uninterrupted availability of Ready-to-Use Therapeutic Food (RUTF). Strengthening measles vaccination, diarrhoea prevention and case management, promoting exclusive breastfeeding and appropriate complementary feeding using locally available foods, and expanding emergency cash and food assistance to vulnerable households in flood-prone areas and tea garden communities are also critical. These interventions should be implemented through a coordinated multi-sectoral response integrating nutrition, health, WASH, food security, and social protection.

Habiganj District

Habiganj District is currently classified in Phase 4, representing a significant deterioration from Phase 2 during the January–April 2025 analysis period. The district is projected to improve to Phase 3 during the September–December 2026 projection period. An estimated 108,074 children under five years of age are affected by acute malnutrition and require therapeutic and supplementary nutrition support.

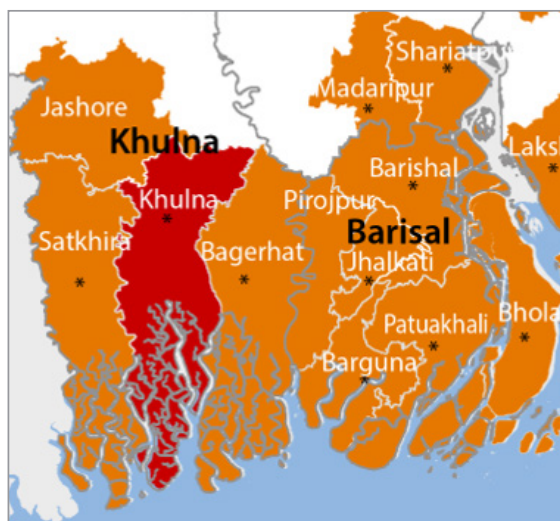
The deterioration in the nutrition situation is primarily driven by the combined effects of recurrent climatic shocks, repeated and severe flooding between 2024 and 2026, and suboptimal IYCF and caring practices. Habiganj's location within the haor basin and its reliance on flood-sensitive agricultural livelihoods make households particularly vulnerable to climate-related shocks. Repeated flooding has disrupted livelihoods, food access, and caregiving practices, contributing to worsening acute malnutrition. Despite these challenges, the IPC AFI analysis classified the district in IPC AFI Phase 2 (Stressed) for both the current and projected periods, indicating that food security conditions are expected to remain relatively stable.

The nutrition outlook is expected to improve during the projection period as the Aman harvest increases household food availability and access, supporting improved dietary intake and child feeding practices. This seasonal improvement is expected to contribute to a reduction in the severity of acute malnutrition, resulting in a projected improvement to IPC AMN Phase 3.

Priority actions should focus on strengthening CMAM services, improving IYCF practices, enhancing preparedness for recurrent flooding, and maintaining integrated health, nutrition, WASH, and livelihood interventions. Sustained nutrition surveillance and early warning systems will be essential to monitor seasonal changes and mitigate the impact of future climatic shocks on vulnerable households.

PROFILE OF THE MOST AFFECTED AREAS - ACUTE MALNUTRITION HOTSPOTS SOUTH-WEST COASTAL AREA DISTRICTS (KHULNA AND BARGUNA DISTRICTS)

Current Acute Malnutrition (January - August 2026)



Projection Acute Malnutrition (September - December 2026)



Key for the Map

IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical

- Phase classification based on MUAC
- Areas with inadequate evidence
- Areas not analysed

- Evidence level:
- * Acceptable
- ** Medium
- *** High

Khulna and Barguna districts are among Bangladesh's most cyclone-prone coastal areas and have experienced repeated exposure to major tropical cyclones in recent years, including Super Cyclone Amphan (May 2020), Cyclone Yaas (May 2021), Cyclone Sitrang (October 2022), Cyclone Mocha (May 2023), and Cyclone Remal (May 2024). These events caused widespread damage to housing, livelihoods, agricultural production, embankments, and WASH infrastructure, contributing to long-term vulnerability. Although no major named cyclone directly impacted the districts in 2026, they continued to experience monsoon-related flooding, heavy rainfall, and localised coastal inundation, disrupting livelihoods, food access, and essential health and nutrition services. The cumulative effects of repeated climate-related shocks, combined with seasonal disease outbreaks and persistent socioeconomic vulnerabilities, continue to increase the risk of acute malnutrition among vulnerable populations.

Districts		IPC AMN Current (Jan-Aug 2026)	IPC AMN Projection (Sep-Dec 2026)	Children acutely malnourished and in need of treatment	GAM%	SAM%	MAM%
Khulna	Magnitude & prevalence	AMN Phase 4 (Critical)	AMN Phase 3 (Serious)	115,172	15%	1.70%	13.30%
	Main drivers	 Measles outbreak	 Tropical cyclone	 Urban/rural migration	 Poor WASH	 Poor childcare practices	 Poor feeding
Barguna	Magnitude & Prevalence	AMN Phase 3 (Serious)	AMN Phase 4 (Critical)	40,165	13.6%	1.8%	11.8%
	Main drivers	 Measles outbreak	 Tropical cyclone	 Poor WASH	 Poor childcare practices	 Poor feeding	 Food insecurity

Khulna District (Khulna)

Khulna District (Khulna) is home to Bangladesh's third-largest city and is a strategic coastal area in the southwest, consisting of both expanding urban centres and climate-exposed coastal zones bordering the Sundarbans. The district is highly vulnerable to salinity intrusion, cyclones, storm surges, tidal flooding, and chronic waterlogging, which affect agricultural production, livelihoods, and access to safe drinking water. Coastal sub-districts—known as *upazilas*—such as Koyra and Dacope are particularly vulnerable due to recurrent disasters and increasing salinity affecting farming and fishing communities. At the same time, climate-induced migration has contributed to the expansion of informal settlements in Khulna City, increasing pressure on basic services and living conditions.

Khulna District is currently classified in Phase 4, based on GAM prevalence (WHZ), with several contributing factors assessed as medium risk. The situation is projected to improve to Phase 3 during the projection period. Key contributing factors include limited access to safe water, suboptimal breastfeeding practices, bottle feeding, inadequate minimum acceptable diet, and child poverty. The 2026 measles outbreak was assessed as a very high-risk factor contributing to the current severity of the nutrition situation.

Khulna Division was among the main epicenters of the 2026 measles outbreak, with more than 1,500 suspected cases reported by mid-April 2026. The outbreak affected multiple districts, including Khulna, increasing pressure on paediatric health services. The high proportion of cases among children under five increased risks of morbidity, mortality, and nutritional deterioration, particularly among already vulnerable children.

During the projection period, seasonal hazards such as cyclones, tidal surges, and saline water intrusion may increase the risk of diarrhoeal diseases and acute respiratory infections; however, they are not expected to cause a significant deterioration in acute malnutrition. The IPC AFI classification is also expected to remain stable, despite a moderate increase in the population in IPC AFI Phase 2 (from 10 to 15 percent). The anticipated improvement in nutrition outcomes is supported by declining measles risk due to expanded vaccination coverage and strengthened outbreak response measures.

Barguna District (Barishal)

Barguna District (Barishal) is located in coastal southern Bangladesh, is highly vulnerable to climate-related shocks due to its low-lying geography and dependence on climate-sensitive livelihoods. Recurrent cyclones, storm surges, tidal flooding, salinity intrusion, and waterlogging have affected agricultural production, fisheries, livelihoods, and access to safe drinking water. Historical events, including Super Cyclone Amphan (May 2020), Cyclone Yaas (May 2021), Cyclone Sitrang (October 2022), Cyclone Mocha (May 2023), and Cyclone Remal (May 2024), have contributed to cumulative vulnerabilities among coastal communities.

Barguna District is currently classified in Phase 3, with contributing factors including poor dietary diversity, suboptimal IYCF practices, limited access to safe water and sanitation, child poverty, and recurrent disease risks. The district was also identified as a measles outbreak hotspot in 2026, increasing risks of morbidity, mortality, and acute malnutrition among children under five.

During the projection period, the nutrition situation is projected to deteriorate to Phase 4 due to continued exposure to monsoon flooding, tidal surges, and seasonal disease peaks, which may affect food access and service delivery. However, ongoing measles vaccination and disease control efforts are expected to reduce outbreak-related risks. Priority actions should focus on strengthening CMAM services, improving IYCF and WASH interventions, enhancing disease prevention, and supporting climate-resilient livelihoods and social protection for vulnerable households.

Barguna District was identified as one of the main measles outbreak hotspots among the 18 districts officially identified as measles hotspots by the Directorate General of Health Services (DGHS), recording the highest incidence rate nationally during the early phase of the outbreak (104.8 cases per million population). An emergency MR vaccination campaign was launched in April 2026, targeting high-risk areas including Barguna Sadar. The concentration of measles cases among young children increases concerns regarding potential impacts on morbidity, mortality, and acute malnutrition vulnerability, particularly among children already exposed to nutritional risks.

RECOMMENDATIONS FOR ACTION

Response priorities immediate/short-term

Ensure timely identification, treatment, and prevention of acute malnutrition while maintaining essential services during disease outbreaks and climate-related emergencies.

- Expand access to life-saving acute malnutrition treatment services by rapidly piloting/implementing CMAM, ensuring availability of locally produced RUTF and supplementary nutrition supplies, and strengthening referral pathways, particularly in IPC AMN Phase 4 areas and hard-to-reach populations.
- Strengthen community-based screening and early detection of wasting through regular MUAC screening, active case finding, and effective referral mechanisms linking communities with health facilities.
- Ensure continuity of essential nutrition and health services during emergencies through mobile teams, outreach services, emergency response mechanisms, and pre-positioning of supplies in cyclone-, flood-, and landslide-prone areas.
- Reduce the impact of infectious disease outbreaks on nutrition outcomes by strengthening measles vaccination campaigns, vitamin A supplementation, diarrhoea and ARI surveillance, and integrated management of childhood illnesses, particularly in high-risk and underserved areas.
- Protect infant and young child feeding practices during emergencies through community- and facility-based counselling, breastfeeding support, appropriate complementary feeding promotion, and tailored social and behaviour change interventions.
- Improve access to safe water, sanitation, and hygiene services in disaster-affected and high-risk areas to reduce exposure to diarrhoeal diseases and other infections contributing to wasting.
- Provide emergency food, specially formulated food (SQ-LNS, MQ-LNS) and cash assistance to vulnerable households affected by flooding, cyclones, disease outbreaks, and livelihood disruption to maintain access to nutritious foods and prevention of child malnutrition.

Response priorities medium/long-term

Address structural drivers of acute malnutrition and strengthen resilience to recurrent climate and health shocks.

- Strengthen integrated prevention and management of wasting within the health system by embedding CMAM services into primary healthcare, adapting national protocols in line with updated WHO recommendations, and improving service quality and coverage.
- Improve maternal, infant, and young child nutrition outcomes by strengthening MIYCN/IYCF programming, including breastfeeding support, timely and adequate complementary feeding, caregiver counselling, and community-based social and behaviour change approaches.
- Improve household access to diverse and nutritious foods through integrated nutrition-sensitive interventions, including livelihood support, climate-resilient agriculture, social protection mechanisms, and targeted assistance for vulnerable households.
- Strengthen primary healthcare capacity and disease prevention systems through improved Integrated Management of Childhood Illness (IMCI), expanded immunization coverage (including measles, polio, and other priority vaccines), and strengthened surveillance and outbreak preparedness.
- Build climate-resilient nutrition and health service delivery models in cyclone-, flood-, salinity-, and landslide-prone areas, including vulnerable coastal districts, haor areas, hill districts, and urban informal settlements.
- Strengthen WASH systems in high-risk areas by expanding access to safe drinking water, improved sanitation facilities, and hygiene promotion, particularly in communities affected by salinity intrusion, flooding, and inadequate infrastructure.

Specific focus should be maintained on highly vulnerable areas, including climate-exposed coastal upazilas such as Koyra and Dacope (Khulna), cyclone- and flood-prone districts such as Barguna, and disaster-affected hill and refugee-hosting areas such as Bandarban, Rangamati, Chattogram, and Cox's Bazar, where repeated shocks, limited access to services, and socioeconomic vulnerabilities increase the risk of acute malnutrition deterioration.

Situation monitoring and update

- Establish and maintain a robust Nutrition Information System (NIS) integrating seasonal nutrition surveys, sentinel surveillance, routine programme data (MIS), and early warning mechanisms to monitor trends and trigger timely response.
- Strengthen multi-sectoral coordination and preparedness mechanisms across nutrition, health, WASH, food security, social protection, and disaster risk reduction sectors to ensure sustained action against acute malnutrition. More specifically, follow-up SMART nutrition surveys are necessary in all vulnerable locations to monitor and assess the evolving needs.
- Explore the possibility of establishing a nutrition surveillance system through community-based sentinel sites and mass MUAC screening with the national vitamin A plus campaign.
- Improving the nutrition information system by creating a nutrition assessment technical working group under the umbrella of the Nutrition Cluster.

Risk factors to monitor

Close monitoring should be maintained, particularly for the following contributing factors that could influence future deterioration:

- Measles outbreak and vaccination coverage
- Diet quality and quantity, especially among young children and vulnerable households
- Care and feeding practices, including exclusive breastfeeding and bottle-feeding practices
- ARI and diarrhoeal disease trends during the cyclone seasons
- Impacts of cyclones, tidal flooding, and salinity intrusion on household food access and health conditions
- Potential impact of flash floods and landslides on access to health and nutrition services

To ensure a proactive response during the projection period, several critical risk factors have been identified for close monitoring. Close oversight must be maintained on dietary diversity, child food security, and general caring practices—specifically IYCF—to catch and mitigate any nutritional deterioration during the lean season. Additionally, surveillance should be intensified for seasonal diseases, including fever, ARI and diarrhoea, alongside regular tracking of household hygiene and sanitation conditions to prevent potential spikes in malnutrition driven by illness.

PROCESS AND METHODOLOGY

Since its inception in 2013, the IPC process in Bangladesh has been led jointly by the Food Planning and Monitoring Unit (FPMU) under the Ministry of Food and the IPC Technical Working Group (TWG). The TWG comprises technical experts from over 35 entities, including relevant government line ministries, UN agencies, international NGOs, academia, and civil society. This multi-stakeholder structure ensures credibility, technical rigor, and national ownership of IPC analyses.

In June 2026, the Bangladesh team conducted the IPC AMN analysis. The TWG steered the process, with WFP, UNICEF and the IPC Global Support Unit (GSU) providing coordination and technical facilitation, and the Nutrition Cluster leading the nutrition-specific components. For the AMN analysis, the TWG organised a two-day IPC Level 1 refresher training, from 21 to 22 June 2026, focusing on IPC protocols and analytical tools from the latest IPC Technical Manual Version 3.1. The analysis workshop was conducted in person from 21 to 27 June 2026. Over 26 analysts participated, representing key government institutions, INGOs, LNGOs, and UN organizations. The analysis included both national and sub-national perspectives, covering 37 geographic units and adhered to the standardised classification protocols, with analysts using available outcome indicators and contributing factors data to reach consensus-based classifications. The analysis workshop was coordinated by nutrition cluster through financial and technical support from UNICEF and WFP. Both the IPC AMN training and analysis sessions were facilitated by an expert from IPC GSU and in-country co-facilitators.

Sources

The main data source was the 2025 Multiple Indicator Cluster Survey (MICS), which included a comprehensive nutrition module covering all 64 districts and was conducted between 24 February and 30 June 2025. These findings were used to inform the analysis of key nutrition drivers and outcomes and to describe the nutritional situation during the period January to August 2026.

- Multiple Indicator Cluster Survey (MICS 2025), Bangladesh Bureau of Statistics (BBS). Preliminary Report November 2025.
- DHIS-2 2023 to 2026 data
- Bangladesh Situation Report #5, Measles Outbreak, ICCG BGD, 25 June 2026
- Bangladesh Situation Report #4, Measles Outbreak, ICCG BGD, 21 May 2026
- Bangladesh Situation Report #3, Measles Outbreak, ICCG BGD, 6 May 2026
- Bangladesh Situation Report #2, Measles Outbreak, ICCG BGD, 23 April 2026
- Bangladesh Situation Report #1, Measles Outbreak, ICCG BGD, 8 April 2026
- IPC Acute Food Insecurity (IPC AFI 2026), IPC Technical Working Group, May 2026
- DIEM 2026
- Household Economy Analysis (HEA 2026), Haor Basin and Chittagong Hill Tracts Region of Bangladesh, Food Security Cluster, March 2026
- Bangladesh Country Profile (OCHA 2026), OCHA ROAP, March 2026
- Nutrition Survey Results conducted in Five Disaster and Cyclone Prone districts by WFP (SMART 2025), UNICEF & NNS, Result presentation, Jan-Feb 2025.
- Integrated Nutrition SMART Survey, (SMART 2024), WFP, ACF, NNS, Final report, Oct-Dec 2024
- Integrated Nutrition SMART Survey Sylhet (SMART Sylhet 2023), WFP, ACF, NNS, Final report, Oct-Dec 2023
- Nutrition SMART Survey Host Community (SMART Host Community, Cox's Bazar 2023), ACF, UNICEF & NNS, Final Report, Nov-Dec 2023
- Baseline Integrated SMART Nutrition Survey in Dhaka Urban Slums (SMART Dhaka Slum 2022), ACF, WFP, Concern & NNS, Final Report, June 2022
- Rapid Nutrition Assessment in Flash Flood Affected Areas (Rapid SMART Sylhet 2022), UNICEF, ACF & NNS, Final Report, Aug 2022
- Bangladesh Demographic and Health Survey (BDHS 2022), NIPORT & ICF, Final Report, July-Dec 2022.

- Follow Up Integrated SMART Nutrition Survey in Kutubdia Upazila (SMART Kutubdia Upazila – Cox’s Bazar 2021), ACF & WFP, Final Report, June 2021
- Follow Up Integrated SMART Nutrition Survey in Pekua Upazila (SMART Pekua Upazila – Cox’s Bazar 2021), ACF & WFP, Final Report, June 2021
- Baseline Integrated SMART Nutrition Survey in Sadar Upazila (SMART Sadar Upazila – Cox’s Bazar 2021), ACF & UNICEF, Final Report, August 2021
- Follow Up Integrated SMART Nutrition Survey in Ukhiya and Teknaf Upazila (SMART Ukhiya and Teknaf Upazila – Cox’s Bazar 2021), ACF & Nutrition Sector, Final Report, February 2021
- Prova, Shadmin & Sarker, Md. Shahoriar & Islam, Rosdania & Mahfuz, Ridad. (2026).
- Application of radar remote sensing for cyclone damage mapping in Bangladesh: A coherence-based approach. 10.5194/egusphere-2026-1545.

Limitations of the analysis

Limited availability of historical nutrition data: Bangladesh does not have a regular national nutrition survey system that provides consistent district-level acute malnutrition data over time. As a result, historical datasets were not available for all 37 analysed districts, limiting the ability to assess long-term trends and compare current findings with previous years.

- Reliance on MICS data: The 2026 AMN analysis primarily used data from the MICS. It is conducted only once every four to five years, which limits the timeliness of the evidence and its ability to capture recent changes in the nutrition situation.
- Challenges related to data availability: At the beginning of the analysis process, only divisional-level estimates were available from the Bangladesh Bureau of Statistics (BBS). District-level estimates, which are essential for IPC classification, were shared later in the process. This affected the timing of the analysis and limited opportunities for a more comprehensive review of district-level findings.
- Evidence gaps for contributing factors: Significant evidence gaps existed for several contributing factors included in the AMN analytical framework. Limited availability of recent and representative data on food consumption, disease burden, dietary diversity, feeding practices and mWASH reduced the strength of the evidence base.
- Reduced confidence in projections: Due to the evidence gaps for several contributing factors, assumptions regarding the evolution of acute malnutrition drivers could not be made with full confidence. Consequently, the confidence level for the projected period classifications is lower than desired, and projection results should be interpreted with caution.

Acute Malnutrition Phase name and description

Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical
Less than 5% of children are acutely malnourished.	5–9.9% of children are acutely malnourished.	10–14.9% of children are acutely malnourished.	15–29.9% of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	30% or more children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident.

What is the IPC and IPC Acute Malnutrition?

The IPC is a set of tools and procedures to classify the severity and characteristics of food and nutrition crises based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedures).

The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security and nutrition policy and programming.

The IPC Acute Malnutrition Classification provides information on the severity of acute malnutrition, highlights the major contributing factors to acute malnutrition, and provides actionable knowledge by consolidating wide-ranging evidence on acute malnutrition and contributing factors.

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IPC Global Support Unit

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Classification of food insecurity and malnutrition was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, CILSS, EC-JRC, FAO, FEWS NET, Global Food Security Cluster, Global Nutrition Cluster, IFPRI, IGAD, Oxfam, SICA, SADC, Save the Children, UNDP, UNICEF, WFP, WHO and the World Bank.

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ANNEX 1: SUMMARY OF CONTRIBUTING FACTORS TO ACUTE MALNUTRITION

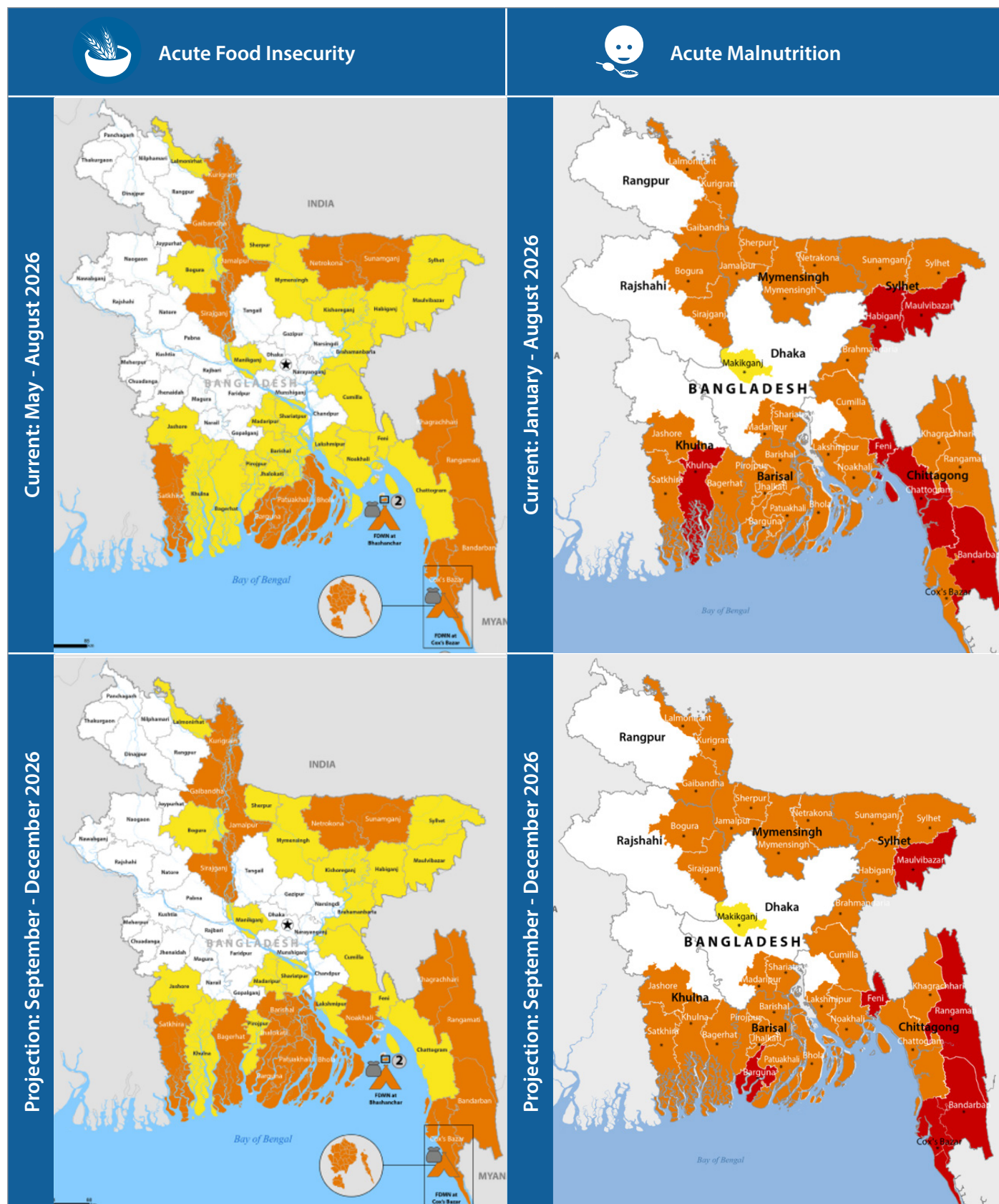
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ANNEX 2: COMPARISON BETWEEN FOOD SECURITY & NUTRITION SITUATION 2026

Comparison analysis between AFI and AMN should be interpreted cautiously due to uncertainties around data comparability, alignment of analysis periods, suitability of district-level evidence, and the lack of a concurrent review process to triangulate findings.



Acute malnutrition is currently more severe than the overall food security situation, reflecting the important role of non-food drivers.

The analysis indicates that the acute malnutrition situation is generally worse than the corresponding food security situation, suggesting that inadequate food access alone does not fully explain the observed levels of wasting. While food insecurity remains an important contributing factor, non-food determinants appear to play a major role in driving acute malnutrition outcomes. These include suboptimal infant and young child feeding and caring practices, limited access to health and nutrition services, poor WASH conditions, chronic vulnerability and poverty. Recurrent health shocks such as diarrhoeal diseases, ARI, and measles outbreaks also continue to drive acute malnutrition. These factors increase the risk of wasting by reducing nutrient intake, impairing nutrient absorption, and increasing nutrient requirements during illness.

Recurrent shocks may have a stronger and more immediate impact on nutrition outcomes than on household food security.

Climate-related events and disease outbreaks, including flash floods, landslides, cyclones, and epidemics, can rapidly affect child nutritional status through disruptions in health services, increased disease burden, and deterioration of caregiving conditions, even when household food availability remains relatively stable. In several areas, IPC AFI classifications indicate a relatively stable or moderate food security situation, while AMN outcomes remain critical, highlighting the cumulative effect of repeated shocks and vulnerability factors beyond food access. According to the recent HEA, natural disasters have put both the survival threshold and livelihood protection thresholds under pressure.

The measles outbreak represents an additional nutrition risk, although its direct impact on acute malnutrition cannot yet be fully quantified due to timing constraints of available data.

The 2026 measles outbreak affected several districts with high nutrition vulnerability, including areas classified in IPC AMN Phase 3 and Phase 4. Given the strong bidirectional relationship between measles and acute malnutrition, the outbreak may have contributed to increased nutritional vulnerability through reduced dietary intake, higher nutrient requirements, increased risk of complications, and elevated mortality among young children. However, the magnitude of its impact on current acute malnutrition levels remains difficult to establish, as most available nutrition outcome data were collected before or during the early phase of the outbreak. Therefore, measles should be considered an important aggravating factor and a potential driver of further deterioration during the projection period rather than a confirmed contributor to the current AMN classification.