SPECIAL REPORT

The impact of the COVID-19 pandemic on the HIV response in Europe and Central Asia

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia

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This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori. The report was produced under contract ECDC/2019/037 by Annabelle Howard (National AIDS Trust) and Katherine Turpie (National AIDS Trust).

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Executive summary

In 2021 and 2022, a survey was developed to assess the impact of COVID-19 on HIV service delivery and monitoring capacity in Europe and Central Asia. Countries were asked whether COVID-19 had an impact on several HIV-specific and non-HIV specific services compared to pre-COVID levels. Although fewer countries reported a reduction in service provision across all HIV-specific services in 2022 than in 2021, the impact is still being felt compared to pre-pandemic service levels. For HIV-specific services, in-clinic and community-based HIV testing saw the largest impact due to COVID-19. For non-HIV specific prevention services, including services related to other STIs, condom distribution, harm reduction for people who inject drugs, and general prevention outreach, most countries reported that services were severely reduced.

Although treatment services were affected, many countries applied creative means to ensure people did not experience breaks in treatment, including longer prescriptions. Many countries were unable to assess the impact of the COVID-19 pandemic on pre-exposure prophylaxis (PrEP) services. This suggests that mechanisms for reporting on PrEP uptake are not sufficiently embedded in the existing monitoring processes. In terms of the policy impact, people living with HIV were recognised as a priority for COVID-19 vaccination in the West and Central regions but not in the East region. Opioid substitution therapy did not appear to be significantly affected, with increases in provision seen in a number of countries. The key population most frequently reported to have experienced a disproportionate impact during the pandemic was sex workers. This was related to factors such as an increase in risk behaviour and reduced access to harm reduction services.

COVID-19 also had an impact in terms of staff and facility resources being diverted away from the HIV response to the COVID-19 response. When considering different types of staff and facility resources, in 2021 the largest impact was seen in clinical services for people living with HIV and human resources for monitoring and surveillance, with 27 countries reporting a diversion for both of these areas. Doctors, nurses, and other human resources were often transferred between departments to urgently address COVID-19 clinical needs. Those services least frequently reported to have been impacted by diversion of resources were prevention services, with only 15 countries reporting such diversions.

This report provides a record of the impact noted by countries on HIV services and monitoring capacity which can be used retrospectively to better understand the effects of the COVID-19 pandemic on the HIV situation in the European Region.

Introduction

The COVID-19 pandemic created unprecedented challenges for healthcare and public health systems worldwide. As of December 2022, the World Health Organization (WHO) European Region had counted over 641 million confirmed cases and over 6.6 million deaths due to COVID-19[1]. Even though healthcare system capacity was strained in a number of ways, it is still crucial to assess the impact of the COVID-19 pandemic on the HIV pandemic and progress towards ending HIV transmission by 2030.

The international community has committed to the Sustainable Development Goal (SDG) of ending the HIV/AIDS epidemic by 2030. Access to HIV prevention, testing, prompt diagnosis and access to treatment are critical for ensuring good health outcomes in people living with HIV and preventing onward transmission.

While there has been considerable, but variable progress towards SDG targets, the COVID-19 pandemic has had a significant impact on that progress. However, the extent of the impact of COVID-19, and governmental responses to it, varied in individual countries and the Region as a whole. .

In 2021 and 2022, a survey was developed and sent to the 55 countries in Europe and Central Asia to assess the impact of COVID-19 on HIV service delivery and monitoring capacity during part of the COVID-19 pandemic period (when society and healthcare were affected). Although there will undoubtedly have been an impact on diagnoses and incidence, this will probably not be noted in surveillance and monitoring data for several years. This report provides a record of the impact noted by countries on HIV services and monitoring capacity which can be used retrospectively to better understand the effects of the COVID-19 pandemic on the HIV situation in the European Region.

In 2021, 40 countries responded to the survey and in 2022, 37 countries responded. The countries that did not provide a response in 2021 were Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Iceland, Liechtenstein, Luxembourg, Norway, Russia, San Marino, Slovakia, Tajikistan, Turkmenistan and Uzbekistan. The countries that did not provide a response in 2022 were Andorra, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Iceland, Kazakhstan, Latvia, Monaco, Russia, Slovakia, Tajikistan, Turkmenistan and Uzbekistan.

The results of the COVID-19 impact survey are presented by European sub-region.

The countries covered by the report are grouped as follows:

West, 24 countries: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Liechtenstein, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, the United Kingdom.

Centre, 16 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Kosovo , North Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Türkiye.

East, 15 countries: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

[1] WHO Coronavirus (COVID-19) Dashboard https://covid19.who.int/ Accessed: 7 December 2022.

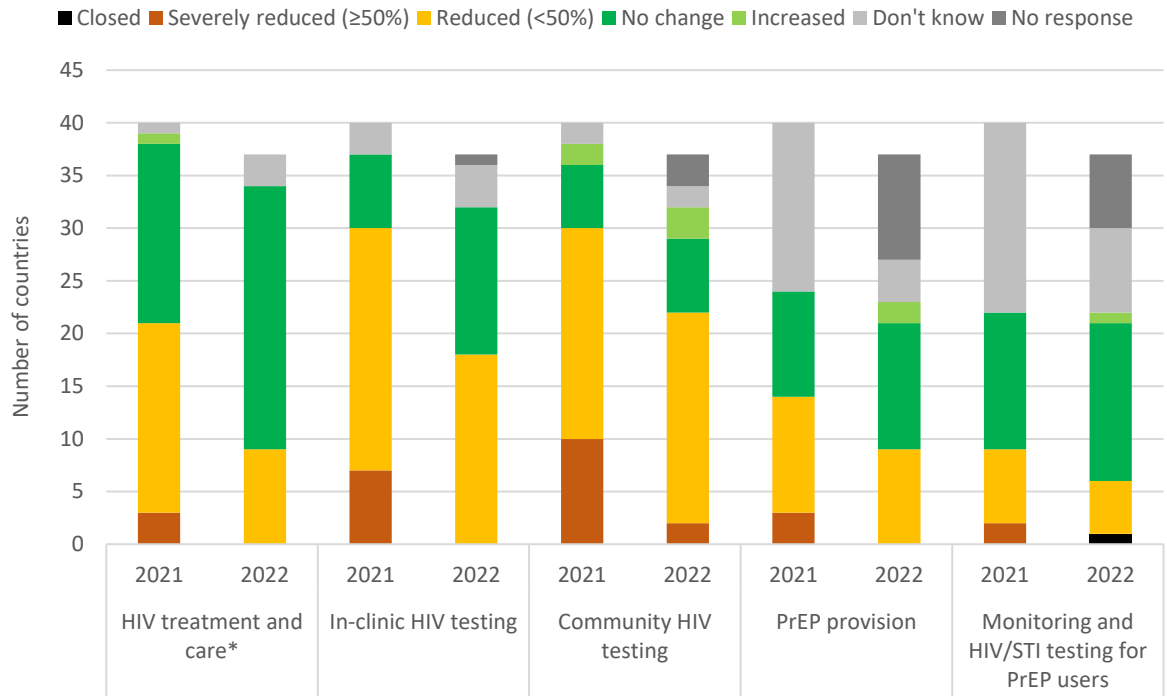
Figure 1. Geographical/epidemiological division of the WHO European Region

Impact on HIV services and prevention

Countries were asked in both 2021 and 2022 whether COVID-19 had had an impact on several HIV-specific and non-HIV specific services compared to pre-COVID levels. For HIV-specific services (Figure 2), in 2022, the greatest COVID-19 impact was on community-based HIV testing, with 20 countries reporting this service as reduced (<50%) and two countries reporting it as severely reduced (≥50%). In 2022, eighteen countries reported a reduction in in-clinic HIV testing.

Although fewer countries reported a reduction in service provision across all HIV-specific services in 2022 compared to 2021, the impact was still being felt compared to pre-pandemic service levels. In 2021, 21 countries reported reductions (including severe reductions) in HIV treatment and care services and in 2022, this had dropped to nine countries. It is important to note that countries will have had different levels of service provision in all of these areas prior to the pandemic, so an increase or decrease is considered relative within and between countries.

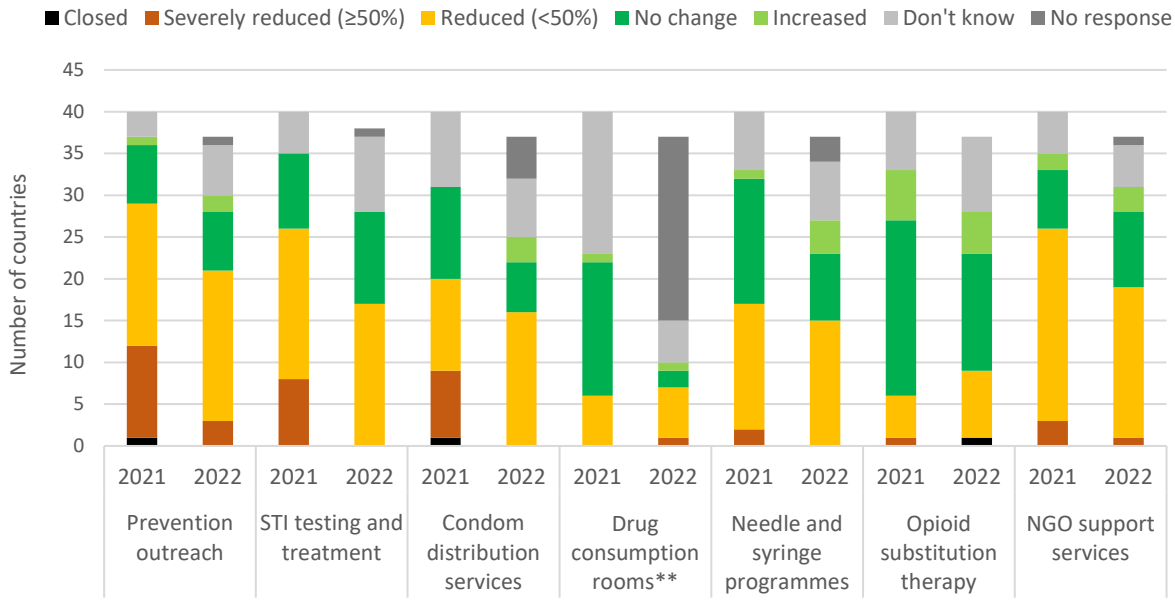
Figure 2. Impact of COVID-19 pandemic on HIV-specific service provision in Europe and Central Asia in 2021 (n=40) and 2022 (n=37)



**Includes HIV care initiation, monitoring, and treatment.*

For non-HIV-specific prevention services (Figure 3), including services related to other sexually transmitted infections (STIs), condom distribution, harm reduction for people who inject drugs, and general prevention outreach, the findings for 2021 were similar in that most countries reported services as severely reduced (≥50%) or reduced (<50%). A total of 29 countries reported either closure or reduction in prevention outreach services, 26 reported a reduction in NGO support services and 26 reported a reduction in STI testing and treatment. In 2021, increases in the provision of opioid substitution therapy (OST) were observed in six countries and in the provision of needles and syringes in one country. As for HIV-specific services, 2022 data indicated that there was less reduction in service provision than in 2021 for prevention outreach, condom distribution services, needle and syringe programmes and NGO support services.

Figure 3. Impact of COVID-19 pandemic on non-HIV specific service provision in Europe and Central Asia in 2021 (n=40) and 2022 (n=37)

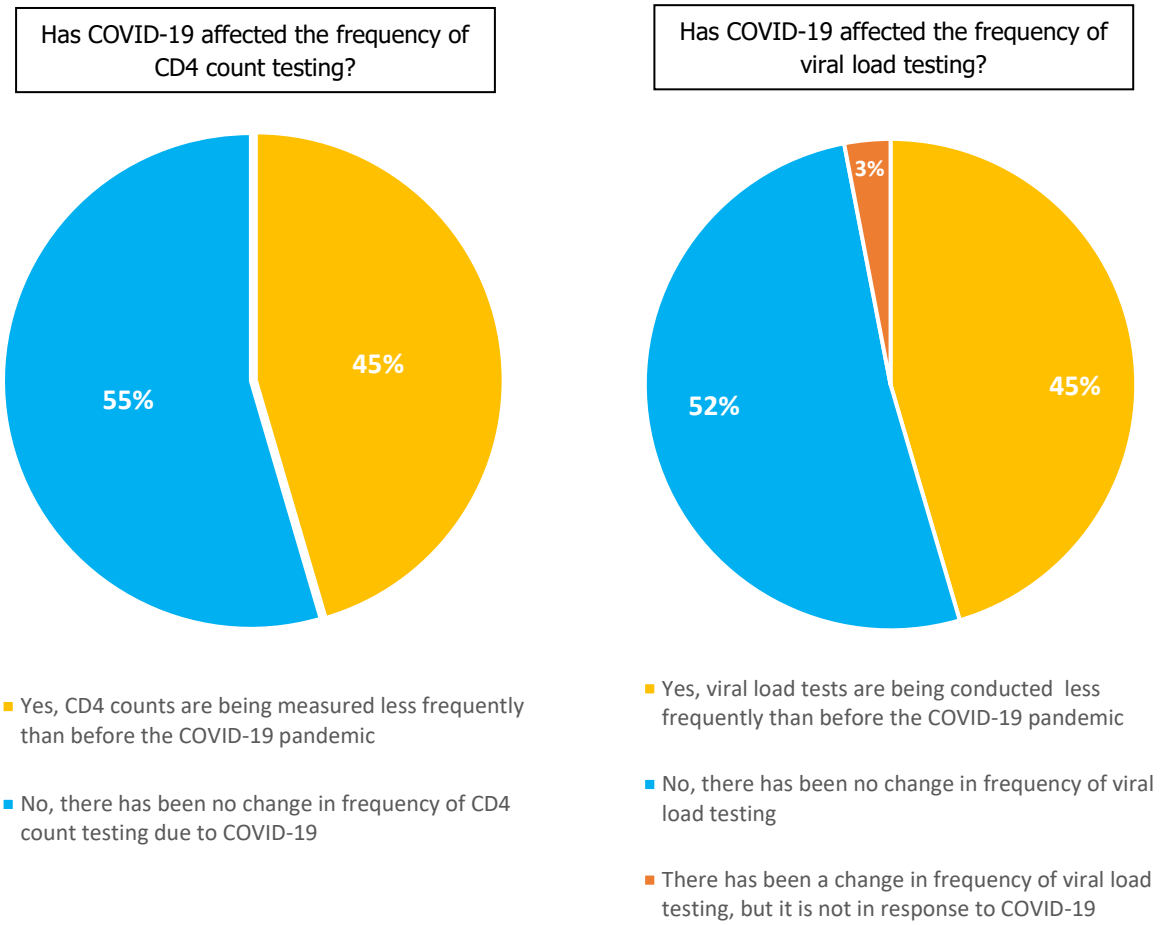


***and supervised injection site.*

The 2022 survey asked questions about how the COVID-19 pandemic had affected the proportion of virtual HIV appointments during 2020 and 2021, compared to 2019, the year prior to the COVID pandemic. For 2019, five countries gave responses and all stated that 5% of HIV appointments or less were virtual. In 2020, this had increased overall – Sweden's virtual appointments remained under 5%, but the other four countries that provided an answer had proportions of appointments ranging from 45% to 90% that had become virtual. By 2021, this had decreased again, but not back to pre-pandemic levels, ranging from 5% to 35% for the five countries that responded.

In 2022, countries were asked to report whether there had been a change in frequency of CD4 and viral load testing due to the COVID-19 pandemic (Figure 4). Forty-five percent of the 33 responding countries stated that CD4 counts were being measured less frequently than before the COVID-19 pandemic. Similarly, 45% of countries reported that viral load testing was conducted less frequently than prior to the COVID-19 pandemic. No country reported that either form of testing was conducted more frequently than before the pandemic, and just one country (Albania) reported that their change in viral load testing was not in response to COVID-19.

Figure 4. Impact of COVID-19 on CD4 count and viral load testing in Europe and Central Asia in 2022 (n=33)



The surveys included questions on vaccination plans for people living with HIV. The 2021 survey asked whether people living with HIV were prioritised for COVID-19 vaccination, and this was followed up in the 2022 survey with questions on the proportion of all adults in the general population, and adults living with HIV, who are fully vaccinated. In 2021, most countries in the West (11) and Centre (9) sub-regions reported that people living with HIV were a priority group for COVID-19 vaccinations, although three countries specified that vaccine eligibility was dependent on having a CD4 count below a specific threshold. Conversely, in the East sub-region most countries reported that people living with HIV were not a priority group for vaccination. Just one country, Italy, provided a figure for the proportion of people living with HIV who were fully vaccinated: ≥95%. Of the 26 EU/EEA countries that provided a response, 17 reported that people living with HIV were prioritised for vaccination, and nine that they were not. Thirty-four countries stated that this information was not available, and no other countries provided a response.

Qualitative descriptions of impact on services

Countries were asked to describe changes in delivery of services compared to before the COVID-19 pandemic, using an open text box. In 2021, 22 countries provided qualitative responses regarding impact on services, and in 2022 this number decreased to 17. Common themes reported in the qualitative data across both years included:

- On-site and in-person services being reduced for many activities, including walk-in clinics, testing, OST prescription, counselling, outreach and support – many were replaced with online or over-the-phone services, or appointment-only arrangements replaced previous 'walk-in' arrangements, with lower frequency.
- Arrangements were made in some countries to administer antiretroviral therapy (ART) through delivery and collection services for those unable to travel or where in-person appointments had been reduced. Lengths of prescriptions for ARVs and OST were also increased in some countries.
- NGOs took a larger role in provision of testing, condoms and support. Some organisations strengthened their counselling and online support services due to an identified need to maintain resilience, tackle loneliness and address mental health issues resulting from isolation due to the COVID-19 pandemic. Some NGOs were also involved in delivery of medications.

- The extent to which HIV services were affected varied by context and depended on whether a clinic/hospital/lab was deployed in the COVID-19 response. For example, some testing services were reduced to make way for increased COVID-19 testing, and online ordering of HIV self-tests was introduced and/or increased by several countries.

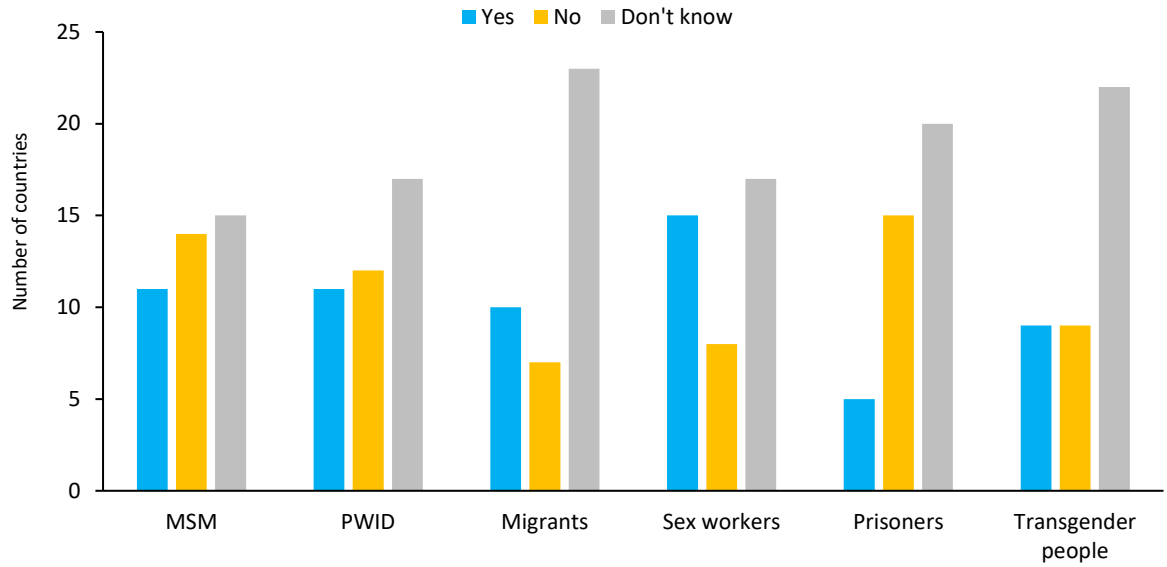
In 2021, three countries listed food delivery as a service provided for people living with HIV during the pandemic, and two countries listed temporary housing/shelter and assistance with rent and mortgage payments, pointing to the role that poverty and food insecurity plays in the lives of some people living with HIV. However, some countries reported services only being severely affected during the first few months of lockdown in spring of 2020, showing that there was a variation in impact, depending on which wave of COVID was being discussed.

In 2022, concerns persisted surrounding the loss of patients to follow-up due to movement and lack of rescheduled cancellations. However, some countries reported that services, such as PrEP, provision of drug consumption rooms and maintenance of OST were being scaled up as the pandemic hit and therefore there was little reduction, and in some instances even an increase throughout the pandemic period, in line with social distancing recommendations.

Impact on key populations

In 2021, countries were asked to report on whether the pandemic had had a disproportionate impact on six key populations living with, or at risk of HIV (Figure 5). These questions were not asked of countries in the 2022 survey. Across the entire region, sex workers were most frequently reported as having been disproportionately affected, while people in prisons and men who have sex with men (MSM) were least frequently identified as disproportionately affected. The highest levels of uncertainty were reflected in the responses relating to migrants and transgender people.

Figure 5. Countries reporting a disproportionate impact of COVID-19 on six key populations, in Europe and Central Asia, reported in 2021 (n=40)



Qualitative descriptions of impact on key populations

Countries replied to open text prompts for details of the COVID-19 impact on key populations in 2021 with the following themes:

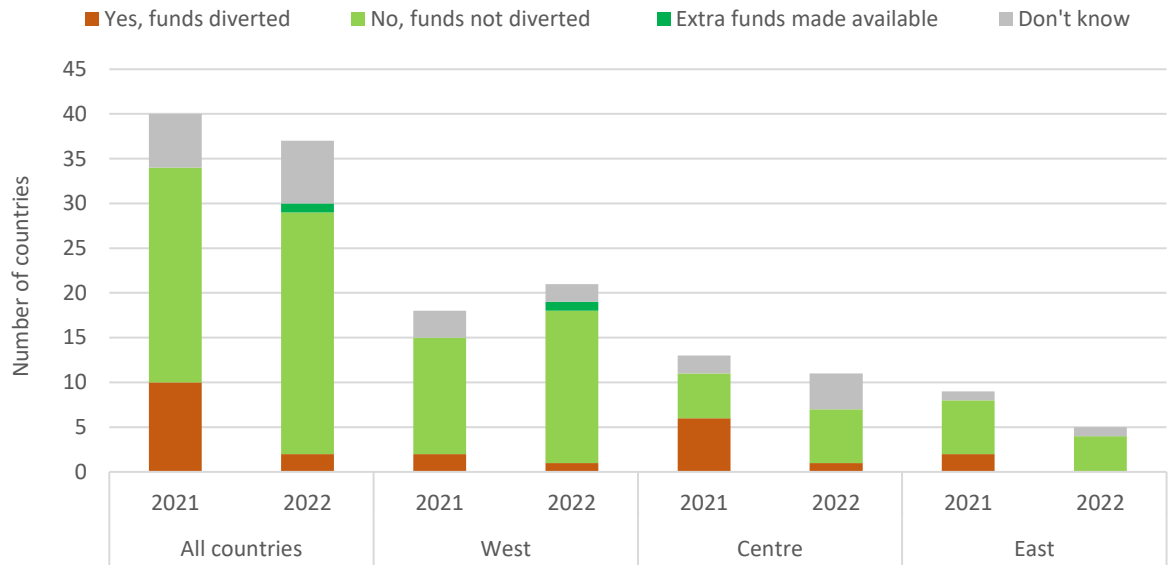
- MSM: the closure of community-based settings for testing and counselling; closure of lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (LGBTQIA+) specific services and community outreach, including in social settings; impact on mental health and social isolation.
- People who inject drugs (PWID): access to clean injecting equipment (needles and syringes) was reduced in some countries but expanded in others, including in some cases allowances for larger amounts of equipment to be distributed at one time; many countries reported reduced access to HIV testing but maintenance of HIV treatment and care.
- Migrants: difficulty accessing online services and, especially for newer arrivals, in-person services; lower income due to lack of work; difficulty maintaining ARV treatment or PrEP due to travel and transport restrictions.

- Sex workers: closure of brothels, night curfews and lockdowns led to lower income and increased poverty; a lack of opportunity to provide regular services resulted in what was described as 'increased risk behaviour' along with reduced access to harm reduction services and condoms.
- People in prisons: few comments were provided on this population, but the comments given noted that there was reduced prevention and testing in prisons, and that HIV treatment was maintained.
- Transgender people: similar to MSM, the closure of LGBTQIA+ services, community outreach, and social settings had an impact on mental health, social isolation, and access to prevention and testing; many countries noted that transgender people would be more likely to engage in sex work and therefore to experience the negative effects listed for the sex worker key population.

Impact on HIV resources and surveillance

Countries were asked about the diversion of resources, including funds, staff, and facilities, from the HIV response to the COVID-19 response. In 2021, 24 of 40 countries (60%) reported that funds for the HIV response were not diverted to the COVID-19 response during the pandemic, while ten countries (25%) reported that funds were diverted, and six countries did not know (15%) (Figure 6). In 2022, 27 of 37 countries (73%) reported that funds for the HIV response were not diverted to COVID-19, while just two (5%) reported that funds were diverted, indicating that COVID-19 may have had more of an impact on funds in 2021 than in 2022. In 2021, no country identified extra funds having been made available for HIV services during the COVID-19 pandemic, and in 2022, there was just one (United Kingdom). The Centre sub-region six countries reported that funds had been diverted in 2021, and two countries from both the West and East sub-regions respectively gave this response in 2021.

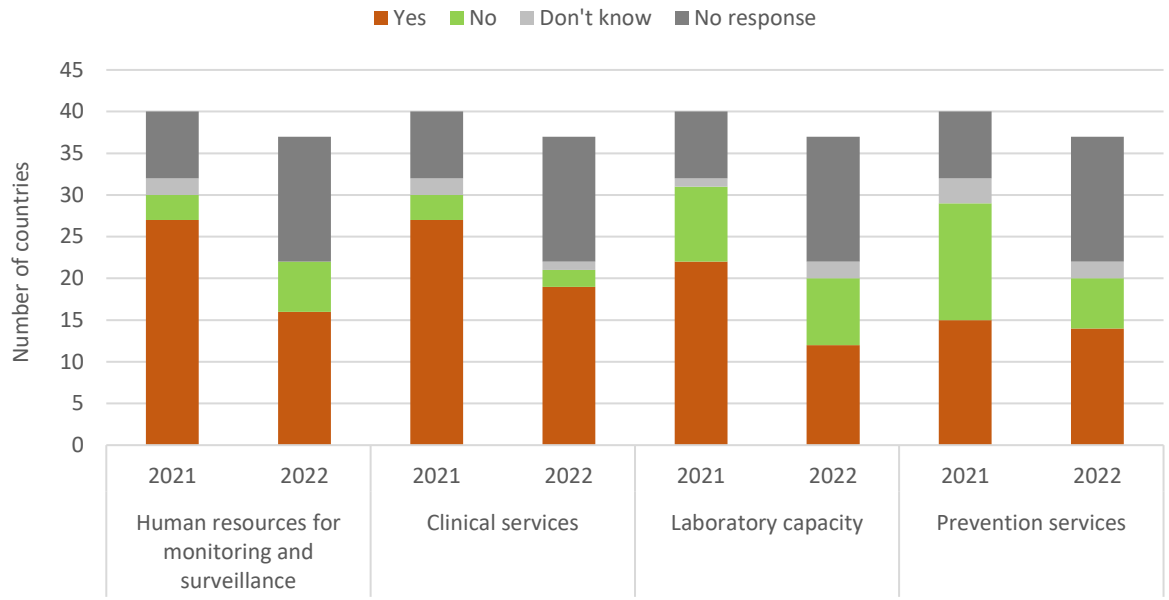
Figure 6. Impact of COVID-19 on HIV response funds in Europe and Central Asia in 2021 (n=40) and 2022 (n=37) and by sub-region



COVID-19 had an impact on staff and facility resources being diverted away from the HIV response to the COVID-19 response. When considering different types of staff and facility resources, in 2021 the greatest impact was seen in clinical services for people living with HIV and human resources for monitoring and surveillance, with 27 countries reporting a diversion for both of these areas (Figure 7). This was reflected in expert focal point text responses, which highlighted that doctors, nurses, and other human resources were often transferred between departments to urgently address COVID-19 clinical needs. Those services least frequently reported to have been affected by diversion of resources in 2021 were prevention, reported by only 15 countries.

The same question yielded different responses in the 2022 survey. The largest impact in 2022 was seen in the same two areas – clinical services and human resources for monitoring and surveillance – but the number of countries reporting a diversion of these services had decreased to 19 and 16, respectively (Figure 8). Focal point text responses continued to support these data, with countries still reporting clinical staff and surveillance and programme services being redeployed to COVID-19. However, some countries reported that the situation was much better than the previous year, despite there still being some delays. Laboratory capacity was the area least frequently reported to have been affected by a diversion of resources in 2022 – reported by only 12 countries.

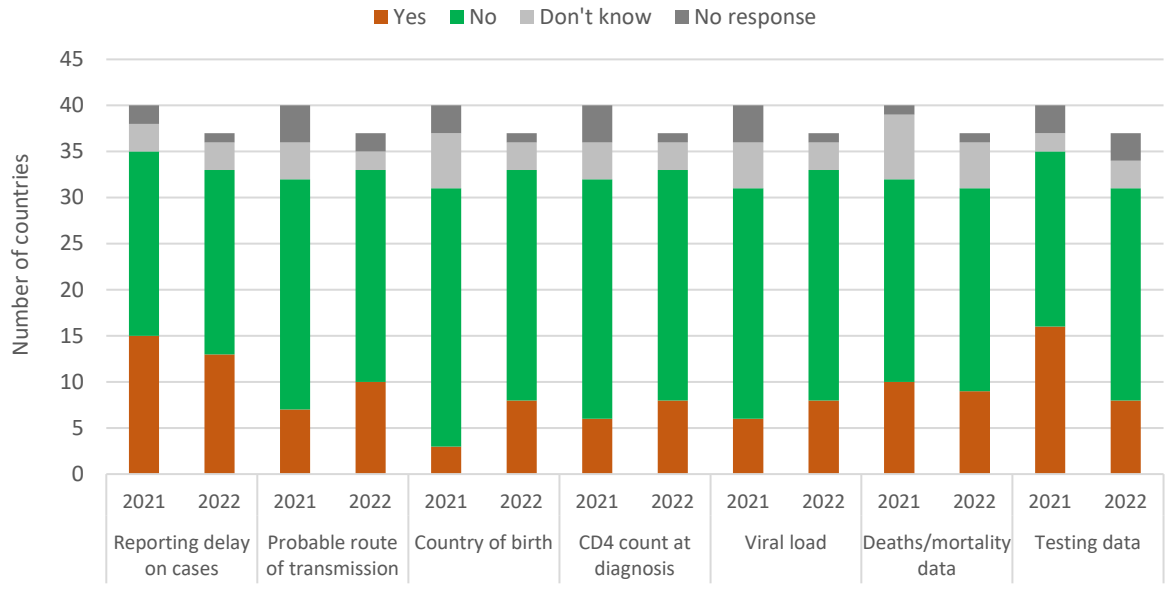
Figure 7. Diversion of staff and facility resources due to the COVID-19 pandemic in Europe and Central Asia in 2021 (n=40) and 2022 (n=37)



Impact on HIV surveillance and monitoring

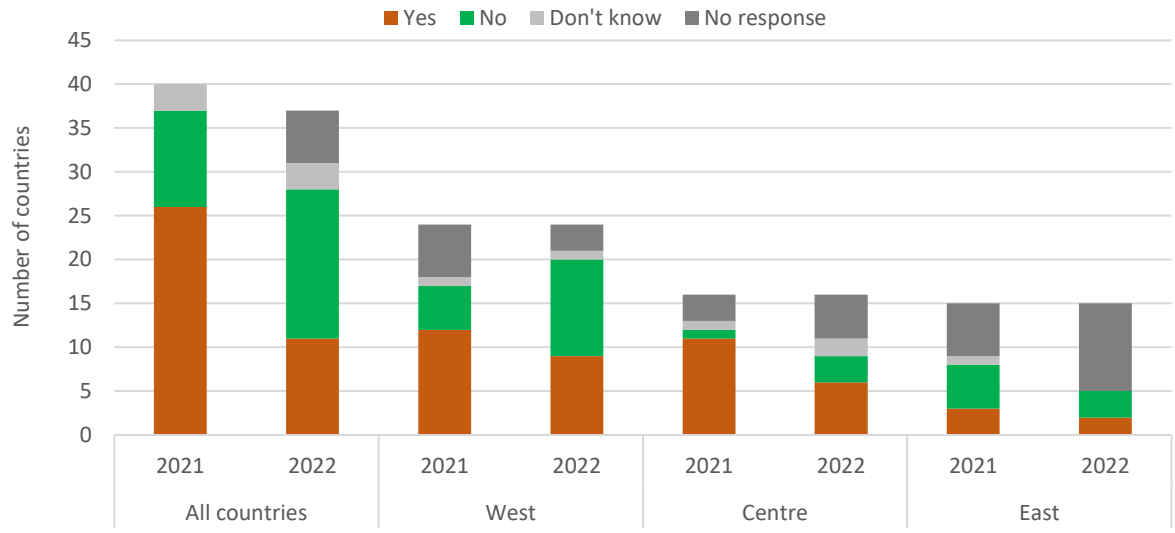
The survey also posed questions relating to country-level HIV surveillance and monitoring in public health institutions. Across both years, most countries responded that the COVID-19 pandemic had not had an impact on their ability to collect HIV surveillance data (Figure 8). In 2021, the impact most frequently reported by countries was a reporting delay on case numbers (15 countries) and inability to collect testing data (16 countries). In 2022, these numbers decreased, with the impact most frequently reported being reporting delays on case numbers (13 countries) and the monitoring of probable routes of transmission (10 countries). The biggest change between years was seen in the ability to collect testing data – in 2021, 16 countries reported that COVID-19 had affected the ability to collect data, while in 2022, the number had decreased to eight.

Figure 8. Impact of COVID-19 on the ability to collect HIV surveillance data in Europe and Central Asia in 2021 (n=40) and 2022 (n=37)



When asked whether COVID-19 affected capacity for HIV surveillance and/or response monitoring in public health institutions, in 2021 most countries (including a large majority in the Western and Centre sub-regions) reported that COVID-19 had affected capacity (Figure 9). Countries in the Eastern sub-region most frequently reported that capacity had not been affected. Three countries, one in each sub-region, reported that they did not know whether COVID-19 had affected capacity for surveillance and/or monitoring. In 2022, the number of countries reporting strong disruptions decreased overall, with the majority of countries in the West and East sub-regions reporting that COVID-19 had not had an impact on surveillance capacity and/or response monitoring that year. However, in the Centre sub-region, six countries still reported that there had been an impact.

Figure 9. The impact of COVID-19 on HIV surveillance capacity and response monitoring in public health institutions in Europe and Central Asia in 2021 (n=40) and 2022 (n=37) and by sub-region



Conclusions

The COVID-19 pandemic had an impact on several important HIV services, including testing, clinical services for people living with HIV and resources for monitoring and surveillance. While there were less reductions in services in 2022 than in 2021, the impact of the pandemic on HIV prevention, testing and care will probably not be fully understood for several years. While this report only offers a retrospective view of the impact of COVID-19 on HIV services and key populations, results from the survey may help to shape services and mitigate disruption to HIV care during future pandemics.

Although treatment services were affected, many countries applied creative measures to ensure people did not experience breaks in treatment, including longer prescriptions. Many countries were unable to assess the impact of the COVID-19 pandemic on PrEP services. This suggests that mechanisms for reporting on PrEP uptake are not sufficiently embedded in the existing monitoring processes. In terms of the policy impact, people living with HIV were recognised as a priority for COVID-19 vaccination in the West and Central regions, but not in the East region. OST appeared not to be significantly affected, with increases in provision seen in a number of countries. Sex workers were the population most frequently reported as having experienced a disproportionate impact due to the pandemic, linked to factors such as an increase in risky behaviour and reduced access to harm reduction services.

There are recognisable limitations to this brief survey. It was subjective, based on the opinions of the expert focal points, and did not reflect quantitative measurements of impact on services and other aspects of HIV and COVID-19 response. While opinion-based data is valuable in the face of a rapidly changing situation, it will not capture variation within countries and in the opinions of in-country experts. For example, the lowest impact of COVID-19 was reported in the Eastern sub-region. It was beyond the scope of this survey to ascertain whether this was due to lower resources and capacity for HIV services in the East to begin with; the impact of different waves of COVID-19 hitting sub-regions at different times; less robust surveillance and reporting systems in this area or this sub-region actually being affected less by COVID-19 than other regions.

Although only one quarter of reporting countries said that funds had been diverted away from the HIV response in 2021, over three-quarters reported diversion of clinical staff and facilities. Diversion of resources appears not to have been matched by closure of services. Similarly, although countries reported considerable impact on the capacity of public health institutions, the majority noted that surveillance data collection had generally not been affected. These types of impact should be measured over time to assess whether the systems have rebounded, or been permanently altered following the changes experienced during the COVID-19 pandemic period.

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