COVID-19 Has Disrupted PrEP Use and STI Testing

However, PrEP still remains widely available, often provided via telemedicine.

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COVID-19 has had a major impact on health care, and the provision of pre-exposure prophylaxis (PrEP) is no exception. Since the start of the pandemic, a Boston clinic has seen declines in the number of people starting PrEP, refills of PrEP prescriptions and testing for sexually transmitted infections (STIs), according to a report at the International AIDS Conference, being held virtually this week.

“COVID-19 has led to major disruptions in PrEP care, especially in vulnerable populations,” International AIDS Society president and conference cochair Anton Pozniak, MD, of the London School of Hygiene and Tropical Medicine, said at an advance media briefing.

People who are not having sex while social distancing or sheltering in place due to COVID-19 do not need to keep taking PrEP. “It’s perfectly fine to take a break from PrEP while not having sex,” Julia Marcus, PhD, MPH, of Harvard Medical School and the Fenway Institute in Boston, recently told POZ.

But for those who are continuing to have sex and wish to stay on PrEP, the pandemic has presented some new barriers.

Douglas Krakower, MD, of Beth Israel Deaconess Medical Center, a research scientist at the Fenway Institute, and colleagues looked at the impact of COVID-19 on PrEP care at the community health center, which specializes in sexual health care for LGBTQIA+ people and is the largest PrEP provider in New England.

The researchers analyzed electronic health data for 3,520 clients with at least one active PrEP prescription between January and April 2020. Most were cisgender men (largely men who have sex with men), 73% were white, 14% were Latino, 6% each were Black and Asian, and the average age was 37. A majority had private insurance, and 13% had Medicaid or other public coverage.

Between January and April, new PrEP starts decreased by 72%, from 122 per month to 34 per month. Over the same period, PrEP refill lapses (defined as not getting a refill before the prior prescription ran out) increased by 191%, from 140 to 407 lapses per month. Overall, the number

of clients receiving PrEP declined by 18%.

Simultaneously, testing for HIV and for gonorrhea and chlamydia decreased by 85%. HIV tests dropped from 1,014 to 151 per month. The clinic saw a single new HIV diagnosis in January, before COVID-19 restrictions were in place.

Gonorrhea and chlamydia tests decreased from 1,058 to 158 per month. Although the number of tests fell, the rate of people testing positive for these STIs increased slightly, from 12% to 16%.

During this period, clinical encounters decreased by 26%, from 1,419 to 1,046. None were conducted remotely via telemedicine in January, but that proportion rose to 98% in April.

The researchers found that vulnerable groups were more likely to have lapses in PrEP care. People age 26 or younger, Latino clients, those who were multiracial and those who were publicly insured were significantly more likely to have prescription refill lapses.

“COVID-19 was associated with major disruptions in PrEP refills, new starts and HIV/STI testing, despite near-complete shift to telehealth,” the researchers concluded. “Studies to understand whether changes in PrEP care reflect decreased sexual risk or barriers to optimal health care are needed.”

Speaking at a Monday media briefing, Erik Lamontagne of UNAIDS noted that in some areas, the economic fallout from COVID-19 has driven some people into sex work. Thus, the pandemic could both increase and reduce HIV risk depending on countries’ specific policies, and the balance is not yet clear.

“It’s important not to stigmatize people who are engaging in sex during COVID-19 so that they are not ashamed to come forward to seek preventive sexual health care,” Krakower emphasized.

Impact of Shelter-in-Place Orders

In a related study, Scott Brawley, MSW, of the American Academy of HIV Medicine (AAHIVM), and colleagues assessed the impact of COVID-19 shelter-in-place orders on PrEP use, risk behavior and PrEP provider practices.

In May, the Centers for Disease Control and Prevention issued new guidance on HIV and STI testing and prescribing practices while physical distancing limitations are in place, outlining alternatives to the recommended testing protocol for people continuing on PrEP.

The researchers conducted electronic surveys of PrEP users and prescribers during a 25-day period at the height of shelter-in-place implementation this spring. The PrEP user survey was disseminated via social media and PrEP advocates, while the prescriber survey was emailed to more than 2,500 providers in the AAHIVM database.

Of the 406 PrEP users who responded, nearly a third reported that they had discontinued PrEP. Most respondents stopped voluntarily, typically because they no longer needed it due to low perceived HIV risk (reported by 89%). About 90% said they had fewer sex partners, engaged in sex fewer times and were less likely to use apps to find partners. In fact, more than half said they had not had sex with a partner while sheltering in place.

However, 11 respondents (8%) said they no longer had access to PrEP. Of these, nearly two thirds said they had lost their job or insurance. In addition, about a third said their provider could not offer a prescription or a refill, and about a quarter said they could not complete routine monitoring tests.

Among those who contacted their provider for a PrEP refill, 49% said the provider offered to refill a prescription without the usual HIV, STI and laboratory monitoring tests, 38% offered a telemedicine appointment and 14% offered an in-person office visit.

The provider survey also showed that PrEP generally remained available. Of the 189 prescribers, most said they were still able to prescribe PrEP while shelter-in-place orders were in effect, despite the fact that 90% reported restrictions at their usual practice sites. About two thirds said they used telemedicine to determine whether a patient needed an in-person visit, while 43% said they used telemedicine exclusively and 3% said their practices had closed. More than half said their ability to order recommended HIV, STI and lab tests had decreased, 42% said it stayed the same and 3% said it had stopped entirely.

More than half of the providers said they had both started new people on PrEP and provided refills for existing users; 41% had done only refills. Most recommended no PrEP regimen changes for current patients. Yet more than half (53%) reported that at least one patient had stopped PrEP—higher than the proportion of PrEP users who said they had done so in the other survey.

A majority of providers (59%) said they had refilled PrEP prescriptions via telemedicine while ordering offsite tests for patients to obtain as soon as they were able. Another 9% deferred testing for three months and authorized a 90-day refill, while 15% opted to forgo these tests and monitoring.

About one in five providers said they had encountered PrEP users with suspected STIs but could not obtain a test. Nearly half (47%) went ahead and treated them empirically, without either seeing the patient in person or having test results to confirm the diagnosis.

The fact that providers usually did not recommend PrEP changes, combined with the empirical treatment of STIs, suggests that providers believe that their patients are still engaging in risk behavior, contrary to the patient survey showing that a majority of respondents had reduced or stopped such activity, the researchers surmised.

“Notably, 10% to 15% of patients reported no change or an increase in risk behaviors, signifying that ongoing access to PrEP is important to mitigate HIV risk,” they said.

“Telemedicine was a critical component of PrEP access during shelter-in-place orders and may continue to be used as a means of PrEP delivery post COVID-19,” they concluded—perhaps being overly optimistic in suggesting that the crisis has passed.

“Reducing the number of new HIV transmissions and ensuring access to critical HIV prevention services must remain a public health priority during this challenging time,” AAHIVM executive director Bruce Packett said in a Gilead press release. “These data demonstrate the crucial role that technology-enabled care can play in helping facilitate the safe and timely delivery of critical public health services. My hope is that clinics and HIV prevention providers can continue to adapt to changing circumstances by offering expanded use of telehealth services and other innovative tools to help meet the evolving needs of people at risk for HIV.”

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