# “Children arrive sicker, later, and harder to save” in Rohingya camps

Paediatric healthcare landscape in Ukhiya and Teknaf Rohingya mega camp

1.5-year-old Hali Masadi was admitted to Kutupalong Hospital with dengue.
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# Executive Summary

The paediatric healthcare needs of children presenting at the Médecins Sans Frontières (MSF) Kutupalong Hospital in Cox's Bazar are changing, with an increase in the number of complex cases, indicating a significant deterioration in this already neglected crisis. **Children are arriving later, sicker, and with multiple overlapping vulnerabilities, particularly malnutrition and mental health distress.** At the same time, primary healthcare capacity, referral pathways, and services provided by other organisations in the Cox's Bazar camps are shrinking due to funding cuts; putting increasing pressure on MSF facilities.

MSF staff at **Kutupalong Hospital are seeing growing numbers of critically ill paediatric and neonatal patients** and are increasingly absorbing needs beyond the intended scope of this secondary level healthcare facility. Kutupalong Hospital, one of the three MSF hospitals in Cox's Bazar, serves as the main referral hub for 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 diarrhoeal diseases to specialised care, such as the treatment of Hepatitis C. So although these findings are drawn solely from our Kutupalong facility, MSF believes this is indicative of a wider shift in the Cox's Bazar context.

Alongside physical illness, **child and adolescent mental health concerns are rising sharply,** including increasing suicide attempts linked largely to family violence, chronic stress, and lack of safe developmental opportunities. These worsening health indicators point to a broader protection and public health crisis for Rohingya children, who are enduring a life of indefinite containment in over-crowded and increasingly unsafe camps. Nine years on from the mass violence and displacement in 2017, around 1.3 million people remain in the Cox's Bazaar camps; with limited rights to livelihoods, education or healthcare, and with no safe, dignified future in sight.

MSF has expanded its paediatric and neonatal care capacity over the last five years to meet urgent needs, but operational expansion alone is not a sustainable solution without **broader system strengthening in the immediate term, and a safe political solution to this ongoing crisis in the longer term.**

# The changing nature of paediatric illness

There was a time when pressure in the Rohingya camps came in waves. MSF prepared, responded, and witnessed recovery. That recovery is no longer happening. **Unlike earlier years, pressure no longer recedes after seasonal peaks.** Our programs in Ukhiya and Teknaf are seeing a system that is consistently under strain – where each new challenge builds on what remains unresolved. **This shift is most visible in paediatrics, making it a sensitive indicator of broader system stress.**

The following analysis is based on continuous clinical observation at MSF's Kutupalong Hospital between 2021–2025, triangulated with hospital activity data and internal reporting. While individual indicators fluctuate, the paediatric program shows a consistent pattern over time: **children are presenting later, sicker, and with more complex illnesses.** It is no longer a single diagnosis that requires simple management, followed by patient discharge. Illness is multi-layered, often with malnutrition as the underlying and undiagnosed cause.

Malnutrition has both physical and mental dimensions: it weakens immunity, slows recovery, and turns common infections into severe cases. A child with pneumonia is no longer just a pneumonia case – it is pneumonia in a malnourished body, often with a history of recurrent infections and delayed treatment. Malnourished children are not only more vulnerable to illness, but also more vulnerable to developmental delays, poor cognitive outcomes, and long-term psychological effects that negatively impact quality of life.

Rohingya Response: Abcess-patient Shofi
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In 2023, MSF's Kutupalong hospital was forced to restrict outpatient and inpatient admissions to only severe cases as staff grappled with soaring patient numbers. Despite this narrowing of admissions criteria—which MSF expected to result in a drop in patient numbers—paediatric admissions only reduced partially, and in the case of children aged five–14 years, they continued to increase.

*Table 1*. Number of admitted paediatric patients at Kutupalong Secondary Hospital, 2023–2025

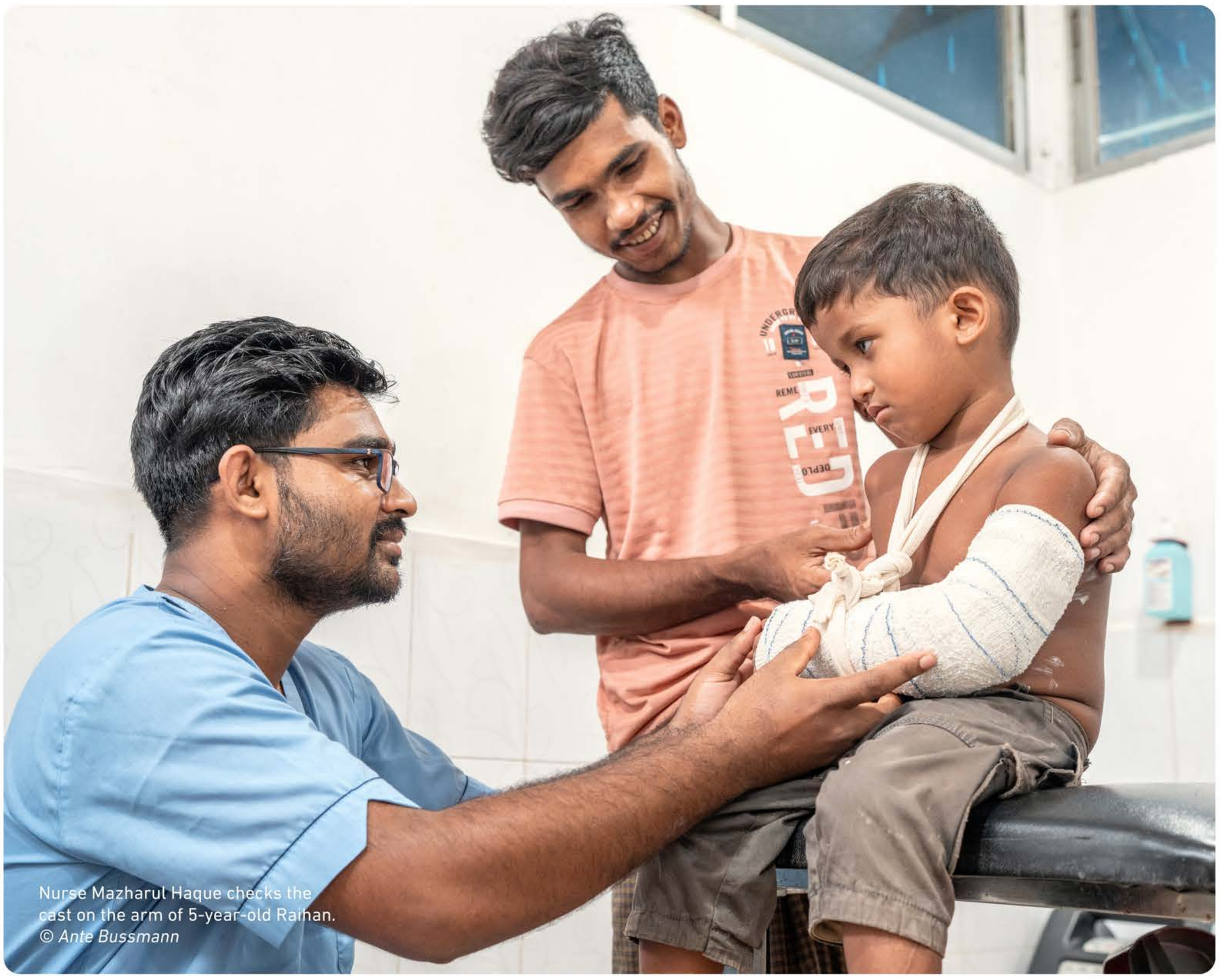
| **Organisation Unit** | **Kutapalong Healthcare** | | | **Total** |
|---|---|---|---|---|
| **Age** (combined in years - automated) / **Period** | **2023** | **2024** | **2025** | |
| <1 year | 5758 | 5122 | 3521 | 14 401 |
| 1 - 4 years | 6916 | 6278 | 5132 | 18 326 |
| 5 - 9 years | 3154 | 3098 | 3309 | 9561 |
| 10 - 14 years | 1886 | 1978 | 2131 | 5995 |
| **Total** | 17 714 | 16 476 | 14 093 | 48 283 |

**MSF is seeing more severe and complex paediatric cases.** The proportion of patients of all ages who need to be transferred to an external facility has been gradually increasing from 2.7% in 2022 to 4.7% in 2026 (74% increase). Amongst children under 15 years of age, the proportion requiring transfer to an external facility increased by 76.5%, from an average of 1.7% during 2022–2024 to 3.0% in 2026.

These more complex presentations are in part due to **families and caregivers who are forced to delay seeking healthcare for their children.** Feedback from MSF patients and staff indicate a crippling intersection of financial constraints, reduced service availability within the camps, uncertainty about where care is available, and competing daily survival needs. This affects feeding practices, healthcare-seeking behaviour, and the ability of families to follow medical advice. The key drivers of illness in children are already affecting their health and well-being before they even reach us. Consequently, sick children are arriving late, and their deteriorations are progressing faster and taking longer to resolve.

**Beyond physical illness, a quieter but equally devastating crisis is unfolding: the declining mental health of children.** Rohingya children are growing up carrying the cumulative burden of inter-generational trauma and persecution, coupled with the chronic stress of displacement, poverty and uncertainty over their future. Suicide attempts among children and adolescents are rising. Facility-based MSF mental health data from 2023–2025 revealed that children under the age of 18 years accounted for 27% (n=160) of recorded suicide attempts (total=586). In other words, one in every four suicide attempts were children. A growing number of children seeking mental health support from MSF were less than 15 years old: from 131 (9.7%) in 2021, to 232 (29.4%) in 2025.

This deeply concerning trend signals a critical failure to protect children from cumulative stressors in the camps. Suicide attempts among children are rarely the result of a single factor; rather, they reflect chronic exposure to violence, hopelessness, family breakdown, and a lack of safe developmental opportunities.



Nurse Mazharul Haque checks the cast on the arm of 5-year-old Raihan.
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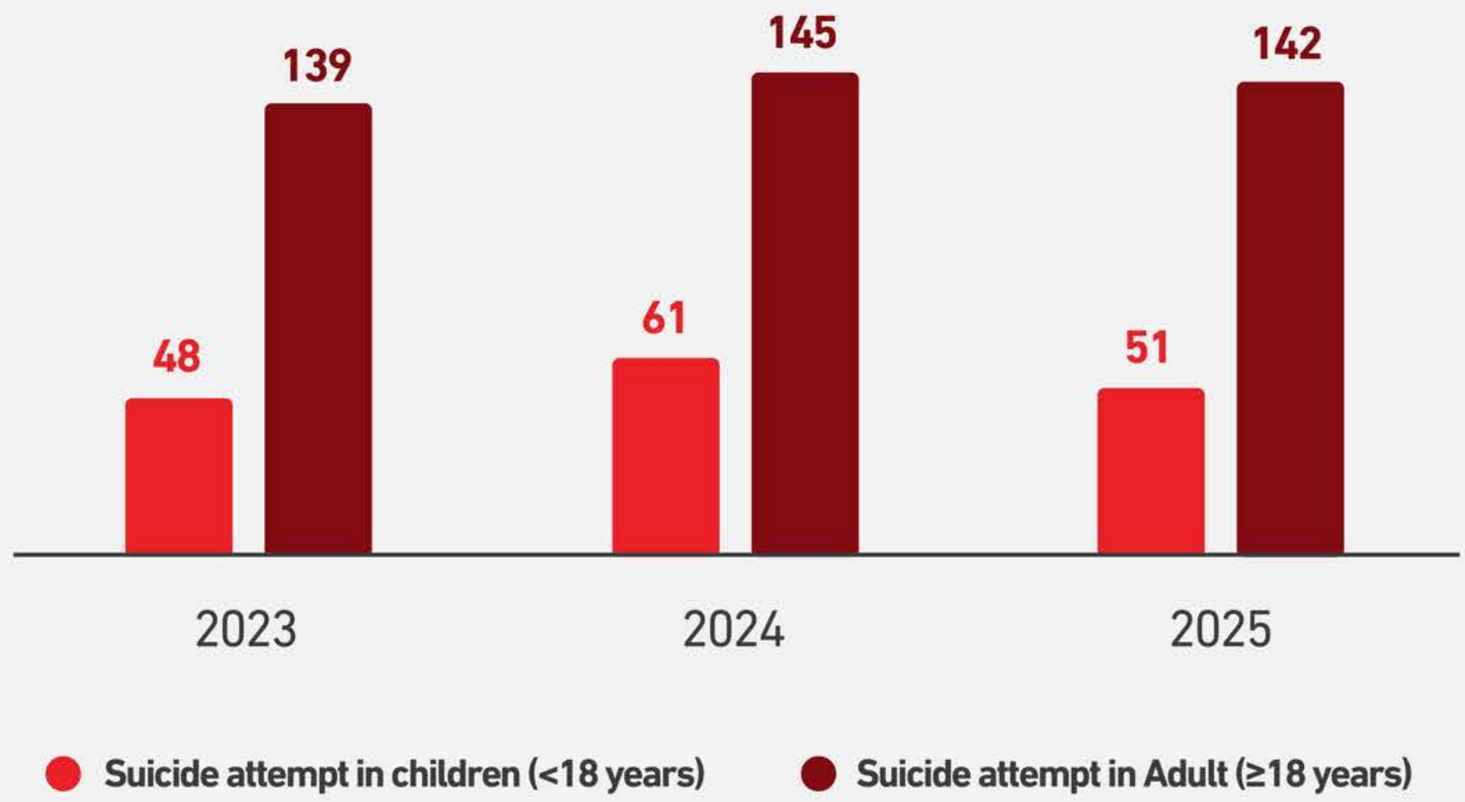
*Figure 1*. Reported suicide attempts among children and adults in MSF OCA Cox's Bazar, 2023–2025




Linked to these figures is an unseen, yet profoundly harmful consequence of prolonged displacement: the **unravelling of Rohingya collective identity and belonging, and subsequent breakdown in social fabric.** Children are increasingly disconnected from their homeland and collective culture, with little hope for the future and within families who have experienced killing, torture and abduction: a recent LAW report in 2025 found that more than 40 per cent of Rohingya survivors directly witnessed the killing of at least one immediate family member during the mass violence in 2017. [1]On top of this, caregivers are living under extreme stress, focussed on daily survival for themselves and their children—trying to secure food, healthcare and education despite cuts in services; navigating the threats of violence in the camps, as well as fires, flooding and disease outbreaks—and are struggling to provide consistent and nurturing care. MSF witnesses how children absorb this stress with insufficient safe outlets for emotional expression. Among the suicide attempts of paediatric cases from 2023–2025, 81 per cent were attributed to family violence.

These figures only reflect the cases seen in MSF facilities, but they illustrate the hopelessness amongst children living in the camps, and the devastating toll that containment and lack of rights is taking on the population. People need access to more effective mental health interventions; and in the longer-term, a political solution that gives them meaningful access to rights. This is also supported by the Public Health Needs Assessment 2025–2026 conducted by the Cox's Bazaar Health Sector, which found that "approximately one in five households (19%) reported that at least one member — adult or child — is currently experiencing emotional distress severe enough to affect daily functioning." [2] The assessment also noted that "the 27% of emotionally distressed individuals who are 17 years or younger represents a concern, as it points to a substantial mental health burden among children and adolescents."

[1] *https://legalactionworldwide.org/accountability-rule-of-law/they-tried-to-erase-us-the-lasting-impact-of-genocide-on-rohingya-children/*
[2] *https://rohingyaresponse.org/wp-content/uploads/2025/10/202510-HEA-SEC-PRE_PHNA_2025_2026.pptx*

# An overburdened healthcare system

Rohingya Response: Convulsions-patient Amin
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**While health needs are increasing, the healthcare system is becoming smaller and more saturated.** Needs are increasing in terms of number and complexity, while capacity is reducing. Funding cuts have led to service reduction across the camps: some partners have withdrawn, while others have slashed scope and staffing. Primary Health Centres (PHCs) continue to operate, but many are functioning at a minimal level with limited capacity to manage anything beyond basic conditions. PHCs often lack skilled staff trained in paediatric and neonatal care, and space for safe inpatient management. As a result, their referral is often late and completed without stabilising the patients adequately prior to transfer.

**Ministry of Health (MoH) facilities are overburdened, and patient referrals are becoming increasingly challenging.** The nearest MoH tertiary hospital, Cox's Sadar Hospital (CSH), is continuously over-capacitated. This leaves Chittagong Medical College Hospital (CMCH), as the only alternative referral hub. However, this is a high-risk decision for the vulnerable neonatal and paediatric patients due to the length of the journey, often taking six hours or longer. Both MoH hospitals are experiencing staff shortages, especially following recent structural changes. This has further reduced their capacity to accept referrals.

**Referral barriers increase pressure on MSF's capacity to provide paediatric and neonatal care**. Our inability to refer paediatric patients to higher referral centres means that increasing numbers of critical patients are managed at our facility – often beyond the level originally intended for a secondary health facility. Kutupalong Project has expanded its paediatric and neonatal services by increasing bed capacity, introducing new critical care tools such as Continuous Positive Airway Pressure (CPAP) and Point-of-Care Ultrasound (POCUS), and strengthening our ability to manage more severe and complex cases. The survival rates and mortality improved but is not sustainable for the hospital alone to respond to the needs. A more coordinated and continuous response in the camps is crucial.

Finally, **environmental factors such as flooding, heat, and poor living conditions continue to drive disease patterns and healthcare demand,** such as increases in acute watery diarrhoea during floods and droughts. Seasonal peaks are becoming more intense, but the baseline between peaks is also higher than before – meaning there is no longer any recovery period for the system.

A landslide section being reinforced in the Kutupalong refugee camps, Bangladesh © Victor Caringal

# Conclusion

Children treated at MSF's Kutupalong Hospital are arriving sicker, later, and with more complex conditions than before. Malnutrition is intensifying the severity of common childhood illnesses and slowing recovery, while delayed access to care and shrinking health services are contributing to worsening paediatric outcomes. Child and adolescent mental health needs are rising, including suicide attempts linked to chronic stress and family violence. Children need more than emergency medical care – they need protection and rights, stability, education, psychosocial support and safe environments.

**This paediatric suffering must not be seen as isolated medical cases but understood as a signal of wider systemic collapse.** MSF remains committed to providing essential lifesaving care to the Rohingya and host communities in Cox's Bazar; and will continue to adapt our medical provision to ensure we reach the most vulnerable patients. However, if present trends continue, then we may be forced to reduce other services to respond to the most complex needs such as paediatric care.

**MSF calls for stronger coordination and action to ensure that children's health is placed at the centre of the humanitarian response, with a clear focus on the full continuum of care for every child.** This must include early detection at community and primary health care level, timely and functional referral systems, strengthened paediatric and neonatal capacity, and practical support to health partners through joint planning, shared tools, and seasonal preparedness. Priority should be given to targeted capacity building for PHC staff, basic stabilisation capacity, integrated nutrition screening and treatment, strengthened referral pathways, and increased child-sensitive mental health and protection. These efforts must be accompanied by meaningful community engagement to address delayed care-seeking, domestic violence, and the need for positive parenting support.

Ultimately, these health interventions must be matched by **renewed efforts to realise durable solutions that uphold the rights of all Rohingya children.**

**A truly sustainable response requires a broader, multi-faceted strategic approach in the medium-term, while in the longer-term the Rohingya people living in Bangladesh need humane, durable solutions and access to rights.**

Rohingya Response: Abcess-patient Josmin
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