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EDITORIALS AND COMMENTARIES

The changing dynamics of HIV/AIDS during the COVID-19 pandemic in the Rohingya refugee camps in Bangladesh – a call for action

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Abstract

The COVID-19 pandemic has affected every country's health service and plunged refugees into the most desperate conditions. The plight of Rohingya refugees is among the harshest. COVID-19 has severely affected their existing HIV/STI prevention and management services and further increased the risk of violence and onward HIV transmission within the camps. In this commentary, we discuss the context and the changing dynamics of HIV/AIDS during COVID-19 pandemic, among the Rohingya refugee community in Bangladesh. What we currently observe is the worst crisis in the Rohingya refugee camps thus far. Because of being displaced, Rohingya refugees have increased vulnerability to HIV, STIs and other poor health outcomes. They have inadequate access to HIV testing, treatment, and care. Their host country has poor capacity to provide services. Complex economic, socio-cultural and behavioural factors exacerbate their poor access to HIV testing, treatment, and care. The unfolding COVID-19 pandemic has changed priorities in the Rohingya refugee camps so that more emphasis is being placed on COVID-19 prevention and treatment rather than other health issues. This exacerbates the already dire situation with HIV detection, management, and prevention among the refugees. Although the government of Bangladesh and different non-governmental organisations provide harm reduction, HIV care, and COVID-19 care to refugees, a comprehensive response is needed to maintain and strengthen health programs for refugees, for both HIV and COVID-19 care. This comprehensive response should include behavioural intervention, community mobilisation, and effective treatment and care. Without addressing the disadvantage of social conditions, it will be challenging to reduce the burden of HIV and COVID-19 among refugees. While the COVID-19 crisis is a global challenge, the international community has an obligation to improve the life, livelihood and health of those who are most vulnerable. Rohingya refugees are among them.

Keywords: HIV/AIDS; prevention; COVID-19; refugees; Rohingya

Introduction

In the context of any global crisis, it is the most vulnerable that suffer most. Refugees have limited access to health care in most of the host societies, especially access to HIV treatment, prevention and care [1]. The COVID-19 pandemic has affected each and every country's health services and plunged refugees to the bottom of the priority ladder. The plight of Rohingya refugees is among the most difficult globally [2].

HIV/AIDS is one of the major global public health issues. Approximately 38 million people were living with HIV as of July 2021 [3]. It is one of the top five causes of mortality and has taken around 33 million lives thus far [3]. It is estimated that 60% of HIV cases are occurring among the key population, including refugees [3].

To provide life-saving HIV/AIDS and sexual and reproductive health (SRH) services in humanitarian settings, the Inter-Agency Working Group (IAWG), in collaboration with the United Nations, non-government organisations (NGOs), and donors, developed the Minimum Initial Service Package (MISP) [4]. Objective 3 of MISP aims to 'prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs', including the identification of stakeholders for implementation, the prevention, and management of sexual and gender-based violence, education aimed at prevention of HIV and STIs; counselling, prevention of newborn and maternal mortality and morbidity, prevention of unintended pregnancies and the delivery of comprehensive SRH services into primary health care [4]. However, the latest IAWG's (2012-2014) evaluation found that the quality and effectiveness of HIV/AIDS and other SRH services in humanitarian settings vary across different regions globally.

The 2017 military clampdown, state-sponsored genocide and violence in Myanmar have forced the Rohingya to flee to neighbouring countries [5]. As of 2017, there were approximately 1.2 million Rohingya refugees in Bangladesh, over 102,000 in Malaysia, 55,000 in Pakistan, over 40,000 in India, and 600 in Nepal [6]. In these camps, Rohingya have been facing serious challenges, including poor access to food, water, healthcare, sanitation, education, and livelihood [7].

The unfolding COVID-19 pandemic is a new challenge in refugee camps. Refugees are at high risk of contracting COVID-19 because of the high-density living and poor sanitation in the camps [2]. The COVID-19 pandemic has significantly increased refugees' vulnerability to poor

health outcomes [7], severely affected the existing HIV/STI prevention and management services, and further increased the risk of violence and HIV transmission in the camps.

Several studies have documented the health status, challenges, and wellbeing of Rohingya refugees [8, 9] against MISP focus areas such as family planning, barriers, and solutions for implementing maternal, newborn, and child health programs [10], attitudes, experiences, coping strategies in relation to gender-based violence [11], and comprehensive abortion care [12]. However, there is very limited evidence concerning HIV/AIDS and other STIs [13]. Here, we focus on the changing dynamics of HIV/AIDS prevention during the COVID-19 pandemic among the Rohingya refugee community in Bangladesh.

HIV care in Bangladesh: structural factors associated with poor access by refugees to HIV care

Among the general population in Bangladesh, the prevalence of HIV is around 0.1% [14]. There were approximately 14,000 people living with HIV, including 1,600 new cases, while cumulatively, 1,588 people had died of AIDS as of November 2021 [14]. HIV prevalence continues to grow among high-risk groups such as people who inject drugs (IDU), men who have sex with men, transgender people, and sex workers [15]. Current data show IDUs contribute to 38% of new HIV cases due to syringe and needle sharing and unsafe sex.

Bangladesh, as a developing nation, has limited capacity for HIV management. Treatment, support and care for people living with HIV/AIDS is mainly provided by NGOs [15], but the latter are struggling to provide continuous and uninterrupted services due to the lack of resources and facilities. In 2016, only 50% of people diagnosed with HIV received antiretroviral therapy (ART), but treatment coverage was even lower among female sex workers and men who have sex with men (25.4% and 23.6%, respectively) [15]. Such low treatment coverage undermines the SDG -3 goal of ending HIV/AIDS by 2030 [15].

This situation has been further exacerbated by the unfolding COVID-19 pandemic, which has already resulted in at least 1,949,725 COVID-19 cases and 29,112 deaths in people of Bangladesh as of February 2022 [16].

HIV prevalence and access to care among Rohingya refugees in Bangladesh

Due to their large-scale forced displacement, there is no systematic data about the health of Rohingya refugees in host countries, nor is there data about their health in their home country Myanmar, where they were deprived of civic and human rights and citizenship [17]. It is estimated that around 5,000 HIV-infected Rohingya people have arrived in Bangladesh, as the HIV prevalence rate amongst the Myanmar population was 0.8% [18]. However, less than 600 cases have been identified and only 277 people with HIV had received treatment and care, while 19 had died due to HIV/AIDS as of the end of 2019 [18].

In Bangladesh, the Rohingya's access to HIV/STI testing and treatment is severely limited [18]. In the refugee camps, health services are mainly provided by international humanitarian agencies including 62 international organisations, eight UN bodies, and 59 national NGOs [19]. These organisations operate 170 basic health units covering 7,647 people per unit, 33 primary health centres covering 39,394 people per unit, and ten secondary care facilities covering 130,000 people per unit [19]. Therefore, the indicators of HIV treatment and care cascade among the Rohingya refugees in Bangladesh are below the MISP standard [5]. Furthermore, in the context of the unfolding COVID-19 crisis, more emphasis has been placed on COVID-19 treatment and care rather than other health issues, exacerbating the already dire situation with HIV detection, management, and prevention among Rohingya refugees.

Factors underlying poor access of Rohingya refugees to HIV care

There are multiple interrelated economic, socio-cultural, and behavioural factors which are responsible for poor access to HIV care for Rohingya refugees [5]. Forced displacement has destroyed Rohingya refugees' livelihood, food security, income, and health [20]. In most of the host countries, they are forced to live in high population density slum districts [2] with no viable sources of income. It is estimated that 66% of Rohingya refugee households have no permanent sources of income. Most households live below the poverty line and are excluded from mainstream society [21]. As a result of the disruption caused by the COVID-19 pandemic, their household income decreased by a further 20% since 2019 [22].

The majority of Rohingya refugees are illiterate, and very few can read and write [23]. Awareness and knowledge about HIV and STIs is poor [5], and most Rohingyas consider HIV and STIs normal diseases [24]. Condom use is generally low [25] and levels of HIV/STI stigma and discrimination are high as conservative cultural norms prevent Rohingya from discussing sexual issues [5]. Sex and sexuality are considered taboo or a 'sin', while HIV and STIs are seen as 'a curse of God, so humans cannot do anything about these diseases' [19].

Rohingya refugee women and children face a disproportionate burden in their new environment. UNHCR reported that 16% of households are female-headed, 5% are child-headed, and 4% have people with disabilities [19]. In a humanitarian setting, one out of every three displaced women and girls face sexual, physical and gender-based violence in their lifetime; while one in five girls are married before 18 years of age and have inadequate access to sexual and reproductive health services [26]. Domestic violence is common; 74% of Rohingya women had experienced gender-based violence, and approximately 56% had unwanted sexual intercourse with their husbands during their lifetime [11]. Gender inequality and gender-based violence increased during the COVID-19 pandemic [27], which

may result in an increased probability of HIV/STI transmission in the foreseeable future.

The international community and humanitarian agencies have already recognised the Rohingya people as the most oppressed population in the world [5]. While Rohingyas fled genocide and extermination in their home country, they have found themselves in a very vulnerable situation in the refugee camps in Bangladesh. Many have had severe traumatic experiences and suffer stress and anxiety [19], some are victims of rape by uniformed members of the Myanmar security forces [5]. There is also evidence of forced prostitution and trafficking in the camps. Rohingya, especially those who live in the Cox's Bazaar district of Bangladesh, are well known as likely to become victims of drug trafficking [28].

Drug use and unsafe injecting practices are known factors that facilitate HIV transmission in Bangladesh and the surrounding region. In Bangladesh, Rohingya refugees are at high risk of drug use and HIV transmission [18]. Those who inject drugs are often excluded from mainstream society due to high levels of stigma and discrimination against injecting drug users [29].

This very difficult situation has been further exacerbated by the COVID-19 pandemic. Poor knowledge about and fear of COVID-19 has been feeding stigma and discrimination against people with COVID-19 [27].

Thus overall, there is an unfolding health crisis in Rohingya refugee camps bought about by a convergence of circumstances. Firstly, because of displacement, Rohingya refugees have an increased chance of contracting HIV, STIs and other infections. Secondly, their access to HIV testing, treatment, and care is inadequate not only because of their refugee status but also because of the poor capacity of the host country to provide services. Thirdly, a host of complex economic, socio-cultural, and behavioural factors exacerbates their poor access to HIV testing, treatment, and care. Finally, the COVID-19 pandemic has changed priorities in all societies, including the refugee camps. The continuing crisis associated with the COVID-19 pandemic is threatening to have a long-term effect on the livelihood and health of Rohingya refugees, including their vulnerability to HIV and poor access to HIV prevention and care.

Although the government of Bangladesh and different NGOs provide harm reduction, HIV care, and COVID-19 care to refugees, a comprehensive response is needed to maintain and strengthen health programs for Rohingya refugees, including both HIV and COVID-19 care [5]. This should include behavioural intervention, community mobilisation, effective treatment and care for both infections [4], as well as a targeted COVID-19 immunisation scheme. Without addressing the underlying dire social conditions, it will be challenging to limit the spread and reduce the burden of HIV and COVID-19 among refugees. While COVID-19 is a common crisis experienced by most countries around the world, the international community has an obligation to work together to improve the life, livelihood, and health of those who are most vulnerable. Rohingya refugees are among them.

Competing interests

No potential conflict of interest was reported by the authors.

Authors' contributions

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