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Session: P-15. COVID-19 Global Response/Response in Low Resource Settings

Background: The effects of the COVID-19 pandemic on people living with HIV (PWH) are unknown. Beyond SARS-CoV-2 co-infection, the pandemic may have devastating consequences for HIV care delivery. Understanding these is crucial as reduced antiretroviral therapy (ART) availability alone could lead to ≥500,000 AIDS-related deaths in 2020–2021. With Latin America now a focal point in the pandemic, we sought to describe the impact of COVID-19 on HIV care at Latin American clinical sites.

Methods: Caribbean, Central and South America network for HIV epidemiology (CCASAnet) and additional Brazilian HIV care sites in Argentina, Brazil, Chile, Haiti, Honduras, Mexico, and Peru were included. An electronic survey of COVID-19 effects on HIV clinic operations was administered in Spanish or English via phone and email, April 28–June 2, 2020. We also compared national COVID-19 case, mortality, and policy data from public sources.

Results: Brazil's and Mexico's epidemics appear most pronounced, with >10,000 confirmed COVID-19-related deaths (Figure 1); countries implemented "social distancing" policies at different times after initial cases, with Haiti earliest and Mexico latest (Figure 2). Nearly all 13 sites reported decreased hours and providers for HIV care. Twelve of 13 reported increased use of telehealth, suspension/postponements of routine HIV appointments, and/or suspension of HIV research. Eleven of 13 reported initiation of new COVID-19 research but suspension of community HIV testing, and nearly half provided additional ART supplies. Nearly 70% reported impacts on HIV viral load testing and nearly 40% reported personal protective equipment stock-outs (Table). All 13 sites experienced changes in resources/services in tandem with national policies; there was wide variation, however, in the number of economic and health supports implemented thus far (e.g., quarantines, tax deferrals, interest rate reductions, etc.), from 172 COVID-19-related policies in Brazil to only 30 in Mexico.

Table: Site Assessment of Impacts of the COVID-19 Pandemic on HIV services in Latin America at CCASAnet and Coorte Sites, N=13

	Yes	No	N/A
Has the locality of this HIV care and treatment unit been subject to a national, state/province, county, or municipal lockdown, restrictions on travel and/or business operations, or social distancing orders to curb the spread of COVID-19?	13	0	
Do restrictions remain in place at the time of survey?	13	0	
Has this HIV care and treatment unit been subject to a national, state/province, county, or municipal order to suspend or reduce non-emergency health services in order to curb the spread of COVID-19?	9	4	
Do non-emergency services remain suspended at the time of survey?	9	0	
During the past 3 months has the COVID-19 response resulted in any of the following changes in operations of the HIV care & treatment clinic?			
a. Decreased Hours/Days	11	2	
b. Decreased # of Providers	11	2	
c. Re-assignment of HIV Providers	8	5	
d. Reduced availability of HIV Providers	7	3	
e. Postponement of appointments/service	12	1	
f. Reconfiguration of hospital/clinic space	11	2	
g. Increased use of PPE	13	0	
h. Increased use of telehealth	12	1	
i. Interruptions in recording data for care	8	5	
j. Postponement of ongoing research	12	1	
k. Interruptions in recording data for research	7	6	
l. Initiation of new research for COVID-19	11	2	
m. Withdrawal/suspension of NGOs	6	5	2
During the past 3 months has the COVID-19 response resulted in any of the following changes in community-based HIV services for patients referred to or enrolled in care at this HIV clinic?			
a. Partial or complete suspension of community-based HIV testing	11	1	1
b. Partial or complete suspension of community-based ART refills	1	10	2
c. Partial or complete suspension of community-based support group meetings/activities	12	0	1
d. Partial or complete suspension of community-based defaulter tracing activities	4	3	6
e. Withdrawal/suspension of activities of non-governmental partners that support community-based programs for patients	7	1	5
During the past 3 months, have ART services at your clinic/hospital been impacted by COVID-19?	7	6	
How have routine ART services at this clinic been affected?			
ART clinics have been suspended or shutdown	1	12	
ART pick up points have been designated in the community	1	12	
Patients are being given additional supplies/refills of ART to reduce the frequency of refills	6	7	
How have ART initiation services for newly enrolling patients been affected by COVID-19?			
ART initiation services have been suspended or shut down	2	11	
Same-day or rapid ART initiation services have been introduced	2	11	
Adherence counseling has been modified to avoid delays in ART initiation	3	10	
Not Applicable (no change)	3	10	
During the past 3 months, have viral load testing services for patients enrolled in HIV care at your clinic/hospital been impacted by COVID-19?	9	4	
How have viral load testing services been affected by COVID-19?			
Sample collection for viral load testing have been suspended	4	9	
Laboratory for viral load testing not accepting samples	3	10	
Viral load results turnaround time longer	2	11	
During the past 3 months, has this hospital/clinic experienced stock outs of HIV test kits?	0	11	2
Has this hospital experienced stockouts of antiretroviral drugs during the past 3 months?	0	13	
During the past 3 months, has this hospital/clinic experienced stock outs of personal protective equipment (PPE)?	5	8	
Which of the following types of PPE have recorded stock out(s)?			
Masks	5	8	
Gowns	3	10	
Gloves	2	11	
Disinfectants	1	12	
Other (see below for specific other)	2	11	
Facial protection	1	0	
Face shields	1	0	
During the past 3 months, has this hospital/clinic provided health education/messaging related to COVID-19 for patients enrolled in HIV care?	10	3	
Does this hospital/clinic have a surveillance system for COVID-19 incidence?	7	6	
Does this hospital/clinic have the ability to do contact tracing for individuals who have tested positive for COVID-19?	9	4	

Figure 1. Cumulative mortality due to COVID-19 in countries within which CCASAnet and Coorte sites are located Figure 1 footnote: Source for mortality counts: the WHO COVID-19 Dashboard, available at: <https://covid19.who.int/> All data were up-to-date as of, and were accessed on, June 17th, 2020

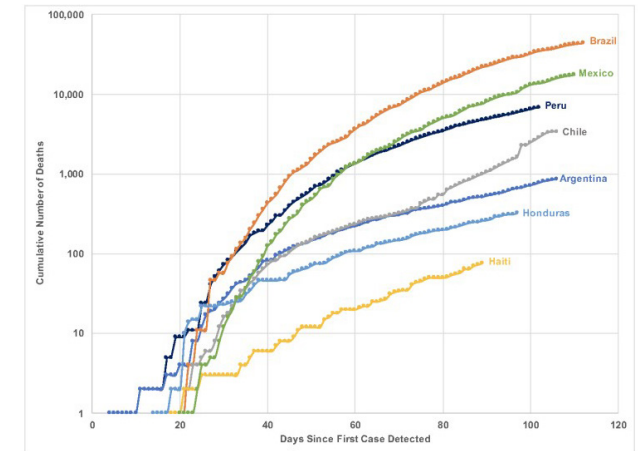
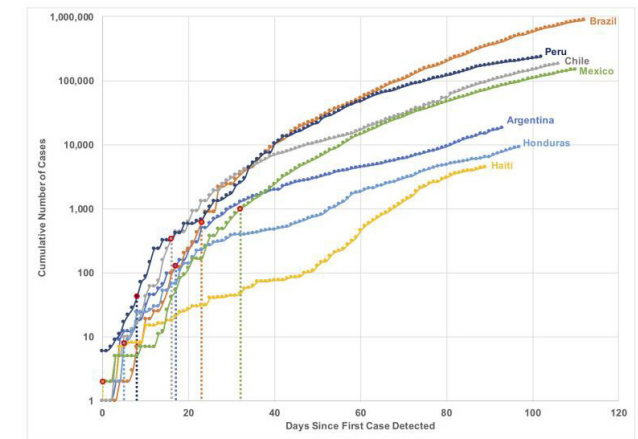


Figure 2. Cumulative cases of COVID-19 in countries within which CCASAnet and Coorte sites are located and dates (relative to the day on which the first positive case of COVID-19 was detected) of general social distancing, public health emergency, or mass quarantine policy introduction (vertical dashed lines), 2020 Figure 2 footnote: Source for case counts: the WHO COVID-19 Dashboard, available at: <https://covid19.who.int/> Source for health policy implementation: the United Nations Economic Council for Latin America & the Caribbean, available at: <https://cepalstat-prod.cepal.org/forms/covid-countrysheet/index.html> All data were up-to-date as of, and were accessed on, June 17th, 2020



Conclusion: The COVID-19 pandemic has already had a substantial effect on daily operations of HIV clinics in Latin America. The downstream effects of these impacts on HIV outcomes in Latin America will need to be further studied.

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476. Gilead Sciences' Commitment to the COVID-19 Pandemic

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Session: P-15. COVID-19 Global Response/Response in Low Resource Settings

Background: COVID-19 has spread rapidly: from the first case in Dec 2019, the declaration of a global pandemic in Mar 2020, to Jun 18, 2020 with >8 M confirmed cases and >400,000 deaths worldwide. Throughout this rapid spread, Gilead has focused on contributing antiviral expertise and resources to help patients (pts) and communities fighting COVID-19

Methods: Gilead is supporting the efforts of governments, partnering with professionals, and community-based org., and collaborating with healthcare providers to accelerate research and access to remdesivir (RDV), the first medicine with demonstrated efficacy in treatment of COVID-19. This is a review of the programs initiated in RDV research, access, research grants and collaborative education

Results: In Jan 2020 Gilead began working with government and regulatory authorities to make RDV accessible to pts globally through the compassionate use and expanded access programs. These programs has treated >2000 COVID-19 pts. By Feb

2020, several phase 3 randomized trials on RDV were initiated. Based on trials completed and published data (n = >2000), RDV was granted emergency use authorization in the US on May 1, 2020 with full approval in 5 countries thereafter and several under review elsewhere. Collectively there will be >12,000 pts enrolled in RDV clinical programs by Dec 2020.

Increasing manufacturing of RDV began at-risk in Jan 2020. By May 2020 Gilead has decreased production time, increased supply and committed to donating all its 1.5 M doses. Under the licensing agreements with generic drug manufacturers, RDV will be available in 127 countries upon approval.

Gilead has committed to supporting research grants to enhance the understanding of the clinical course and outcomes in vulnerable population, long-term sequelae, and evaluate real world safety and effectiveness of COVID-19 therapies.

Finally, Gilead has provided corporate grants to support the efforts of community-based orgs and public health entities to expand education on COVID-19

Conclusion: Gilead has initiated a global, multifaceted rapid response that reflects the unprecedented emergency posed by SARS-CoV-2. This includes increasing RDV production, access, timely initiation of phase 3 RDV trials, and establishment of grants programs for community projects, research and education

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477. Implementing a Follow-up Call Program for Ambulatory patients with COVID-19 in a Tertiary Center in Mexico City

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Background: The Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán is a teaching hospital which was converted into a Coronavirus disease 2019 (COVID-19) designated hospital on mid-March 2020. In Mexico City, the COVID-19 peak started in mid-April 2020. A considerable proportion of those diagnosed with SARS-CoV-2 infection were treated by ambulatory care. We aimed to describe the clinical characteristics at diagnosis of ambulatory patients diagnosed with COVID-19, their willingness to donate plasma and their clinical outcomes at one month of the follow-up call program implementation.

Methods: A call strategy follow-up program (FUP) was established on April 19, 2020. All ambulatory patients received at least 3 calls every 48–72 hours, followed by 2 weekly calls. A team of voluntary medical students, general practitioners, fellows, and medical specialists was assembled for this purpose. Signs of alarm (fever >72 hours, shortness of breath, respiratory insufficiency) and other clinical signs were collected on every call. Willingness to donate plasma and possibility of a correct home isolation were also addressed.

Results: From April 19 to May 18, 2020, a total of 360 patients tested positive for SARS-CoV-2, of whom 350 were followed. Their median age was 44 years (33–51), and 55% were female. 145 (41%) had completed all FUP calls and 194 (55%) referred to be asymptomatic in their last call. We identified 8 patients with signs of alarm during the calls, and 2 of them required hospitalization. During the FUP, 66% referred fatigue that limited their activities, 56% anosmia or dysgeusia, 32% headache, and 22% diarrhea. 90% were capable to properly isolate in their homes. Willingness to donate plasma was assessed in 89 patients, of whom, 75 (84%) manifested their willingness to donate.

Conclusion: Ambulatory follow-up is feasible and effective to identify those in need of hospitalization. Remarkably, half of the ambulatory patients had no comorbidities and presented anosmia/dysgeusia as the most frequent symptoms during follow-up. Willingness to donate plasma was high in this cohort.

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478. Psychological Distress among Infectious Disease Physicians during the Response to the COVID-19 Outbreak in the Republic of Korea

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Background: This study aimed to investigate psychological distress among infectious disease (ID) physicians during the coronavirus disease (COVID-19) outbreak in the Republic of Korea.

Methods: Using an online-based survey link sent via text message and email, we conducted a survey from April 21 to 25, 2020, targeting all ID physicians currently working in ID (n = 265). The questionnaire was based on the Maslach Burnout Inventory-Human Services Survey and the Depression, Anxiety, and Stress Scales, and information was collected on factors protecting against psychological distress and difficulties in relation to COVID-19.

Results: Of 265 ID physicians, 115 (43.3%) responded, showing burnout (97, 90.4%), depression (20, 17.4%), anxiety (23, 20.0%), and stress (5, 4.3%). There were no differences in terms of distress between ID physicians who were directly involved in the care of patients with COVID-19 or not (Table 1). Greater than 50% of physicians valued their work and felt recognized by others, whereas < 10% indicated that sufficient human and financial support and private time had been provided during the outbreak. The most challenging issues concerned a lack of human resources for COVID-19 treatment or infection control, a shortage of personal protective equipment or airborne infection isolation rooms, pressure for research, and lack of guidelines for COVID-19 management (Figure 1).

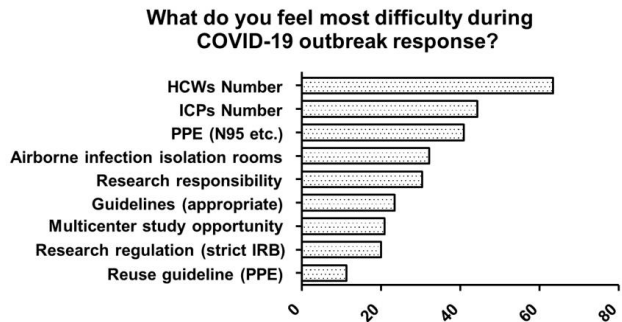
Table 1.

Table 1. Prevalence of depression, anxiety, stress, burnout and mean DASS-21/MBI-HSS scale score according to care of patients with COVID-19

Outcome	COVID-19 patient care, Yes (n = 78)		COVID-19 patient care, No (n = 37)		P-value		
	Prevalence, n (%)	Score, mean ± SD	Prevalence, n (%)	Score, mean ± SD			
DASS-21							
Depression	20 (17.4)	5.45 ± 4.16	14 (17.9)	5.58 ± 4.30	6 (16.2)	5.19 ± 3.90	0.643
Anxiety	23 (20.0)	3.88 ± 3.74	17 (21.8)	3.85 ± 3.63	6 (16.2)	3.95 ± 4.01	0.894
Stress	5 (4.3)	6.23 ± 3.86	4 (5.1)	6.21 ± 3.94	1 (2.7)	6.30 ± 3.75	0.905
MBI-HSS scale							
Emotional exhaustion	97 (84.3)	34.92 ± 10.01	68 (87.2)	35.96 ± 10.32	29 (78.4)	32.73 ± 9.25	0.108
Depersonalization	76 (66.1)	10.55 ± 5.69	51 (65.4)	10.71 ± 6.01	25 (67.6)	10.22 ± 5.01	0.669
Personal accomplishments	76 (66.1)	31.66 ± 8.18	51 (65.4)	32.21 ± 8.54	25 (67.6)	30.51 ± 7.34	0.302
Burnout	104 (90.4)	NA	71 (91.0)	NA	33 (89.2)	NA	0.774

Abbreviations: DASS-21 Depression, Anxiety, and Stress scale-21; MBI-HSS, the Maslach Burnout Inventory-Human Services Survey; NA, not available; SD, standard deviation

Figure 1. Difficulties in response to the COVID-19 outbreak. Abbreviations: COVID-19, coronavirus disease 19; HCWs, healthcare workers; ICPs, infection control practitioners; IRB, Institutional Review Board; PPE, personal protective equipment



Conclusion: During the COVID-19 outbreak in the ROK, most respondents reported psychological distress. Preparing strategies for infectious disease outbreaks that support ID physicians is essential.

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479. Mobility Restrictions and COVID-19 Pandemic Outbreak Control

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