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Continuity of HIV Care in the Presence of COVID-19

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From its initial outbreak in Wuhan, China, in December 2019, coronavirus disease (COVID-19), which is caused by a novel coronavirus known as Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2)[1], evolved from a "public health emergency of international concern" to a World Health Organization (WHO) declared pandemic by March 2019, with then more than 118,000 confirmed cases in 114 countries[2]. As of August 5, 2020, there were 18,558,774 confirmed COVID-19 cases and 701,665 SARS-CoV-2-related deaths worldwide[3], with one emergency authorized treatment of seemingly limited utility[4], a U.S. National Institutes of Health recommendation for the use of dexamethasone in patients requiring supplemental oxygen[5], and uncertain prospects for the development of a vaccine by early 2021[6].

Many national health systems had not kept pace with global pandemic preparedness standards for years, leaving them overwhelmed by the emergence of COVID-19. A 2019 WHO report by member states in relation to the 2005 International Health Regulations (IHR) found that countries in most geographic regions self-reported deficiencies across 13 critical capacity areas[7,8]. In 2019, the average self-reported core implementation capacity in relation to national health emergency frameworks ranged from a low of 40% to 58% in the African and Southeast Asian regions, respectively, to a high of 75% in the Western Pacific region, and 73% in both the European and North-South American regions[8]. Averages across six regions were equally concerning for several other core capacities, including coordination and national IHR focal point functions (70%), surveillance (73%), risk communication (60%), health service provision (63%), human resources (63%), and legislation and financing (66%)[8]. Here, too, though, there was significant variation across regions, with predominantly the African region, reporting lower levels of capacity for health service provision (41%), risk communication (43%), and legislation and financing (43%)[8].

Most national health systems were able to mitigate these emerging pandemic preparedness shortfalls by leveraging the infrastructure and resources that were designed for other, more mature pandemics, such as HIV. It is difficult to quantify whether the morbidity and mortality associated with the COVID-19 pandemic would be worse without such leveraging, but it is becoming increasingly clear that leveraging the HIV response infrastructure has disrupted access to and utilization of HIV services, including due to a repurposing of the HIV health workforce. What is more, a highly fragmented and inconsistent approach from country to country to balance the need for an aggressive public health response with an unprecedented economic calamity portends future challenges.

A survey of HIV treating clinicians conducted by the International Association of Providers of AIDS Care (IAPAC) in April 2020-June 2020 found that 53% of respondents from 75 countries were treating patients with SARS-CoV-2 infection[9]. In the United Kingdom, South Africa, and the United States, those percentages stood at 57%, 57%, and 48%, respectively[9]. Clearly, a surge of mostly infectious disease specialists and other health-care personnel was needed to manage a wave of SARS-CoV-2 infections in almost every nation of the world, but at what cost to the standard of HIV care?

Survey respondents globally reported disruptions in HIV services, including HIV antibody testing (35%); antiretroviral therapy (ART) initiation (29%); laboratory monitoring for viral load (46%); pre-exposure prophylaxis (PrEP) initiation (31%); case management (42%);

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trauma-informed mental health services (45%); and harm reduction services (28%)[9]. Novel innovations have emerged to address the challenges posed by such an unprecedented virus, including telemedicine, differentiated service delivery, and multi-month antiretroviral drug dispensing[10]. However, these innovations do not seem to have attenuated levels of concern among survey respondents about the impact of COVID-19 on issues such as poor ART adherence (93% in South Africa reported being "moderately" to "very" concerned), decreased availability of trauma-informed mental health services (92% in the United Kingdom reported being "moderately" to "very" concerned), and increased sexual and other risk-taking (89% in the United States reported being "moderately" to "very" concerned)[9].

Moreover, survey respondents in the field noted what is being revealed through disaggregated data about how disparities built into health systems affect clinical outcomes, including mortality, for non-White patients infected with SARS-CoV-2 (as well as HIV and most other diseases). Globally, 76% of respondents indicated being "moderately" to "very" concerned about racial disparities in COVID-19 clinical outcomes in their respective communities[9], mirroring limited data that have been made publicly available about elevated levels of COVID-19 mortality for Black and Latino patients (23% and 16.6%, respectively) in the United States of America[11], or racially disparate mortality rates in Brazil, where Black and mixed-race patients died at a rate of 55% versus 38% of White patients[12]. It bears noting, too, that the proportion of those hospitalized in some countries is skewing younger than had been anticipated and appears to be highly correlated with underlying health conditions that are associated not only with race and ethnicity, but structural barriers to accessing and utilizing health care.

The COVID-19 pandemic has revealed the fragility of HIV responses in both the global North and the global South, at various stages across the continuum of HIV prevention and care and by varying degrees of severity. Yet, while we cannot yet measure the precise impact of HIV service disruptions on numbers of new infections or deleterious health outcomes, including viral rebound and mortality, the COVID-19 pandemic is sure to have had an impact as statistics replace anecdotes. Without question, public health officials will face greater obstacles to achieving the United Nations goal of ending the public health threat posed by AIDS by 2030, as a result of SARS-CoV-2. People living with HIV will need civic and community leaders to develop stronger, more resilient HIV response systems to address not only the COVID-19 pandemic, whose time horizon remains unknown, but also the next novel viral infection.

José M. Zuniga, PhD, MPH, is President/CEO of the IAPAC, which organized the May 6, 2020, "Continuity of HIV Care in the Presence of COVID-19" virtual conference, some of whose presentations are featured in this AIDS Reviews *issue.*

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