The Response to the HIV Epidemic Provides Valuable Lessons for Treating COVID-19

Understanding the role of systemic racism in both epidemics.

October 28, 2020 By H. Dawn Fukuda, Stephen Lee and Greg Millett

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There are many parallels between the response to COVID-19 and the HIV epidemic. HIV leaders such as Anthony Fauci, MD, and Deborah Birx, MD, are playing a key role in the United States response to COVID-19, and a recent survey of health departments by NASTAD found that 91.9% of U.S. health department HIV prevention programs are detailing staff to their jurisdiction's COVID-19 response. Unfortunately, many of the mistakes that were made in the early years of the HIV epidemic are being repeated now. To truly get a handle on the COVID-19 pandemic, we need to reexamine the successes and failures of the HIV response to help lead us to better decisions today.

Perhaps the biggest misstep in the early stages of the HIV epidemic was not recognizing the role systemic racism played in the spread of the epidemic. Much like COVID-19, HIV is concentrated in communities of color. Early on, too much focus was placed on individual's behavior, such as condom use, rather than structural determinants of risk. It took longer than it should have to recognize that racial HIV-related disparities have more to do with social determinants of health (such as poverty, employment status, lack of access to health insurance/health care) than behavioral factors, and to explicitly name racism (not to mention homophobia and transphobia) as the central driver of HIV-related health inequities.

Health disparities related to COVID-19 are similarly grounded in structural inequalities.

However, we cannot address the main driver for racial disparities without naming the main problem: systemic racism. If we truly seek to learn from the mistakes we made with HIV, federal, local and community health agencies need to name racism as one of the root causes of disparate health outcomes, partner with impacted communities and community leaders, and promptly deploy interventions that prioritize the most impacted populations.

Once we were able to recognize the role systemic racism played in worsening the HIV epidemic, we were able to respond with a network of innovative policy solutions to improve outcomes for people living with HIV (PLWH). The Ryan White Care Act, AIDS Drug Assistance Programs (ADAPs),

and authorization of Syringe Service Programs (SSP) — where such programs were authorized — were foundational policy responses that had a massive impact on the HIV epidemic. Today, half of individuals living with HIV in the country receive support from the Ryan White program, and nearly three-quarters are racial/ethnic minorities. Thanks to Ryan White ADAPs, effective medications are available to PLWH across the country. Viral suppression rates for individuals in the Ryan White program are consistently high, including for Black, Latinx, Asian and non-white individuals reporting multiple races/ethnicities.

At the same time, we have known for a long time that we cannot end an epidemic with public health grant funding alone. This is true of both HIV and COVID-19. Dedicated funding from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) has been critical to HIV efforts, but must also accompany dramatic scale up of public and private insurance access. Passage of the Affordable Care Act was an incredible victory for HIV efforts, but we have much further to go to ensure universal access to comprehensive insurance coverage.

Between the early HIV prevention efforts grounded more narrowly in behavioral intervention, and the more evolved efforts grounded in policy solutions, the most significant component of the HIV response that worked well was the direct services that were supported through new and dedicated funding streams from sources like HRSA and the CDC. These services supported HIV-positive individuals to navigate a complex health care and social service system, and enabled them to successfully manage a chronic, infectious, stigmatized, and (for many at one point in time) disabling disease.

There are three important lessons from the HIV response that apply to the COVID-19 pandemic: 1) the opportunity to call out racism from the federal to the local and community levels as a primary driver of these health disparities manifested by COVID-19; 2) the value of a harm reduction approach, recognizing that every step to reduce risks of COVID-19 exposure and transmission is significant; and 3) to demand that some part of the response must deploy publicly-funded (and/or insurance reimbursed) culturally competent direct services and that these services must prioritize those with the highest level of need.

We learned from the HIV response that these prevention and health promotion services are ideally delivered by community members themselves, who represent and have credibility with those they aim to serve. We have the data that tell us where impacts of COVID-19 are most severe. Now is the time to scale up mitigation and surveillance strategies such as COVID-19 testing while also being more surgical and strategic by delivering intensive care and services to heavily affected geographic areas and populations. If there are also policy approaches that can support this methodology, even better.

HIV is still with us today, and many of us continue in the fight to End the HIV Epidemic and reduce HIV-related health disparities. COVID-19 may also be with us for many years to come, and it will be the foundations we build today that will determine our ability to overcome this pandemic, and to ensure that no one is left behind.

This opinion was written by H. Dawn Fukuda, a member of the NASTAD board of directors, Stephen Lee, MD, executive director of NASTAD, and Greg Millett, vice president and director of public policy at amfAR, The Foundation for AIDS Research.

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