

Ensuring retention in care for people living with HIV during the COVID-19 pandemic in Rome, Italy

The new coronavirus disease known as COVID-19 has spread dramatically across Europe, impacting national healthcare systems, particularly in Spain, the UK, France and Italy. As of 30 August 2020, these countries accounted for 75.2% of total mortality for COVID-19 in Europe.¹ The WHO estimates that in these top 4 European countries, there are approximately 550 000 people living with HIV (PLWH) who need routine clinical assistance.² Recent observations suggest their access to care can be seriously hindered by shifts in clinical efforts of HIV specialists towards patients with COVID-19.³

Ensuring retention in care for PLWH is essential to maintain drug-associated viral suppression, effective physical monitoring, drug side-effect surveillance and reductions in HIV transmission and mortality.⁴ Moreover, during the COVID-19 crisis, maintaining HIV continuum appeared relevant also to monitor some common conditions among PLWH, such as diabetes, hypertension, immune-inflammation disorders and ageing,⁵ which represent potential risk factors for severe physical illness due to SARS-CoV-2.^{6,7}

Since the start of the national lockdown on 9 March, many HIV centres in Italy have drastically reduced daily access of PLWH.⁸ In this context, the HIV/AIDS unit of the S. Gallicano Dermatological Institute promptly rescheduled many clinical activities but continued daily health assistance for 556 patients with HIV, mainly men who have sex with men (MSM) (394/556, 70.9%), on antiretroviral therapy (ART) (525/556, 94.4%) and aviraemic (HIV-RNA <20 copies/mL, 506/525, 96.4%).

To maintain patients in HIV-care continuum during the lockdown, the following interventions were rapidly implemented: (1) phone or e-mail confirmation of scheduled visits only for non-aviraemic patients, for those needing periodical blood tests or non-deferrable clinical evaluation; (2) home delivery of monthly ART doses from the hospital pharmacy to deferred or lockdown-restricted patients; (3) postponement of all scheduled diagnostic procedures for patients with non-life-threatening comorbidities; and (4) implementation of a unit-based teleconsulting, telephone calls

and messaging app services. Importantly, no changes in accessibility of newly HIV-infected individuals and their early management were introduced.

From 9 March to 10 June, the aforementioned initiatives reduced the attendees by 46.0% (median visits per day: 7 vs 13), without modifying the number of needed blood tests per day, the number of urgent consultations or the amount of delivered ART doses compared with the pre-COVID-19 era. During the same period, 230 (41.4%) patients received ART doses at home; 134 (24.1%) used teleconsulting (2 median teleconsultings per day) and 65 (11.7%) phoned or texted to communicate with the HIV team (3 median contacts by phone/messages per day). To date, no patients with acute SARS-CoV-2-associated symptoms have been visited in the unit, and preliminary data from a SARS-CoV-2 seroprevalence study on 367 patients up to 20 August showed that 6 (1.63%, 95% CI 0.75 to 3.52) of these were IgG-positive. None of these were hospitalised.

A postintervention analysis conducted on the 506 patients who were aviraemic before the lockdown and consulted up to 20 August showed that 503 (95.8%) remained aviraemic.

Our experience suggests that retention in HIV care can be assured also during COVID-19 restrictions through an accurate triage of patient needs, without significant additional resources and with measurable benefits in terms of continuum of care.

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Acknowledgements The authors acknowledge Dr Emiliano Fidone and Dr Massimo Sansone for drug delivery, and Silvia Foracappa and Andrea Levi for their help in applying the new procedures. They also thank Dr Michael Kenyon for his review of the English language.

Contributors MG and AL conceived the idea for the report; MG and MGD performed the data collection and interpreted the results; MG, AL and MGD prepared the manuscript for publication; AL, AC and MG consulted the patients and collected clinical data; FP performed the serological tests; ALM and MSP conceived and

cured the drug delivery from the hospital pharmacy. All authors have read and approved the final version of the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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To cite Giuliani M, Donà MG, La Malfa A, *et al*. *Sex Transm Infect* 2021;**97**:317.

Received 17 June 2020

Revised 10 September 2020

Accepted 27 September 2020

Published Online First 12 October 2020

Sex Transm Infect 2021;**97**:317.

doi:10.1136/sextrans-2020-054650

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