



Independent observer  
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## AS THE WORLD SHUTS DOWN DUE TO COVID-19

On 27 December 2019, a doctor in Hubei province in China noticed four unusual cases of pneumonia, three from the same family. He notified the local Centres for Disease Control the following day. In short order, all the relevant Chinese authorities and the World Health Organization were informed. The retrovirus causing the disease was identified in early January. By January 13, the first test kits were available. China began shutting down cities, placing people in mandatory quarantine, and banning travel. By March 16, the country had 81,020 reported cases. (All the figures in this article, unless otherwise stated, are taken from the Johns Hopkins Covida website: [coronavirus.jhu.edu/map.html](https://coronavirus.jhu.edu/map.html), on 16 March 2020. The website is constantly updated.) It is instructive that there have been 67,798 confirmed cases in Hubei; 3,099 deaths and 55,094 people who have recovered. There are relatively few new cases being reported from China in mid-March (a total of 29 in China on March 16, compared to 13,784 in the rest of the world, according to WHO). The focus of the epidemic then moved westwards, first to Iran with (as of March 18) over 16,000 cases, then Italy with more than 31,000 cases. The epidemic has taken hold across the western world and North America with the number of cases ranging from 596 in Canada to 11,826 in Spain. The situation is fluid and the number of cases continues to climb. Central and South America generally report fewer cases and the region is probably some weeks behind the rest of west. The data from sub-Saharan Africa are a puzzle. The Lancet published a comment on February 27 warning of the “Looming threat of COVID-19 infection in Africa: act collectively, and fast”. It suggested “Because of the high volume of air traffic and trade between China and Africa, Africa is at a high risk for the introduction and spread of the novel coronavirus”. This does not seem to have materialised to date. At the moment the largest African COVID-19 epidemic is in Egypt, with ‘only’ 196 cases, followed by South Africa, with 85 reported cases; next comes Algeria, with 60 cases, followed by Senegal, with 26 reported cases. At the time of writing all other African countries that report cases had fewer than 10 cases each, and a number had none. Why is this? Possible answers are: The continent and countries are behind in terms of the spread of the epidemic and cases have not developed; There is a failure to report cases, especially since many countries have weak health-care systems, inadequate surveillance and little

laboratory capacity as well as limited public health infrastructure; Conditions in parts of Africa are less conducive to the spread of the epidemic, for example, it may not spread as easily in hot environments. What does this have to do with HIV and AIDS? Both COVID-19 and AIDS are caused by retroviruses. The diseases spread into the human population through zoonotic transmission: chimpanzees and sooty mangabey monkeys in the case of AIDS, and probably bats to pangolins to humans in the case of COVID-19. In both instances the animals were a food source, and transmission probably took place in markets. The first cases of AIDS were seen in 1981 but the virus was only identified in 1983. It spread across the world with alarming speed. It was not until 1996 that the first effective medical treatments were developed. In the past 40 years there has been much progress. People who are infected can, if they obtain and are adherent to drugs, live normal lives. Prevention remains a challenge. However, the world knows how transmission occurs and how it can be prevented. Key populations can be identified, and the interventions targeted. Although there is still no vaccine or cure, the scientific response to AIDS, especially in virology and immunology, was rapid. This laid some groundwork for the knowledge about and response to COVID-19. There are, however, significant differences. The first is in transmission: HIV is not easily transmitted; it must be introduced through body fluids into a person's body. The main modes of transmission are unprotected sexual intercourse, contaminated blood or blood products, and breast feeding. The use of drugs for AIDS treatment are effective at preventing transmission. COVID-19 is far more infectious and is spread through coughing, sneezing and transfer of the virus from surfaces, mostly via hands-to-face, into a patient. The advances in epidemiology have been valuable in informing the global response and bringing the COVID-19 outbreak under control in some parts of the world (as now seems to be the case in China, South Korea, Taiwan and Singapore). The Chinese authorities decided the most appropriate response was to shut down Wuhan city. The restrictions on movement were extended across the country through a mandatory national holiday which effectively prevented people from travelling. There was extensive contact tracing. The second difference: HIV takes years to develop into AIDS. COVID-19 has a short incubation period, generally less than two weeks. Most of those infected will experience few symptoms and may not even know they were affected (though could still have been infectious and unknowingly transmitted the virus to others). The severity of the epidemic increases with the age of those infected. The Chinese CDC reported 2.3% of all the people with confirmed cases of COVID-19 in China died. The fatality rate rose to 14.8% in people over 80; the fatality rate was 1.3% in the 50- to 60-year-old cohort; 0.4% in 40-year olds; 0.2% in the 10- to 39-year-olds; and negligible for children under 10. (Sharon Begley, 'Who is getting sick, and how sick? A breakdown of coronavirus risk by demographic factors', Statnews <https://www.statnews.com/2020/03/03/who-is-getting-sick-and-how-sick-a-breakdown-of-coronavirus-risk-by-demographic-factors> accessed 16th March 2020) It seems the reason older people are more likely to fall ill, require medical interventions and die is due to co-morbidities. Put simply, this is the presence of other diseases, a weaker immune system, or simply worse overall health (and in China perhaps the high prevalence of smoking). The diseases associated with these co-morbidities that are mentioned in the literature to date are mainly non-communicable. They include hypertension, diabetes, respiratory system disease, and cardiovascular disease. (Yang J, Zheng Y, Gou X, Pu K, Chen Z, Guo Q, Ji R, Wang H, Wang Y, Zhou Y, Prevalence of comorbidities in the novel Wuhan coronavirus (COVID-19) infection: a systematic review and meta-analysis, *International Journal of Infectious Diseases* (2020), doi: <https://doi.org/10.1016/j.ijid.2020.03.017> accessed 16th March 2020.) The issue of HIV and COVID-19 co-morbidity has received little attention to date. This is because we have not yet seen significant cases in places with a high HIV burden. There has been only one set of guidance disseminated on this, from the Southern African HIV Clinicians' Society, which says: "At the moment, very little is known about the interaction between HIV and COVID-19. Nonetheless, some reasonable assumptions based on experience with other infections, such as influenza, can be made with regard to immune-suppressed individuals." (This should be available on their website, <https://sahivsoc.org>) Essentially their advice is that HIV-infected people who are on treatment probably should not worry. The greatest concern must be for those who are HIV positive and not on treatment, especially those with TB. They and their health-care providers should focus on getting people tested and on treatment. More research and thinking needs to be done on this. There is very little further information at this stage. Aidspan will monitor this and ensure we provide updates on the status of the COVID-19 epidemic in areas where HIV is a concern and on possible

interactions. On March 4, the Global Fund released a guidance note in response to COVID-19: “Working within its mandate to fight HIV, TB and malaria and to strengthen systems for health, the Global Fund is encouraging countries to reprogram savings from existing grants and to redeploy underutilized resources to mitigate the potential negative consequences of COVID-19 on health and health systems. In exceptional cases, countries may be able to reprogram funding from existing grants to COVID-19 response.” (<https://www.theglobalfund.org/en/news/2020-03-04-global-fund-issues-new-guidance-in-response-to-covid-19/>) Peter Sands, the Global Fund’s Executive Director, said that the Fund is committed to a pragmatic and flexible approach in supporting countries. Quite how this will fit with the mission of ending HIV, TB and malaria is unclear. As the South African guidance notes, getting HIV-positive people on treatment for HIV is in itself protection against COVID-19. This is a rapidly evolving situation of great global concern. Alan Whiteside OBE, DEcon, is an academic and a member of the AIDSPAN board, with 30 years’ experience working in the field of HIV and AIDS.

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