

Médecins Sans Frontières

Médecins Sans Frontières (MSF) translates to Doctors without Borders. We provide medical assistance to people affected by conflict, epidemics, disasters, or exclusion from healthcare. Our teams are made up of tens of thousands of health professionals, logistic and administrative staff - bound together by our charter. Our actions are guided by medical ethics and the principles of impartiality, independence and neutrality. We are a non-profit, self-governed, member-based organisation.

MSF was founded in 1971 in Paris by a group of journalists and doctors. Today, we are a worldwide movement of over 69,000 people.

The MSF Charter

Médecins Sans Frontières (MSF) is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honour the following principles:

Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and maintain complete independence from all political, economic or religious powers.

As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.

The texts in this report provide descriptive overviews of MSF's operational activities in Bangladesh between January and December 2024. Activity report is representational and, owing to space considerations may not be comprehensive. The place names and boundaries used in this report do not reflect any position by MSF on their legal status.

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Half a million outpatient consultations. Tens of thousands of emergency interventions. Hundreds of survivors of sexual violence are receiving care. A series of ad hoc crisis responses. These are just some of the figures presented in Médecins Sans Frontières' 2024 Activity Report, a reflection of the scale of medical needs amongst some of the most vulnerable people in Bangladesh. The communities we worked with this year included economically vulnerable factory workers in Kamrangirchar; Rohingya refugees contained in the camps in Cox's Bazar; rural families affected by floods in Noakhali and Feni; new arrivals fleeing indiscriminate violence in Myanmar; and marginalized families within host communities in and around Ukhiya.

Yet while numbers provide a sense of scale and efficiency, they can obscure the resilience, dignity, and agency of those behind them-women and girls, boys and men, the elderly, their families—each navigating their own health challenges with determination. In this year's report, we have included testimonies from patients and community members, amplifying their voices, expanding on témoignage. Their voices speak of the everyday obstacles of seeking care: from access barriers following violent displacement in Rakhine to recuperating after flood-related losses; from negotiating conservative family expectations childbirth-particularly around discomfort with being attended by male medical staff-to the economic importance of free prenatal care; and the profound relief of simply being heard without judgment.

addition to these personal accounts, the health challenges themselves must be understood in context. In Kamrangirchar, child laborers and their families sought care for conditions linked to unsafe

factory environments, while women and girls continued to face stigma when accessing sexual and reproductive health services, particularly in the aftermath of intimate partner violence. In Noakhali, following heavy rains, patients with acute watery diarrheal illness due to contaminated water sought help at overstretched government health facilities. Even amidst this crisis, community members and organizations partnered with MSF to restore access to safe water.

For Rohingva refugees in Cox's Bazar, the health consequences of prolonged containment remain severe. High population density, impermanent shelter, and inconsistent government maintenance of water and sanitation systems have led to repeated outbreaks of diarrhea and a steady rise of scabies. The toll on mental health is equally grave: containment policies that limit movement, education, and work systematically erode both personal agency and collective hope. The prospect of safe return to Myanmar remains remote. Compounding this have been the rising levels of insecurity within the camps, including violence linked to armed groups, kidnappings, and extortion. Such uncertainty has made many too afraid to leave their shelters, often delaying medical care until absolutely necessary. Gendered barriers remain acute, with intimate partner violence continuing to fracture the lives of many women. Host community members, too, remain a vital part of our patient population, accounting for nearly 20% of outpatient consultations and almost half of all childbirth deliveries. Local government health and sanitation capacities, often overstretched, have required sustained support from humanitarian and developmental actors-recently including MSF.

In 2024, the broader political and regional context added further uncertainty. The quota reform protests in August temporarily disrupted national stability. Meanwhile, renewed conflict in Rakhine triggered another protracted wave of refugee arrivals. Internationally, shifts in U.S. aid policy in early 2025 caused major disruptions across the humanitarian landscape. Although MSF does not rely on U.S. government funding, many of our patients expressed anxiety about what these changes may mean for their future.

Despite these challenges, MSF remains stead-fast in our commitment to delivering impartial, patient-centered care in Bangladesh. The situation of over a million Rohingya refugees—one of the world's most protracted and complex humanitarian crises—continues to embody the medical and ethical imperative at the heart of our social mission. In the year ahead, we will continue to consolidate and adjust our programming, respond where needs are greatest, and stand in solidarity with those whose lives remain defined by exclusion and containment.

Orla Murphy

Country Representative Médecins Sans Frontières / MSF Bangladesh



MSF TIMELINE IN BANGLADESH

MSF has been committed to supporting Bangladesh with medical and humanitarian assistance for over 50 years, implementing a range of activities across the country in response to evolving needs.

MSF first provided medical assistance to Bangladesh in 1972 following the country's independence, when MSF sent medical doctors to Bangladesh to help rebuild the health infrastructure, including hospitals in Khulna and northwest Bangladesh, and a blood bank in Dhaka. Since then, MSF has been present in Bangladesh for various natural calamities, outbreaks, and refugee crises, notably during natural disasters in 1985, 1998, 2007, and 2022 in Sylhet, where MSF provided emergency assistance in response to cyclones and floods.

1972 MSF provides support rebuilding health infrastructure in Dhaka, Khulna, and the northwest. 1985 MSF provides emergency assistance in response to the May cyclone. 1992 After the arrival of 250,000 Rohingya refugees, MSF mobilizes medical services in Cox's Bazar. 1998 MSF responds to major flooding across Bangladesh. 2001 MSF starts its primary healthcare project in the Chittagong Hill Tracts with a focus on malaria. The project had a research wing 2007 that investigated the effectiveness of an MSF responded to Cyclone Sidr artemisinin-based malaria in southern Bangladesh. MSF established a Health, Nutrition, treatment regimen. and Water & Sanitation project in 2008 Nayapara and Kutupalong camps MSF responded to a nutritional in Cox's Bazar. emergency in Rangamati Hill District, Chittagong Hill Tracts. 2009 MSF established Kutupalong

field hospital in Cox's Bazar. We also responded to Cyclone Aila.

2010 In partnership with the Ministry of Health, MSF began treating kala azar in Fulbaria. MSF started working in Kamrangirchar, providing 2013 nutrition services as well as The Kamrangirchar project introduced mother and child health services. occupational health for factory workers. 2014 Responding to malaria in Bandarban, MSF supported the Ministry of Health (MoH) program. In collaboration with the MoH, a research program on the effectiveness of liposomal 2017 amphotericin B in the treatment of More than 750,000 Rohingya fled post-kala-azar dermal leishmaniasis targeted violence in Myanmar; (PKDL) started in Fulbaria, MSF scaled up medical and Mymensingh. humanitarian activities in 2019 response. MSF started an Infection Control and Prevention (IPC) project in Cox's Bazar Sadar Hospital. 2020 In response to the COVID-19 pandemic, MSF expanded its medical activities. 2021 MSF started supporting a 40-bed COVID-19 inpatient unit in Cox's Bazar Sadar Hospital. 2022 MSF contributed to the National Mental Health Act and supported the government's response to flooding in Sylhet. 2023 MSF also set up dedicated scabies treatment centers in MSF consolidated eight health facilities in Cox's Bazar with Jamtoli and Hakimpara facilities. complementary water and sanitation projects. As a result of MSF 2024 advocacy about the two-year-long scabies outbreak, health actors in the MSF facilities in Cox's Bazar treated camps responded with a mass drug hundreds of war-wounded patients administration at the end of the year. from Myanmar. MSF also closed down one of its clinics in Madborbazar, Kamrangirchar. The MSF team provided treatment for acute watery diarrhea to flood-affected people in Noakhali.



Since the influx of Rohingya refugees from Myanmar in 2017, MSF has been working tirelessly to provide essential healthcare services in the densely populated camps of Cox's Bazar. Today, MSF's services encompass inpatient and outpatient healthcare ranging from treatment of chronic diseases such as diabetes, hypertension and mental health to 24/7 emergency care room services, neonatal and paediatric care, primary healthcare, and women's healthcare. Kutupalong Hospital, one of the three MSF hospitals in Cox's Bazar, also acts as the main referral hub in the camps to secondary and tertiary healthcare facilities outside the camps, including for surgery. The MSF medical teams treat patients for a wide range of conditions, from respiratory tract infections and diarrheal diseases to more specialised care like treatment of hepatitis C. The densely populated camps and poor hygiene and sanitation conditions are making the Rohingya refugees vulnerable to diseases and outbreaks.

In Dhaka's Kamrangirchar area, MSF operated two clinics in Ali Nogor and Madbor Bazar and offered reproductive healthcare, medical and psychological treatment for survivors of sexual and gender-based violence as well as occupational health services to factory workers.

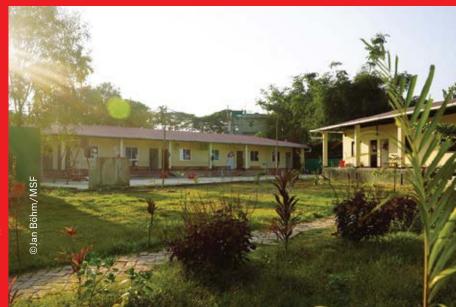


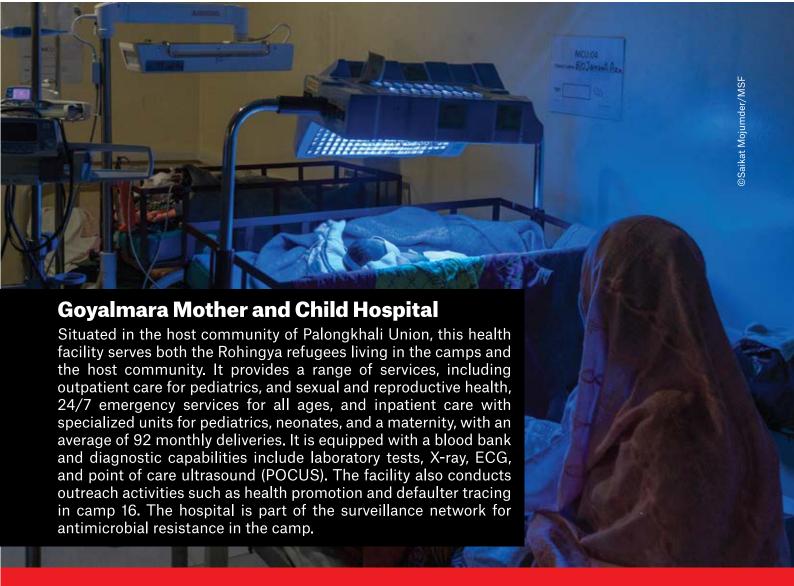


Kutupalong Field Hospital

The Kutupalong Field Hospital provides comprehensive healthcare services to both the host and Rohingya communities. The hospital operates an Outpatient Department (OPD) with extended hours, offering a range of services including priority consultations, sexual and reproductive health

care, vaccinations, inpatient department for tuberculosis patients and in collaboration with physiotherapy Humanity & Inclusion organization. The 24/7 emergency room is equipped with point-of-care diagnostics and a procedure room, and receives referrals from other medical facilities. The hospital also includes a mental health department, isolation department, and an Inpatient Department (IPD), with specialized wards for neonates, pediatrics, adults, and maternity, as well as a well -equipped laboratory offering a range of diagnostic tests.

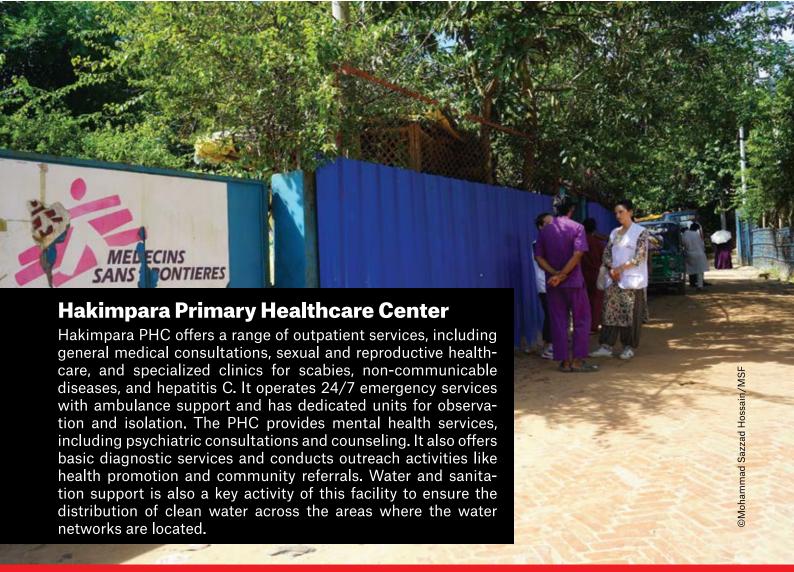


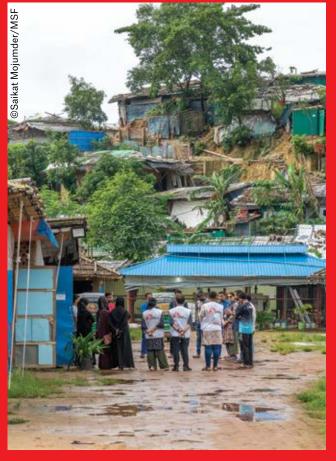




Hospital on the Hill (HoH)

Located inside the camp, the HoH facility operates outpatient departments for general medicine (adults and children), treatment of non-communicable diseases, hepatitis C, and offers psychiatric consultations and counselling services, as well as sexual and reproductive health services, including comprehensive sexual and gender-based violence services. The HoH facility also serves as a referral hospital for adult non-surgical cases and provides inpatient care with specialized units for adults (including Intensive Care Unit), and a pediatrics short stay unit. The 24/7 emergency room offers basic diagnostics and stabilization. Patients requiring surgery are referred to the Kutupalong Field Hospital. HoH is equipped with a blood bank and diagnostic capabilities including a well-equipped laboratory, ECG, and point of care ultrasound (POCUS). The facility also conducts outreach activities such as health promotion and defaulter tracing in camps 8W, 13, 17 and 18.





Jamtoli Primary Healthcare Center

Situated in Camp 15, Jamtoli PHC provides similar outpatient services as Hakimpara PHC, including general consultations, sexual and gender-based violence care, sexual and reproductive healthcare with 11 beds for delivery, specialized clinics for scabies, hepatitis C and non communicable diseases, screening for malnutrition, and referrals to therapeutic centers. It also operates a 24/7 emergency department with an ambulance service and has dedicated units for observation and isolation. The primary healthcare center offers mental health services, basic diagnostic services, and conducts outreach activities. Our team also provides water and sanitation support, malnutrition screening and referrals to therapeutic centers.



Balukhali Specialized Clinic

In Balukhali specialized outpatient department, MSF provides sexual and reproductive healthcare, mental health/psychiatric and sexual and gender-based violence care, vaccination, health promotion, and water and sanitation services.

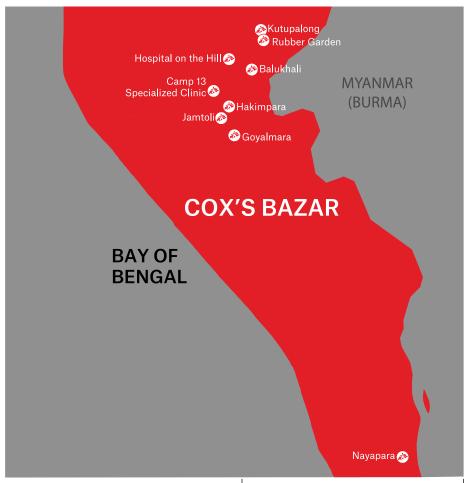
@Monika Sharkar/MSF



Rubber Garden and Nayapara

MSF also has two multi-outbreak response facilities in Rubber Garden (54 beds) and in Camp 26/Nayapara Registered Camp (100 beds).

COX'S BAZAR





847,227People reached through health promotion



513,551Outpatient consultations

sessions



107,780People treated for respiratory tract infections



99,127 Emergency consultations



83,323People treated for scabies



59,117Non
communicable
disease
consultations



45,974Mental health consultations



26,844 Family planning users



20,205Patients admitted in MSF facilities



13,614Patients treated for Acute Watery Diarrhea



3,182Patients treated for dengue



2,587
Patients treated for violence related injuries (excluding gender-based violence)



2,362Patients treated for hepatitis C



2,277Patients treated for sexual and gender-based violence



2,003MSF-supported deliveries (host)



1,909MSF-supported deliveries (Rohingya)

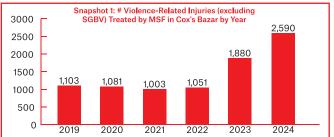
OVERVIEW OF ACTIVITIES IN COX'S BAZAR

VIOLENCE IN THE CAMPS



Unpredictable Frontlines: The Shifting Landscape of Armed Violence in Rohingya Refugee Camps

Rohingya refugees living in the Cox's Bazar camps have been suffering from the spillover of territorial disputes between armed groups, facing direct violence-related injuries as well as the broader psychosocial and economic toll of living in constant fear. Since 2022, the scale and location of armed violence affecting Rohingya refugees in the Ukhiya camps has fluctuated, impacting different blocks unevenly over time through to the end of 2024. Intimidation, extortion, abductions, and forced recruitment have contributed to an increasingly volatile environment.



"Violence-related injuries" are physical harms intentionally caused by another person or group. These include injuries from beatings, stabbings, gunshots, explosions, torture, or other deliberate attacks. Cases are recorded when individuals come to MSF for treatment. While MSF does not systematically document the identity of perpetrators, anecdotal accounts, interviews with patients and personnel, along with broader contextual observations, strongly suggest that the significant increase in cases observed in 2023 and 2024 is largely attributable to armed violence perpetrated by armed groups

Rohingya patients and personnel have reported persistent fear and anxiety, often linked to being targeted or being in the wrong place at the wrong time. Many have delayed or avoided leaving their shelters unless absolutely necessary, including to access essential humanitarian services such as

Snapshot 2: Shifting Patterns of Armed Violence in the Camps

MSF facilities across the mega-camp have seen fluctuating levels of violence-related injuries* throughout 2024.

- Jamtoli PHC (Camp 15 South): Averaged 54 cases/month. Lowest in February (20), peaked in September (105), despite a 24-hour suspension.
- Hospital on the Hill (Camp 8W Centre): Averaged 27 cases/month. February saw 14 cases; November the highest with 36.
- Kutupalong Field Hospital (North-East): A referral hub averaging 135 cases/month April saw 62 cases; October peaked at 250.

*Figures reflect unique patients and are not double counted between facilities.

healthcare. During a particularly violent episode in 2024, one MSF facility was forced to suspend operations for 24 hours until the immediate situation stabilized. MSF was not alone in this; other humanitarian actors were also compelled to scale back activities at various times, further compounding the difficulties faced by Rohingya families. During such

flare-ups, humanitarian workers -especially camp-based team members (Rohingya personnel)-faced obstacles reaching their workplaces and were at times targeted for extortion or recruitment by armed actors.

In 2024, the violence was further exacerbated by a broader deterioration in the political and security context. In May, armed groups in the camps escalated recruitment efforts- resorting to coercion, intimidation, extortion, physical violence, and detention- particularly targeting young men, including children. These actions were justified by invoking the intensifying conflict in Rakhine State (Myanmar), regardless of how instrumentalized those claims may have been.

MSF observed ongoing and evolving forms of recruitment in the communities surrounding its facilities, with May marking a sharp escalation. At least 130 attempted forced recruitment incidents were documented that month, compared to just 11 in April. Most were identified through community outreach activities, though MSF also encountered several cases in which individuals sought refuge at its facilities, as well as patients who had sustained injuries after resisting recruitment. Camp-based team members were not immune to these dynamics and some reported facing pressure themselves, with a number temporarily refraining from coming to work out of fear of being targeted.

From July to September, the transition in Bangladesh's government - associated with nationwide quota reform protests that quickly escalated into calls for the resignation of the former prime min-

ister- temporarily disrupted security presence in the camps. Armed groups took advantage of this gap, triggering a major escalation of violence in the southern camps in September (see Snapshot 2). At the same time, as the conflict in Rakhine progressed to Maungdaw and Buthidaung, civilians from Myanmar fled across the border into Bangladesh. During the

Snapshot 3: War-Wounded Patients Treated by MSF in 2024

MSF treated 175 patients with very recent war-related injuries- primarily from gunshots, explosive devices, and bombs-at its facilities in Cox's Bazar in 2024.

- 109 cases were treated in August alone, with 87 of those occurring between the 6th and 17th of August, coinciding with intense cross- border violence in Rakhine.
- Only 30 cases before August, and 36 after August.
 Of the 109 August cases:
 - 36% were children under 18;
 - 12.9% were women (18+).

The high proportion of children and women among the wounded strongly suggests that at least some of the attacks were indiscriminate and impacted civilians.

peak of these hostilities, MSF reported a sharp increase in war-wounded civilians arriving from Myanmar, who were treated and stabilized at MSF health facilities.

Since September, the number of such cases has declined. However, Bangladesh's closed border policy has continued to generate serious protection risks, including financial exploitation by smugglers, exposure to dangerous crossings, detention in improvised holding sites with unknown conditions, and forced returns to active conflict zones. At different moments, thousands who managed to cross the border and reach the camps have lived under the uncertainty of being reported, detained, extorted, or forcibly returned. While new arrivals no longer face the same fear of immediate return today, concerns have shifted toward ongoing extortion and abuse, as well as limited access to basic resources. Many continue to restrict their movements and avoid seeking essential services, despite advocacy efforts that have secured access irrespective of registration status.

Meanwhile, local media have continued to sensationalize the situation in and around the camps. Oversimplified portrayals of Rohingya as the root cause of insecurity have contributed to harmful stereotypes and reinforced public narratives that criminalize refugees. These narratives both directly and indirectly support calls for repatriation and justify continued containment policies.

Although the physical fence around the camps remains porous, the specter of tighter restrictions by police at any moment exerts a constant psychological pressure. This ever-present uncertainty functions as a form of structural violence, with significant impacts on mental health, autonomy, and dignity - limiting agency, deepening dependency, and heightening exposure to exploitation in a legal gray zone.

In mid-November, Bangladeshi authorities facilitated discussions among armed groups, resulting in a temporary pause in hostilities. The involvement of national intelligence agencies, police, and the military in these negotiations reflected the breadth of state actors in managing the security situation. While overt violence has since declined, serious risks persist, particularly around coercive recruitment linked to the Rakhine conflict. The durability of this fragile calm remains uncertain, shaped not only by the intentions of armed groups, but also by the evolving political context and the level of engagement by the relevant authorities. Further compounding the situation are shifts in humanitarian funding policies, which threaten to erode an already overstretched and constrained protection system.



HEPATITIS C



Since 2020, MSF has been offering free hepatitis C virus (HCV) screening, diagnosis, and treatment to Rohingya refugees in Cox's Bazar. In the first year of its implementation, there were plenty of unforeseen challenges in the HCV care model in this community, mainly the misconception of the community about the disease, the lack of education about the disease and understanding, and a lack of preliminary studies about prevalence, genotype, and major routes of transmission. A prevalence study conducted by MSF in the Rohingya refugee camps—found that a significant number of people – about one in every five adults – have what's called an active hepatitis C infection. This means that the virus is currently present in their bodies and can cause harm to their liver. In total, MSF estimates that around 85,000 adults in the camps are living with this active infection. In collaboration with the World Health Organization (WHO) and the Health Sector, MSF called for a coordinated humanitarian effort in the camp to implement a large-scale test and treat campaign. The response to MSF advocacy was slow but eventually successful, resulting in the mobilization of more than 60,000 treatments for refugees suffering of hepatitis C. The test and treat campaign is going to start in 2025, with MSF expected to treat 30,000 patients.

Between October 2020 and December 2024, MSF initiated treatment for more than 10,000 hepatitis C patients in the Rohingya camps.

In 2024, MSF collaborated with the Ministry of Health on the development of the first national guideline for hepatitis C, although until its final endorsement, it is still not possible for UNHCR/WHO to include it into the minimum essential health service package in the Rohingya camps.



The Rohingya refugee camps in Cox's Bazar face critical water access challenges, threatening health and dignity for nearly a million people.

Poor water and sanitation conditions in the Cox's Bazar refugee camps continue to expose the Rohingya community to preventable diseases. A recent study by MSF shows that seven years since the acute emergency phase of the response to support Rohingya refugees in 2017, critical access barriers to water and poorly maintained networks continue to pose a serious risk to the health and dignity of more than one million people confined to the Cox's Bazar camps.

MSF has been one of the key parties supporting the development and maintenance of water and sanitation facilities since the violent mass-displacement of the Rohingya from Myanmar into Bangladesh in 2017. In 2020, we adapted our water and sanitation activities to ensure the longer-term sustainability of these services. This involved handing over most of our water and sanitation activities to local organisations. We continue to collaborate closely with relevant water and sanitation operators in the camps to provide support in addressing critical maintenance gaps in these services.

Over the years, we have seen how the containment of the Rohingya in unhygienic camps, depending on dwindling humanitarian assistance and limited access to safe healthcare, increases instances of communicable diseases like scabies, cholera, Hepatitis C, and others. In 2023 for instance, the Bangladesh camps experienced the highest surge in cholera cases in the past five years, while a scabies outbreak affected almost one in two people.

In 2024, MSF conducted a '5 Star Survey' on behalf of the WASH sector, evaluating the water infrastructure across all 33 Rohingya refugee camps. This assessment reviewed water networks based on five key performance indicators: flow capacity, distribution timing, network functionality, water treatment, and user satisfaction. While progress has been made and the overall water quality in the Rohingya refugee camps has improved, the MSF study found significant shortcomings. Funding gaps and the lack of accountability by Water and Sanitation actors in the camps significantly impact the maintenance and improvement of critical WASH infrastructure. Gaps in operation and maintenance of water networks across the camps create significant disparities between camps and inequity in access to water. In many camps, there is still not enough water provided for everyone, and certain areas continue to lag behind significantly. Also, the timing of water distribution is still unreliable in many places, with some people only having access for very short periods each day. Unavailable or dysfunctioning water systems in one location push people to seek water elsewhere, putting additional burden on functioning water systems. In addition, the cleanliness of the water has worsened in many camps, increasing the risk of preventable diseases. The survey supports

findings from MSF's water and sanitation study (LQAS) conducted also in 2024 as part of a regular monitoring and community feedback mechanism.

These ongoing challenges highlight the urgent need for concerted action among donors, authorities, and WASH partners. To mitigate these escalating public health risks, immediate and focused interventions are required, including:

- Local agencies should prioritize timely repairs, skilled staffing, and robust monitoring systems to build resilience. Collaboration across sectors and active engagement with affected communities are vital to deliver sustainable solutions.
- Enhanced coordination among WASH actors and sustained financial commitments from donors, alongside exploring alternative funding avenues, is critical.
- Increased funding is essential to repair infrastructure, standardize water treatment, and ensure equitable distribution. In parallel, donors must closer and more effectively monitor the implementing agencies' performance and reporting, along with adequate accountability mechanisms.





MSF remains concerned about the ongoing scabies outbreak in the Rohingya refugee camps in Cox's Bazar, which also impacting the local host community. Since 2022, MSF has been actively working to control the spread of this disease through the establishment of dedicated temporary treatment centers at our Jamtoli and Hakimpara primary healthcare facilities. Following the mass drug administration (MDA) campaign conducted in December 2023, a significant initial decrease in scabies cases was observed at these specialized centers.

However, our data indicates a concerning trend of increasing scabies cases in the Rohingya community starting in the second quarter of 2024. This contrasts with a gradual decline in cases reported from the host community during the same period. The persistent rise in patient numbers is currently overwhelming MSF's capacity and diverting essential resources from other critical health services across the camp. This makes it harder for us to respond to the overall growing healthcare needs of the community. In anticipation of continued challenges in 2025, the operational structure of our scabies clinics will be adjusted, involving a reduction in dedicated clinical staff for this specific service. Consequently, the implementation of priority criteria for treatment will become necessary to manage resources effectively. Furthermore, MSF will continue its advocacy efforts with the Ministry of Health and other relevant actors to advocate for increased access to scabies treatment across all health posts and primary healthcare centers serving both the refugee and host populations.

After the comprehensive mass drug administration (MDA) campaign in December 2023, MSF recorded a significant overall reduction of 42% in scabies consultations in 2024 compared to the previous year. Despite a planned second MDA in August 2024 that was ultimately not implemented, the incidence of scabies within the Rohingya community demonstrated a concerning upward trajectory throughout the year, reaching an alarming caseload exceeding 100 patients per clinician in the fourth quarter. Analysis of the 2024 epidemiological data reveals a relatively stable percentage of complicated scabies cases across the year and in comparison to 2023. Nevertheless, MSF teams have observed a progressive increase in newly arriving individuals from Myanmar presenting with extensive and frequently infected scabies lesions. This observation highlights potential challenges in early detection and effective management of the condition within the newly arrived population. MSF remains committed to addressing this public health issue within the constraints of our operational capacity and will continue to adapt our strategies in response to the evolving needs of the community.



Kamrangirchar

MSF began operations in Kamrangirchar, Dhaka, in 2010 with a focus on malnutrition in children under five. In 2013, the project shifted focus to sexual and reproductive health (SRH) for adolescents, sexual and gender-based violence (SGBV) care, and occupational health (OH). Services were delivered through MSF clinics, engagement with the Upazila Health Complex, and referrals to other medical and protection actors.

Following a global review and financial reprioritization, MSF announced the closure of medical activities in Kamrangirchar by the end of March 2025.



KAMRANGIRCHAR





16,787Sexual and reproductive healthcare consultations



7,798Consultations provided at occupational health Clinic



629Sexual and gender-based violence patients



9,607Antenatal consultations



3,959Family planning consultations



367MSF-assisted deliveries



OVERVIEW OFACTIVITIES IN KAMRANGIRCHAR

In Kamrangirchar, a hub for informal factories and vulnerable migrant workers, MSF's Occupational Health (OH) interventions have played a pivotal role in addressing workplace hazards and health disparities. Over the years, MSF has provided over 84,562 consultations, encompassing medical care, psychosocial support, and community sensitization for factory workers. Despite significant progress, critical gaps remain, with 45% of OH patients being minors and 55% presenting with moderate acute malnutrition (MAM). Data also highlights a concerning prevalence of non-communicable diseases, such as diabetes, hypertension, and asthma, often exacerbated by poor working conditions and unhealthy lifestyles. These findings underscore the urgent need for collaborative efforts between MSF, child protection organizations, and government agencies to safeguard worker health, eliminate child labor, and establish sustainable occupational healthcare models tailored to the needs of informal workers.

MSF's comprehensive Sexual and Reproductive Health (SRH) and Sexual and Gender-Based Violence (SGBV) services in Kamrangirchar have significantly improved access to care for women, children, and vulnerable groups. Between 2015 and 2024, MSF clinics provided over 263,436 SRH consultations, including antenatal and postnatal care, family planning, and emergency obstetric services. However, persistent barriers, such as late presentation of survivors due to stigma and limited adolescent-friendly services, hinder timely care. The alarming prevalence of intimate partner violence among young women and high rates of adolescent pregnancies emphasize the need for expanded collaboration with child protection agencies and the authorities.



EMERGENCY FLOOD INTERVENTION IN NOAKHALI & FENI



The monsoon season in August 2024 brought record rainfall leading to widespread flooding across the country in 2024. Eleven districts were affected with over 5.4 million people displaced. The Noakhali and Feni districts located in the southeastern area of the country experienced some of the most severe flooding. The closest river in Feni overflowed, inundating homes, farmlands, roads and infrastructure.

In Noakhali, MSF supported the pediatric acute watery diarrheoa (AWD) ward, focusing on treating patients in the 250-bed Noakhali General Hospital's inpatient department. The hospital had seen a significant increase in the number of AWD cases right after the flood water started receding. MSF team set up a triage system, reinforced infection and prevention control to manage the risk of spreading acute diarrhea among people, and clinical management of cases. MSF also recruited two health promoters, two medical doctors, six nurses and 24 cleaners to ensure proper medical care and hygiene at the hospital.

MSF distributed 1,000 kits containing mosquito nets, torches, soap, washing powder, diapers, toothbrushes, toothpaste and sanitary napkins in five locations of Kabirhat upazila, with the support of local NGO. The team disinfected and repaired broken tubewells (wells in which a long tube or pipe is bored underground) to ensure access to safe drinking water, and disinfected water tanks in the hospital to prevent the spread of disease. Moreover, the team engaged with the community to train them on how to disinfect water sources or repair tubewells damaged by floodwater. We also distributed the necessary equipment for this work. In Feni, MSF activities were limited only to water and sanitation and the team disinfected and repaired tubewells and provided training to the community. In total the water and sanitation team trained 45 volunteer teams in 45 villages in Noakhali and Feni.

On 4 October, MSF handed over the emergency intervention to the Ministry of Health as our support was to acute needs for one month.

VOICES FROM THE FIELD



Hamida

A mother in MSF Kutupalong hospital

I'm Hamida, from Moricchya, Cox's Bazar. When I was pregnant, I knew I wanted the best care for my first child. Although there was a private clinic nearby, I had heard that MSF's Kutupalong Hospital provided high-quality care, totally free.

Usually, my family has some reservations about seeing male doctors at the hospital as they prefer the women to be seen by female doctors. I always accept their decision. We usually visit a nearby pharmacy if we have any physical issues as there is a woman who gives medication. This often keeps me away from seeking further medical care. However, financial barriers are another issue. We now have six people in my family. My husband is a farmer and drives a car sometimes. He is the sole earner in the family, and it's tough to take care of six people. Even my older father-in-law and mother-in-law visit a nearby pharmacy for medication as it's cheaper.

When I conceived, I decided to visit Kutupalong Hospital. My in-laws were not in favor of this as even the journey from Moricchya to Kutupalong would cost us money. I convinced my husband and started visiting with my mother for check-ups and follow-ups.

Thankfully, MSF's experts were there. I had a safe delivery and gave birth to a healthy baby girl! I'm so grateful for their care and expertise.

VOICES FROM THE FIELD



Arafat Ullah

66 My name is Arafat Ullah, and I'm an 18-year-old.

Back home in Myanmar, education was my path to a better future. Here, after 12th grade, it's a dead end. There are no universities, no chance for me to become a doctor, an engineer, or anything I've ever dreamed of.

Food is scarce. I depend on rations of rice and lentils, barely enough to survive. Water is even harder to get. Broken pumps mean long waits, and illness from unclean water can strike at any time. The MSF clinic is a lifeline, but the queues are endless, and the fear of gangs at night keeps many from seeking help when they need it most.

This isn't life; it's an existence filled with darkness and a stolen future. All I want are the basic rights everyone deserves—food, water, a roof over my head, a chance to learn, to heal, and to become who I was meant to be.

I belong in Myanmar. There, I could be a doctor, a teacher, a business owner. Here, I'm nothing. My identity, my dreams—they're fading with each passing day. I just want to go home. I want to be a doctor. Is that too much to ask?

VOICES FROM THE FIELD



Javed Hussain

My name is Javed Hussain and I work as a clerk in a court of law, a life of order and documents now rendered meaningless by the chaos around us. It started subtly, the relentless rains, the slow creep of water. Then, we were flooded by the rain water. The street was under water, the yard was under water, yet inside our house, miraculously, the floors remained dry – a small mercy amidst the overwhelming despair. We were collecting rain water and drinking that water. The only water we had. And then came the inevitable: the wrenching grip of diarrhea.

My mother, my wife, my relatives – one by one, they fell ill. And the children, their small bodies so vulnerable, they were hit the hardest. They've been scattered across different hospitals. The fields, our lifeline, the promise of golden paddy, were submerged, the crop utterly lost. Twenty to twenty-five thousand taka worth of seeds, our investment, our hope for the future, simply rotted away beneath the floodwaters. My fish pond, another source of sustenance and income, is gone, vanished without a trace. But it's not just my burden; it's the shared devastation of everyone here.

No one has been spared.

For days, we battled the relentless illness with whatever meager resources we had. The village doctor's remedies offered no solace for my child's weakening body. After three or four days of worsening symptoms, we made the agonizing journey to Sadar Hospital. There, amidst the unfamiliar smells and sounds, the doctors hooked him up to a saline drip for a few long hours. A flicker of improvement, a fragile hope, allowed us to bring him back home. But the fear lingers, a constant shadow in this waterlogged world, a reminder of how easily life can be swept away. In Noakhali, MSF supported the paediatric acute watery diarrhea (AWD) ward, focusing on treating patients in the 250-bed Noakhali General Hospital's inpatient department.

A YEAR IN PHOTOS



CONCLUSION

Médecins Sans Frontières (MSF) has maintained a consistent and meaningful presence in Bangladesh for over five decades, responding to a wide range of emergencies, from the post-independence crises and natural disasters to disease outbreaks and one of the world's most protracted displacement situations. In Cox's Bazar, MSF health facilities continue to deliver essential services: emergency care, chronic disease management, maternal and child health, mental healthcare, and specialized treatment for infectious diseases such as hepatitis C. Host community members also rely on these services, often due to local capacity challenges related to healthcare and water and sanitation.

But the challenges patients face are deepening. Containment policies applied to the Rohingya have become entrenched with daily life in the camps shaped by restrictions on mobility, education, and livelihoods, in addition to the environmental conditions of a large population in a crowded space. The impact is not only physical, but deeply psychological, undermining people's agency, fostering dependency and at-risk coping mechanisms, and exposing individuals and families to heightened protection risks, related to the potential impact of armed violence. Compounding this is the strain on humanitarian resources due to the U.S. Government change in its aid policy. While MSF does not accept funding from the U.S. Government, recent reductions in aid -most notably in 2025, likely cascading into 2026- will have ripple effects across the response. For families already managing precarious health and humanitarian conditions, these reductions feed anxiety and will test their resilience.

More broadly, MSF is increasingly concerned about the accountability for Water, Sanitation and Hygiene and healthcare services across the camps. Despite the scale of MSF's operations and the positive impact demonstrated through medical data and individual success stories, significant challenges remain. MSF continues to respond recurrent spikes in acute watery diarrhea and scabies, and concerning trends in water and sanitation infrastructure. For those contained in the camps, the consequences are direct and personal.

Furthermore, the impending closure of MSF's activities in Kamrangirchar highlights the ongoing need for sustained and collaborative efforts to address the health and protection needs of vulnerable populations in Dhaka. While MSF has achieved notable success in providing crucial medical care and advocating for improved health responses, the evolving complexities of the humanitarian landscape in Bangladesh necessitate continued vigilance, adaptation, and strong partnerships with national and international stakeholders to ensure the well-being and dignity of those most in need.

As we look to the year ahead, MSF remains committed to impartial, needs-based medical care. But principled action requires more than operational presence. It requires attention to the quality and dignity of care, honest conversations about the consequences of political choices, and a willingness to confront the structural barriers that continue to define life for over a million displaced people. We will continue to adapt our programs, bear witness, and stand in solidarity with those too often overlooked.





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