Eurasian Women's Network on AIDS

Women, HIV and COVID-19

in Countries of Eastern Europe and Central Asia

How COVID-19 affects women living with HIV and those vulnerable to HIV in countries of EECA

Report on the results of the women- and community-led research in 10 countries of Eastern Europe and Central Asia

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LIST OF ABBREVIATIONS USED ACRONYMS

ART – Antiretroviral therapy
EECA – Eastern Europe and Central Asia
EWNA – Eurasian Women's Network on AIDS
OST – Opioid substitution therapy
STI – Sexually transmitted infections
LBT – Lesbians, (female) Bisexuals, Trans* women
SRH – Sexual and Reproductive Health

INTRODUCTION

The COVID-19 pandemic is bringing destructive social and economic consequences all around the world.

At the time of launching this research, various evaluations of the pandemic's impact on public health care systems, social and legal support, on diverse groups of people, including those using a gender-based approach, had been conducted. These studies were conducted by United Nations agencies and donors and by civil society [1].

In its paper "Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic", published in June 2020, UNAIDS emphasizes that the most marginalized populations are hardest hit by stark gendered disparities. Women and girls are at heightened risk of domestic violence, inadequate access to essential health care (both before and during the pandemic), COVID-19-related punishment, economic insecurity, and the imposition of unpaid and unrecognized care work. Combine this with the stigma and intersectional discrimination that marginalized women and girls already face, and we can see that women and girls are undeniably being "left behind" [2]. Their only support are activists from community-led organizations.

Just as the HIV epidemic reflects blatant social inequality and injustice, the problems uncovered by the COVID-19 epidemic will only intensify, unless we take decisive steps to protects the rights of women and girls in all their diversity, providing them with access to health care services, education, protection from violence, and also to social, economic and psychological support.

This study is unique as it was organized and conducted using the resources of the women's community and is clearly focused on the marginalized women in Eastern Europe and Central Asia (EECA), including women who live with HIV, women who use drugs, sex workers and lesbian, bisexual and trans* women, referred to as key populations.

METHODOLOGY

The objective of this study is researching the influence of the COVID-19 pandemic, quarantine measures, self-isolation and other limitations that affect the access of women living with HIV, and women from the key populations in EECA countries to services for the protection of sexual and reproductive health, the realization of rights and freedoms, HIV treatment and prevention and protection from gender-based violence.

The research group, led by the Eurasian Women's AIDS network and composed of women experts from the communities, posed the following questions:

- For women from key populations, how did the pandemic impact the provision of services for the protection of sexual and reproductive health and rights (SRHR), for the treatment of HIV and protection from violence?
- How do vulnerability factors that are specific for women from the key populations manifest themselves in the context of the epidemic, and what is their impact on the quality of life and health of women in the COVID-19 situation?
- How does the COVID-19 pandemic and the restrictions related to the pandemic impact the development and sustainability of women's organizations?

An important feature of the study was the use of a “community-led” approach. The key role of the community of women living with HIV and women from key populations was ensured at all stages of the research organization, methodology development, its implementation, its interpretation and analysis of interviews, validation of results and the elaboration of recommendations.

The research was conducted using the method of expert semi-structured expert interviews among community leaders representing service and advocacy organizations in the field of HIV.

The research was conducted in ten EECA countries: Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Uzbekistan and Ukraine. Five respondents from several cities from each country were recruited, including EWNA country representatives and representatives of local women's networks/organizations, including service organizations. The selection and invitation of participants was carried out through the EWNA coordinators, taking into account the following inclusion criteria:

- Women living in the target countries of the study.
- Membership in EWNA, or affiliated with a national/local network, organization or group of women living with HIV/from key populations.
- Competence in health and rights of women living with HIV /vulnerable to HIV, including access to services protecting sexual and reproductive health and rights, HIV treatment and protection against gender-based violence.
- Knowledge of the current situation with the limitations caused by COVID-19 and their impact on access to services for women from the key populations.

The research team developed an interview guide with a sample list of questions (see Annex 1). The participants received preliminary questions prior to the interview, so that they could prepare and gather the necessary information.

In total, from June to August of 2020, 50 interviews were conducted with representatives of 50 organizations and community-led groups. All interviews were conducted online, were recorded on a dictaphone and completely transcribed, after which a thematic content analysis was carried out on the basis of the transcripts. Documented case studies and key citations were used to describe trends in access to HIV prevention and treatment services, SRHR and protection from violence, the vulnerabilities of women with HIV and from key populations, and the development, sustainability and resilience of women's networks in the context of the COVID-19 epidemic.

When conducting the study, priority was accorded to the safety of its participants and to data confidentiality. The names of the participants are mentioned only with their consent; the report does not contain information that could indicate the source of information. All safety rules and confidentiality requirements were detailed in the “Information for Participants” and “Informed Consent Form”, which all participants received and signed prior to the conduct of the study.

Distribution of respondents by groups:

Representatives of key groups of women who participated in the study:

*Women living with HIV – **37** women*

*Women who use drugs – **11** women*

*Sex workers – **6** women, including **1** trans* woman*

*ЛLBT women – **3** women, including **2** trans* women*

*Experts, activists – **4** women*

"We're just lucky it's summer."

FOOD AND SHELTER

Many women from key populations who were living under the poverty line even before the pandemic, found themselves left without a livelihood after the introduction of the quarantine measures. Respondents from each country described how they could not provide basic needs for themselves and for their children. Many faced a lack of money even to buy food:

"People are starving here. Many became unemployed. There's not enough money for bread. The quarantine is still continuing, the situation is getting worse and worse". Georgia

"A girl calls in and cries, she has two children, no money, nothing to feed the children". Kazakhstan

"I felt affronted for those women, I am one of them. This outrage is for the fact that a woman cannot feed her kids, to provide them with a roof over their heads. We are just lucky that the summer is warm". Kyrgyzstan

The most affected group is migrant women, including those living with HIV, for whom hunger also means the inability to take ARV therapy:

"We quit therapy, we just quit. The consultants couldn't find them". Kyrgyzstan

"We have many women who came from the zone of military conflict. Food is number one . Health was the last thing on their mind". Ukraine

Another serious problem was the inability to pay for housing:

"Many people were left completely homeless. If you don't pay for the apartment – go outside. The Baptist church provided us with four rooms for migrant sex workers, who got stuck in our country because of COVID". Georgia

"People were left without earnings, without money. If you are a tenant, you could have just been evicted. Nowhere to go". Kazakhstan

"One woman has five children, no husband. She got evicted from her rented apartment. She moved to a grove with her children. Neighbours feed her and her children". Kyrgyzstan

Women respondents from Kazakhstan, Kyrgyzstan and Russia describe the housing situation faced by sex workers and transgender women as follows:

"The girls lost their income, now they have all moved out of their rented apartments, because they have nothing to pay with. And they moved, for example, to a one-room apartment for five to six girls. And those five girls had two children. They live in this apartment, and they provide sex services there". Kazakhstan

"We have a district of the Osh market. There are many private houses converted into hotels. And in such hotels, sex workers also work, and the owners, of course, closed the hotels. They left a small room for those sex workers who could not move out. And they put their children to sleep in this room.

The weather was still quite cold when the state of emergency was introduced. And they themselves stayed on the street, in the courtyards of those houses, spending nights in barns. People survived as they could". Kyrgyzstan

"Naturally, trans-women were under attack, because in our country our trans women are engaged in sex work. They live in rented apartments, and they rent them on a day-by-day basis, so, generally speaking, some of those people were left without a roof over their heads".* Kyrgyzstan

"They donated money to us, we bought food, we put together food parcels for both sex workers and transgender sex workers, and for just transgender people who found themselves in Russia and just cannot leave". Russia

Community-led organizations everywhere have responded to emergencies, when women were unable to provide basic life needs, even if they did not provide such services before the pandemic.

"We found those left without a livelihood. We found those who were kicked out. That is, if she does not pay the rent – she is evicted. We were finding the people at the very bottom, the ones with huge problems". Tajikistan

"We, as an organization, provided social support on our own behalf. We had discussions and took in those women who need something. Those who rent an apartment, who are out of work, who cannot pay for communication services, for all kinds of things". Armenia

"Now, we're able to buy flour, butter, medicines, refer them to a doctor, to a gynaecologist, to a surgeon. All in all, we help all women who survived severe violence. We brought food for the children". Georgia

"We were ready to stay connected, we worked very quickly. It's clear that the priority support, the first request is for food. What advocacy? We do not need your webinars or any educational and entertainment events, we are hungry, we have nothing to eat. We have no masks, no antiseptics, we have nowhere to live". Kyrgyzstan

However, often the help of the community is personal help, "heart to heart" succour.
"A lot of women called and had requests. The situation was such that I divided my grocery bags, which they brought to me, and shared them with other women. There was no baby food. The city AIDS centre was giving it out, but not to everyone, there was not enough, there was a shortage. I had a bit of money saved up, so I went to the market to buy infant formula. I helped on my own account". Kyrgyzstan

EMPLOYMENT

The main reason for a sharp decline in socioeconomic status is the loss of jobs – both in the formal and informal sectors of the economy. The problem with employment affected both men and women, but the latter to a greater extent, as in the EECA region, they are responsible for all the burden of caring for children and housework:

"There were problems because many lost their jobs and they had no financial support. Work is generally a problem in Georgia even normally, and during the quarantine, the chances of finding a job are almost zero". Georgia

"Someone lost their job, some began spending more time at home, some tried not to send their children to educational institutions, to kindergartens. Children stayed at home for a long time. Because of this, many women could not work". Belarus

"And women complained a lot, especially if they had small children, they had to work at night, too. They were very stressed. They had to cook, to take care of sick family members. And still they had to earn their living". Ukraine

For women survivors of violence, the job loss situation also carries the risk of returning to a situation of violent situation:

"Our women, who have survived domestic violence, work in places where they receive piece-rate pay. If they lose their job, they lose their means of livelihood. There is also a risk that they will not be able to support their children, and will be forced to return to the abuser in the house". Armenia

Women affected by TB, women who returned from prison, women who use drugs – each of these groups had their own reasons long before the start of the pandemic, reasons why they could not officially get a job.

"Women affected by tuberculosis – even before, they couldn't find a job because of the constraint imposed by their disease. And people with dependence too. These are the groups that have suffered the most from the categories we work with". Belarus

"Many women here work unofficially. Most of them are women, who were released from prisons. Even those who have not been released now, but 2-3 years ago -- they still think, 'I am a bad person, I am worse than others. Who will hire me'? And they are cleaners, they work at construction sites, moving bricks". Russia

As mentioned before, the most difficult situation concerns sex workers and trans women employed in sex work.

"There's no work. Here we sit idle. Trans migrants, like most migrants, were left without work both in Russia and in Tajikistan. Sex workers simply do not have any work. Because of the virus clients have disappeared". Tajikistan

"The girls who worked on the highway by themselves are still working, but only a few remained there, and they work with great caution. Therefore, they, of course, suffered greatly during this quarantine". Ukraine

GOVERNMENTAL SOCIAL PROTECTION AND BARRIERS IN RECEIVING IT

State social assistance in EECA countries at the beginning of the pandemic was awarded to only a few categories of citizens. Large families, persons with disabilities and pensioners are traditional categories of the population for the social protection system in the region.

In Georgia, Kazakhstan, Russia and Ukraine, citizens who have lost their jobs and who have officially registered at the unemployment office could also count on receiving financial assistance from the government due to quarantine measures. Women living with HIV, women without children from key populations were not included in the category of those in need of government assistance.

"Everywhere, it was communicated and stated that social support will be provided to poor families, persons with disabilities and single pensioners. This group of people was the priority. I applied, submitted the lists of our women. There were more than 30 people there. No one got anything from the government". Kyrgyzstan

"For example, if parents, or one of the parents has lost their job, the government helps them to somehow support their children. The LGBT community is not on this list at all. Of course, there were no programmes for them". Armenia

"Women from our target groups are not on the lists of people in need of government social protection, especially during an emergency. Even before, they were thrown out of all programmes. We want to reach the decision-makers, so that our women who have less than five children, are also included on the list of recipients of these benefits. And in general, so that our women have programmes close to their real needs". Kazakhstan

The lack of a legal sex work system has resulted in sex workers being unable to receive benefits:

"Sex work is in fact an illegal activity, so seniority is absent. They don't receive any kind of assistance at all. To get registered at the unemployment office is difficult, to show earnings, in fact everything associated with documents, registration of permanent residence, documents for children... It has a snowball effect". Ukraine

Even if a woman had formal grounds to apply for payments, she would have to surmount numerous bureaucratic impediments, which are especially hard for women from vulnerable groups:

"You need to have an ID, which many do not have. Our people are not registered and go around without documents. They still have the red Soviet Union passports". Kazakhstan

"Government support was for those who are registered with the employment service. But as it turns out, not everyone has e-mail. None of this was available in paper format". Russia

Separately, the barriers associated with the digital divide should be highlighted. Many women from the key populations lack not only the skills required to register in government support systems, but also have no computers, cell phones or Internet access.

The digital divide affects not only access to social assistance among those who need it most, but also prevents women from gaining community support in quarantine and self-isolation:

"They don't know how to ask for help. Women simply don't have a telephone, they don't have the Internet. People don't even have a TV set at home, speaking about the poverty level". Uzbekistan

"What kind of online support are we talking about? It's not always a given that they have money on their phone even to make a call". Ukraine

Community organizations and civil society activists have personally supported women living with HIV and women from key populations to overcome these barriers, and have provided computers with Internet access, helped them to register and to learn how to use electronic systems.

"We helped so many to get help from the government. For example, some had no registration, no documents – we organized all that". Armenia

"I got people together to write applications and to somehow fight for their rights. Two or three, out of all of those I provided with consultations, received help, the rest received nothing". Uzbekistan

The amount of governmental support to the eligible categories of the population varied in EECA countries. At the same time, the amount of assistance was minimal, or there was no such assistance at all. For example, in Tajikistan, the government did not provide financial support to the population at all, while in Russia families with children could receive payments of about US$120 for each child.

"They paid out about US$60-70 a month. It's a tiny amount." Georgia

"We had payments twice, somewhere around US$100 – in March and April, and in May, the quarantine was lifted. The government did not provide any assistance for housing". Kazakhstan

"At first, the government provided financial assistance, but very little. Later, the government committed to paying for gas, electricity, but only for one month – for March". Armenia

"There was a government decree that low-incomes families would be paid about US$15 per quarter". Tajikistan

Thus, this support was negligible because of its small amounts, bureaucratic barriers and the very fact that women from key populations were not a priority.

"People realized once again that they are not protected at all, that when they find themselves in such a situation, they cannot count on the government. Both those who were employed officially and those who were employed unofficially, and also those who did not work at all. And it turned out that everyone had one and the same question: What should we do?" Moldova

HIV PREVENTION

IN THE PANDEMIC

"She was fined for violating an emergency situation – syringes had to be given out, but it was forbidden."

HARM REDUCTION AND PREVENTION AMONG SEX WORKERS

With the introduction of the quarantine measures in EECA countries, HIV prevention for key populations became a low priority. In Kazakhstan, the work of friendly offices in the AIDS centres was suspended.

For example, some women reported that ARV drugs were dispensed for people living with HIV on the street near the AIDS centre, and the clinic doors were closed for sex workers and women who use drugs, both literally and figuratively.

In Georgia, the number of services provided by NGOs has decreased. For example, sex workers were only able to get tested for HIV and receive one condom per week.

In the capital of Kyrgyzstan, Bishkek, a laboratory with which an NGO had established cooperation, was closed down and sex workers were no longer able to get tested for STIs.

"Everyone switched over to more important issues, to everything related to the coronavirus. Even HIV became a low priority for the government". Ukraine

The NGOs that implement harm reduction programmes had to reorganize their work in order to maintain contact with clients who, in a pandemic and lockdown situation, needed syringes, condoms and testing no less than before. Low-threshold prevention programmes for women from vulnerable groups have been the only way to access health care for many years.

"Many sex workers do not have access anyway, because they are not assigned to family doctor groups. We have a mandatory residence registration, and basically all of them get medical care through us". Kyrgyzstan

In Ukraine, the health-care system is organized differently, but this does not negate the importance of low-threshold programmes in a pandemic:

"Condoms, therapy, consultations and suppo*rt are needed. That is, it is necessary not to forget, not to shift the emphasis, but to keep and introduce some access, to change approaches in the provision of services. The needs remain and they are growing."* Ukraine.

After the introduction of the lockdown, the work format also changed. For example, in Kramatorsk, Ukraine, the work was moved from fixed-site harm reduction points onto the streets, and in Temirtau, Kazakhstan, street outreach work was banned, and contact with clients was conducted mainly online, or via a specially organized hotline during quarantine, as in Tajikistan.

"We organized a telephone hotline for sex workers, where they were able to get a consultation not only about COVID-related issues, but also about STI. Many had to self-medicate. We tried our best to ensure that women have enough condoms. This was the only thing we could do". Tajikistan

"During the state of emergency, we could only distribute condoms to sex workers, and to conduct online counselling by phone, or online on social networks". Kyrgyzstan

To get permission to continue working in the context of the pandemic, community-led organizations sought

to communicate with the authorities directly, and to explain how important it is not to interrupt the provision of HIV prevention services. In Kazakhstan and Ukraine, such permits were obtained, although this required considerable efforts on the part of community-led organizations. However, an outreach worker in other settings was fined:

"We made special passes for our employees, so that they could move around the city and outside the city, as it was possible only if you carried one". Ukraine

"We had a disciplinary meeting for one of our outreach workers. She was fined for violating the emergency situation – she had to hand out syringes, but it was forbidden". Moldova

The integration of COVID-19 prevention services into HIV services in many cities happened with lightning speed, even though community-led organizations initially did not receive any government support. The reason of this integration is flexibility, informal approaches to problem-solving and the use of internal resources of the community:

"Outreach workers had neither masks nor antiseptics. Girls and women who live in my centre, were sewing masks, and we were giving them out to the people who use drugs". Kazakhstan

"We provided disinfectants and masks to our employees in sufficient quantity, and also provided masks for our clients. We restructured some project budgets to provide direct humanitarian aid for women with children and for women who found themselves in a precarious situation". Ukraine

ACCESS TO OPIOID SUBSTITUTION TREATMENT (OST)

With the onset of the epidemic, the clients of the opioid substitution treatment (OST) programmes faced enormous difficulties in receiving OST medication, mainly methadone.

The reason for these difficulties is in how the OST programmes were initially organized in the EECA countries: from the very start of the programmes' implementation, the condition was set that clients should receive methadone daily, personally visiting the OST point at the state narcological (drug treatment) clinic, in some cases – at the AIDS centre.

The negative impact of this approach, which runs counter to global practice, on the socioeconomic situation of women and on their access to other types of medical care, was repeatedly documented by community-led organizations over the last decade. The documented cases formed the basis for complaints about human rights violations to international committees [3]

Demands to allow the distribution of OST medication for so-called "stable clients" have been repeatedly voiced by the community in almost all EECA countries, where such programmes are implemented. However, only in Moldova and Ukraine has this been discussed at the government level in the last few years.
The lockdown situation exacerbated this problem, and it became obvious that it was impossible to implement OST programmes without the permission to dispense the medication for several days. This situation, to some extent, served as the catalyst for resolving this issue, yet not immediately and universally, and not to the extent that it would meet the needs of women who use drugs.

The situation was most pressing in Temirtau, Kazakhstan, where due to the coronavirus pandemic, OST clients were transferred to an OST site point in another city:

"During the time of COVID-19, the narcological clinic building was repurposed for patients who are suspected to have the virus, and for the people who are on substitution therapy, they opened an OST office in the city of Karaganda. Every morning people had to travel 20 kms to take the medication. Many are tired of travelling, some even want to drop out of the programme altogether". Kazakhstan

Another participant in the study from Almaty also mentions repeated attempts by the community to solve the problem with access to OST and the government's inaction in this matter:

"And they wrote a bunch of letters, and they engaged UNAIDS and UNODC, everyone they could. UNAIDS wrote to the President to somehow resolve this situation. We didn't succeed". Kazakhstan.

In Belarus, no formal lockdown measures were introduced, and there were no formal grounds for at least a temporary permission to issue the medication for several days. At the same time, because the authorities did not want to recognize the problem with the coronavirus infection, both the general population and participants in the OST programme lived in an information vacuum regarding the incidence of the infection, health risks and whether seeking help in connection with the coronavirus would not entail restrictions in rights. In Belarus (as in many other EECA countries), the issue with dispensing medications to OST clients who are in infectious disease wards or are hospitalized due to other somatic problems, has not yet been resolved.

"Even if people have some COVID symptoms, but they are on a methadone programme, they will never report that they are sick. They understand that no one will bring methadone to their homes. In our location, methadone is not dispensed for a week, it is provided only based on daily visits. We do not yet have a tablet form". Belarus

In Georgia, Kyrgyzstan, Moldova and Ukraine, it was possible to get the medication for several days. This was done as a result of the community's persistent demands from the outset of the pandemic, preceded by years of advocacy for changes to the national substitution therapy protocols.

"*Despite the fact that the substitution therapy programmes have been working in Ukraine for a long time and function smoothly, the quarantine has shown that the attitude of doctors and narcologists is still quite specific. And it was very hard to obtain permission to receive the medication for at least 3-5-7 days".* Ukraine

In Georgia, a wave of overdoses preceded the adoption of regulations to allow dispensing OST medications for several days:

"When the pandemic started, there were overdoses. At first, there were problems with dispensing the medication "on hand" and people had withdrawal symptoms. It took a week to settle the issue". Georgia

But the provision of OST medication for several days for "stable patients" did not resolve all the problems. Firstly, the female clients who recently started the treatment or were classified as "unstable" by the medical staff were forced to come to the OST sites daily, being exposed to both the risk of being infected with the coronavirus infection and the risk of being detained by the police for violation of the self-isolation regime.

"The work was not organized very well. A decision was taken that those who are stable should be given methadone for five days. But it turned out that out of 39 clients, only 10 were issued for five days. And this creates conditions for infection, for non-compliance with sanitary and quarantine measures". Kyrgyzstan

Violation of the confidentiality OST clients' personal data is one of the most serious problems caused by introduction of quarantine measures. Again, not doctors, but the community-led organizations came to help clients to communicate with the police officers and checkpoints:

"It was very difficult at first. We contacted checkpoints when women were stopped. They wrote a note when they left the house that they were receiving methadone. Patients sometimes contacted us. We contacted the police explaining how vital it is, and that a person cannot miss therapy". Armenia

In Armenia, Georgia and Ukraine some OST clients pay for the treatment, because the number of places funded by the government or by the Global Fund programmes is limited. In some cases, the clients go to paid OST programmes because of the better quality of services, or because this way one can avoid being officially registered in the state narcological clinic. In an epidemic, the community organizations (not social services) tried to find funds to pay for their treatment:

"In our country, free methadone is available only for 500 individuals. Many people who were in a paid programme were unable to pay. We wrote to the donor to get permission to pay for the two-month course, so that these people would not be left without treatment". Armenia

In many cities of EECA countries, public transportation did not work for several weeks. The only means of city transportation left was by taxi – a financially inaccessible means of transport for women from vulnerable groups. Moving around the city was also difficult due to the lack of passes for women who use drugs:

"Women on substitution also walked. The prices for taxi were very high. For example, my colleague who receives substitution therapy had to go back and forth, had to go to get therapy every five days. Where is she supposed to get the money?". Ukraine

"Everyone tried to get there by whatever means they had. Some walked, some hitchhiked. Many were stopped, interrogated, many, it so happened, were taken away, but then released". Kyrgyzstan

"One substitution therapy patient had a small baby. It took her half a day to get to the OST site. This is a problem – leaving the child for half a day with someone, two to three hours for getting there and back. It was an ordeal". Kazakhstan

But getting to the OST site does not mean getting their medication.

"They gave out methadone for a week, for five days, and after five days they came again. Let's say, if they used to come at eight in the morning, take the medication and leave, then during the quarantine, OST was delivered at 11:00, and the point itself is open until 13:00. That is why there was pandemonium at the substitution therapy points". Kyrgyzstan

At the time of writing this report, substitution therapy programmes were still working in EECA countries, despite the complications in accessibility and barriers that the women had to overcome. Recruiting new clients to the programmes was suspended, and the quality of OST, already low in countries in the subregion, deteriorated.

"The substitution therapy programme somewhat lost its meaning. It is supposed to help to get back into society, and here somehow it was such a disaster". Kazakhstan

IMPACT OF THE PANDEMIC

ON ACCESS TO HIV TREATMENT

"Sorry, but where did the AIDS centre move to?"

The first reaction of many women living with HIV to the quarantine was panic over the lack of information from the AIDS centres about how access to HIV treatment would be organized during the COVID-19 pandemic.

> *"Panic. Everyone has the same situation, everyone in unison: 'what will happen if we cannot take the therapy?' I myself had a fit of panic. I was also pregnant at the time. I felt so lost".* Uzbekistan

As it turned out, this panic was not unfounded, as the analysis of the interviews showed that in all EECA countries the pandemic led to certain disruptions in the operation of the AIDS centres, interruptions in the supply of ARVs, and the clients had difficulties in accessing the places dispensing therapy and diagnostics.

WORK OF THE AIDS CENTRES DURING THE PANDEMIC

The introduction of measures focused on countering the COVID-19 pandemic has affected the work of many AIDS centres in the EECA countries.

In Kaliningrad, Russia, AIDS centres were repurposed "for COVID-19". In other cities, for example, in Novosibirsk, AIDS centres were closed, among other reasons, because infectious disease specialists of AIDS centres provided assistance to patients with the coronavirus infection on the basis of other medical institutions, or the number of specialists who see patients got reduced, as it happened in Samara.

> *"They closed the HIV departments, giving as a reason that they could not risk lives of HIV-positive people with weakened immune systems close to COVID. But we saw that these people with a weakened immune system and HIV infection can easily get infected in normal hospitals. Therefore, the closure of the department did not really help to isolate our patients from COVID".* Russia

In Yerevan, Armenia, the AIDS centre continued to operate, but was repurposed into a hospital unit, where women with HIV were referred for in-patient treatment before the outbreak of the pandemic.

> *"We have two hospitals in our country, infectious and multidisciplinary. All HIV positive people were sent to these institutions. But due to the quarantine, the hospitals were repurposed, and now they only accept patients with COVID. Our beneficiaries were simply left on the streets. And we had to look for other options for them".* Armenia

The situation with closing of AIDS centres and the reduction of their services needs to be viewed in the context of the narrow specialization approach in organizing HIV treatment in EECA countries.

AIDS centres are the main, and, often, the only place where HIV positive people can get ARV medication and have CD4 count and viral load tests to monitor treatment.

Thus, the closing of an AIDS centre or a sharp reduction in staffing leads to the risk of interrupted treatment on a citywide scale, or even an entire region and country.

Organizations that work in the sphere of HIV work closely with AIDS centres to support access and quality of the treatment, but not replacing their function of organizing the treatment process.

"Now, the country has one AIDS centre in Yerevan. The people who live outside of Yerevan, all of them are registered in the AIDS centre and they all receive medications, tests, everything, everything, everything. After the roads were closed and it was impossible to move, they had problems with accessing treatment". Armenia

"We have only one AIDS centre for the entire republic. We talked about decentralization before the pandemic. That every person should have a choice as to where to receive those medications. At a prescription pharmacy or at a local health centre. So that they have everything close by". Moldova

Even if the AIDS centres formally continued to operate, changes in their mode of operation and associated restrictions in access to treatment for women living with HIV caused by this were noted by survey participants everywhere. In some places, AIDS centres were physically relocated to another place during the pandemic, and in some places, they tried to change the work format with patients from face-to-face visits to telephone consultations, and to divide the time of reception between "urgent" and "non-urgent" cases.

"Now, it is a totally different area of the city. And not everyone can get there, get information, advice, as the centre is very difficult to find". Moldova

"The AIDS centre has been redesigned for the most part to work over the phone and to dispense medications". Russia

"In the beginning, people came by taxi, they stood near the AIDS centre, and they were given the medications. And only those who, at the doctors' discretion, required examination, were admitted to the centre for examination by an infectious disease specialist on the condition of wearing gloves and masks. If someone had a temperature over 37, they were not admitted". Ukraine

In Belarus, where no formal lockdown was introduced, the changes were similar to those in other countries of the region, and in some cities, women living with HIV experienced difficulties in receiving therapy:

"Unofficially, access to medical facilities was restricted. Our office for consulting and diagnostics for people living with HIV was even moved. It was removed from the infectious diseases hospital and transferred to the clinic". Belarus

In Russia, where self-isolation was officially introduced, women with HIV also received conflicting signals from the health-care system:

"Women with children were advised by the local doctor not to go anywhere if they don't need to. As a result, later in the AIDS centre they were met rather coldly by the doctors, since they had to take blood samples from the child". Russia

In terms of access to the services of AIDS centres during the pandemic, diagnostics have suffered the most.

"In our AIDS centre, services were greatly reduced. Before, we did testing every four months, and monitored our health. And now every six months. Previously we had CT scans, X-rays, and other things at the expense of the Global Fund money, but now this option doesn't exist, we need to pay for it". Georgia

"CD4 count, viral load was not even tested in this period. We were told that there are CD4 count tests, but that we should limit visits to the AIDS centre". Kazakhstan

"We didn't have diagnostics for this period either. Only now branches are starting to open s. Yet, you still cannot get a viral load test". Belarus

"The diagnostics has stopped altogether. Our laboratory, which was for viral load tests, has been converted into a COVID laboratory". Moldova

ACCESSIBILITY OF PUBLIC TRANSPORT AND DELIVERY OF ARVS

The main obstacle for receiving ARV medication was the lack of transport, both for women living with HIV from remote areas and within large cities.

"Throughout April, we had very strict travel restrictions. People were physically unable to get to the AIDS centre". Russia

"People of our community, they mainly live outside of Yerevan. And even if they live in Yerevan, only taxis were working. And not everyone can afford a taxi to get the medication at the only AIDS centre we have". Armenia

"The risks of interrupting the treatment were great, some people couldn't get there, they had no money for a taxi". Ukraine

In Uzbekistan, an HIV-positive woman with cancer walked 22 kilometres to receive ARV treatment. This is how the study's participant describes this situation:

"It is not easy to walk 22 kilometres in our heat. I think she was very, well, very committed. I felt pain at that moment, because I could not help her. It was sad that a person found themselves in such a situation living in a city. I'm even scared to think what is happening in the regions". Uzbekistan

In addition to the lack of transport, the women living with HIV faced the problem of passing through checkpoints that were set up in many cities to enhance the self-isolation regime.

In many cases, women were unable to cross the checkpoints to move between cities to receive their ART, and coordinated efforts between many participants were required to restore access to ART.

"Doctors, nurses, volunteers, staff, consultants, NGOs delivered ARVs". Kyrgyzstan

Organizations and networks of the community were establishing and coordinating interactions between the parties.

"It was possible for medical organizations to travel through the checkpoints. They also delivered the medications to the out-patient clinics. Then a person would collect it from there." Kazakhstan

To get to the centre on their own, the women had to get a pass. In some places, like in Taldykorgan, Kazakhstan, the AIDS centre was issuing the clients certificates, but in some cases the procedure for obtaining a pass was complicated, or simply absent:

"I didn't apply [for a pass], because I got a consultation and they told me that it is a very time-consuming process, that there are long lines and they sort out who should get one and who should not." Kyrgyzstan

"You could move around, but then disclosure of one's HIV status was required for that. Not everyone is ready to show that they are registered in the AIDS centre when the police stop you. One woman was in the car, and delivered ARVs as best she could. Because she had transportation and she didn't conceal that she was a person living with HIV and an employee of the organization." Uzbekistan

As a result, in many countries access to HIV treatment was threatened and the community organizations began to deliver ARV drugs on their own.

"I am in Kiev directly receiving my antiretroviral therapy. I couldn't get there by myself. It is good that we have social workers who sent me the medication by mail". Ukraine

"We delivered ARV therapy three months in advance to all clients in the regions where we work. The AIDS centre asked us to call those who could not come and deliver them the medication". Tajikistan

“Our social workers and HIV service organizations provided this access to each HIV-positive woman, in every region.” Moldova

The activists of the community organizations often had to travel long distances on foot to deliver ART.

“I personally was delivering it. I had to walk about 7-8 kilometres one way, it was very hot. I wore my mask, gloves, took the medication, if I had to deliver medicine or infant formula, I just went at my own peril and risk”. Kyrgyzstan

“The girls from the organization were delivering it, walking, to a certain address, or to wherever they agreed, they met somewhere in the city”. Moldova

In fact, the community had to play the key role in organizing access to ART, and success greatly depended on contacts inside the community made before the pandemic, and on the experience of networks working with the government sector. Here one needs to remember that in the last decade, financial investments in community networks in most EECA countries have been minimal, which limited their development and sustainability.

“All non-governmental organizations in their regions delivered the medication to those who were accessible. There are people who do not know us, who left their data at the AIDS centre, but it was impossible to find them. We have information that people were left without pills. That is, we looked for them, but we did not find all of them”. Moldova

The stigma related to HIV was always an obstacle in accessing ART. In the context of the pandemic and changes in the delivery of treatment, the fear of being identified as a person living with HIV has complicated the situation for many women with HIV:

“Difficulties arose in small villages and rural settlements. Why? Because when the bus arrives, with the inscription of the social centre “Viatsa ku Spiratsa”, the neighbours will ask questions. The hard part was not delivering the therapy, but persuading the person to come out and receive it. Our bus stopped outside the village, and the social workers had to walk and meet the people somewhere to prevent the residents from seeing our bus”. Moldova

“People live in families, everyone knows everyone. This greatly influenced access: people did not go to their district out-patient clinics”. Uzbekistan

While WHO gave clear recommendations to provide the ARV therapy for six months, precisely because access difficulties were inevitable, in EECA countries the medication was dispensed for two or three months. ART was issued for six months in exceptional cases:

“There are recommendations according to which people living with HIV were supposed to receive their medication for a longer period”. Belarus

“In Vitebsk someone was given immediately for three months, if the medication was in stock – for four, and some received just for one month, and even the package was divided up”. Belarus

“People received ten pills each. For just ten days, it was very problematic”. Armenia

“Until 24 March, everyone was given therapy for two months”. Uzbekistan

TREATMENT STOCK-OUTS

One of the reasons for the dispensing of ARVs for a relatively short period is ARV supply interruptions; the problem was further complicated by the closure of borders.

"There was one problem – interruptions in antiretroviral therapy. We replaced some forms and a lot of people started showing some kind of allergic reactions. This situation has arisen again in connection with COVID". Belarus

"There was such an influx of people living with HIV into the AIDS centre in great numbers, they wanted to get their medication for several months. There was not enough medication, because they haven't arrived yet, because the borders started to close". Armenia

"We have shortage of darunavir, it is either issued either for one month, or they will change the treatment regimen, if possible. And these interruptions, I don't know how much they are related to COVID-19. I think it was just a coincidence, and this is very bad". Russia

Each of these complications in and of themselves – the interruption in the supplies of ARVs, the transport that was not operating due to the lockdown, a lack of information from the health-care system, stigma associated with HIV are not unique to the EECA region. Women living with HIV have faced treatment stock-outs or other difficulties with access to services to one degree or another in other regions as well [4].

However, what possibly makes the situation in EECA unique is the extreme degree of centralization of the system, closely linked to the AIDS centres and the systematic ignoring of signals from community-led organizations over many years about access barriers to HIV treatment.

ACCESS TO HIV TREATMENT AMONG WOMEN MIGRANTS

At the very beginning of the pandemic, the borders were closed and movement between countries proved to be impossible, or extremely difficult, both within the EECA region and when returning home from other regions. As a result, women living with HIV who were abroad in March 2020 were cut off from their home and faced difficulties in accessing ARV.

For most women living with HIV their usual supply of medications for several weeks should have run out long before the borders opened. It was not possible to obtain ART medication via the government health care system. This was not possible even before the COVID-19 epidemic started, when access to ARV treatment for migrants was carried out only via the Global Fund programmes, but not in all countries.

"We have here female migrants from Kyrgyzstan and Uzbekistan. We do not provide health care to migrants in our country, or it is provided in a limited way with Global Fund money, according to the lists. There are more people than opportunities". Kazakhstan

"There was no coordination after the border closure. Some representatives of Azerbaijan, Moldova and Ukraine ended up in Georgia, and they got access to ART, but not via government institutions". Georgia

There was no official information on how to access HIV treatment if women living with HIV and belonging to key populations ended up in another country. In some cases, women with HIV could buy ARV medication in the host country only for a short period and at personal expense:

"I was in Turkey and could not get home. I ran out of the two-month supply of medications. I applied to an organization in Istanbul. If I went to the pharmacy, I would have to pay up to US$1,000. And the people living with HIV advocacy organization issued me a 50 per cent discount. I had no information on who was involved in addressing this issue". Georgia

Most women with HIV, who found themselves abroad, had no money to buy ARV medications. Contacting AIDS centres in another country was also difficult because of stigma and fear of disclosing HIV-positive status in another country.

"One woman had a three-drug regimen; the AIDS centre only had two. They said she needed to contact her doctor for him to write a prescription that needs to be picked up by her friends or family in Abkhazia. She refused because she does not want to tell anyone anything. No one knows that she is taking the medication". Kyrgyzstan

Access to HIV treatment is done using the resources of the community organizations, mainly through established international linkages between the community-led networks and previous experience in responding to disruptions in access to ART. Frequent interruptions in the supply of ARVs, typical for EECA countries, led to the fact that the community networks began to form "stocks", "first aid kits", "banks" of ART to be able to prevent the interruption of therapy in those moments when the government cannot provide continuity of access to treatment:

"In some places NGOs handed out their own therapy, sometimes a personal supply, they were gathering it bit by bit from everywhere, securing [the treatment]". Kazakhstan

"We very quickly established international relations. Many women do not have earnings as such, many go abroad. We quickly established contacts, so that the people outside the republic could at least receive their treatment in a timely manner". Moldova

In April 2020, the Eurasian Women's Network on AIDS launched a hotline – ART HELP, – aimed at helping HIV positive male and female migrants and people living with HIV who are stuck in other countries due to border closures on account of quarantine restrictions on COVID-19 limitations. The project was supported by the Regional UNFPA Office for Eastern Europe and Central Asia. During its operation (April-October of 2020), 102 HIV-positive people from 13 countries called the hotline:

"*I once again contacted your project. I saw on Facebook that you are giving ARV to those who are left without medication".* Georgia

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

"They did not terminate her pregnancy, they said, "Come later, after the quarantine".

CONDITIONS BEFORE THE COVID-19 PANDEMIC

For the women living with HIV and those from key populations, even before the beginning of the COVID-19 pandemic, there were barriers and obstacles to receiving sexual and reproductive health (SRH) services. For example, in Tajikistan you need to pay the doctor for an abortion, and in Kyrgyzstan and Uzbekistan – for diagnostics:

"Abortions without money – no way. They rudely say that the government does not pay the doctors extra for this work, so you have to pay. Everything has remained as it was". Tajikistan

"Speaking about the outpatient clinics, not everyone has laboratory and functional diagnostics. A gynaecologist will take a simple swab for leucocytes. If we talk about the diagnostics of other infections, in our country we do not have any free services at all". Uzbekistan

"All services related to SRH of women, they all are paid and provided in commercial private clinics. All those tests, screenings, laboratories — it's all provided on a paid basis". Kyrgyzstan

Internal and external stigma, and also a lack of sensitivity to the problems of HIV-positive women increases the problems in access to the SRH services, including for pregnant women. Psychological support and social support of HIV-positive pregnant women fall on the shoulders of NGOs because such services, as a rule, are not provided by the government:

"Our gynaecologists are not well-informed about HIV. We had to accompany women to the gynaecologist and give a mini lecture to the doctor. If the doctor is not knowledgeable in this matter, then a woman can be traumatized during pregnancy. They do not understand the internal stigma, the emotional vulnerability, the specificity of taking ARV medication, how they affect women and what the side effects can be during pregnancy. There is no psychologist in the medical facility who could also help. It all falls on the shoulders of the NGO. And the organizations that, in fact, specialize in this, are also practically absent in the country". Belarus

"Those limitations have always been there, stigma, mainly stigma. Even doctors who are to have some skills in providing these services to women, stigmatized these women". Armenia

In Uzbekistan, women living with HIV have good access to contraception, but activists think that in this way the government is trying to ensure that they do not give birth to children. The gynaecologists themselves are actively offering hormonal contraception to women living with HIV. Condoms for HIV-positive women in Uzbekistan are issued only in the AIDS centre, and in Belarus – only in the civil society organizations. In Ukraine, contraception is not funded from the state budget unlike in Kazakhstan:

"For our women, contraceptives, well, they were even too affordable. They don't really want those women to give birth. We have hormonal injections – generally ok, you can come, and they'll give them to you. Gynaecologists themselves call our women asking them to pick up hormonal contraceptives. There is a problem with barrier contraception, you can get it only at the AIDS centre". Uzbekistan

"As for getting contraceptives, well, if you know some non-governmental organizations…". Belarus

"If we take, for example, governmental services, antenatal clinics, I know that women in labour who have given birth, they come later and are offered a UTI, and they are given pills". Kazakhstan

"Contraception is a big problem, and again it comes to the point that a woman chooses whether to feed her children, to eat herself, or save some money for the spiral. Our condoms are quite expensive. In our country contraception is not funded by the government". Ukraine

Access to SRH services in Central Asia is strongly influenced by culture and traditions, such as the authority of the mother-in-law, and having many children:

"It depends on the families and on the women themselves, how dependent they are on their relatives. Especially on their mother-in-law. Most often they control, we have such a mentality". Tajikistan

In Tajikistan, childbirth at home is still common, especially in rural areas. This is not only because of the health-care infrastructure and lack of economic opportunities for women, but also to the great distrust in the health-care delivery system:

"In our country, childbirth at home is still practiced. And in remote regions there are no conditions as in cities. People prefer to give birth at home rather than going and contracting some hospital infection". Tajikistan

The survey participant from Moldova singled out the problems of women who live in rural areas, who do not have any access to family planning:

"Women in rural areas give birth and they do not know that they have a choice. They are not used to using contraception. It's funny for them. For them, this is the norm –women in rural areas give birth to a lot of babies". Moldova

Before the outbreak of the pandemic, the SRH services were integrated into many AIDS centres in the EECA region, thus providing HIV-positive women with access to gynaecologists in the centres. In Russia, visits to gynaecologists are a condition to access ARV therapy. At the same time, the general system of OB/GYN health care in the countries has also adapted to providing services to HIV-positive women, and the standards of obstetrics have changed:

"We have two gynaecologists at the AIDS centre, and women can easily visit them if they want. It appeared several years ago. Before, we had no gynaecologists. If I am registered, I receive therapy, if I fail to go through the full check-up with all the doctors, including the gynaecologist, they will not give the therapy." Russia

"Now they even allow natural childbirth, if the viral load is undetectable. At least, now they consider this, at least they allow childbirth. Before, everyone was sent for a caesarean section". Uzbekistan

"Women with HIV and women with drug addiction issues can come to the AIDS centre. In the friendly office, a gynaecologist will see you, take a swab, he can issue contraceptives, and we have a separate doctor for pregnancy management. The commercial sex workers also know this information". Kazakhstan

The notion of "sexual health" is almost non-existent, both for the women themselves and for the specialists. It is often combined with "sexual and reproductive health". A woman is valuable as long as she can give birth to healthy children; other aspects of her life and health are of little interest to the government:

"I am generally silent on sexual health. Sexual health, very few turn to sexologists there". Russia

"As for antenatal clinics, they always see pregnant women -- this is something sacred but after childbirth – figure it out yourself". Russia

"How to explain to her what sexual health rights she has. Honestly, I don't know". Belarus

The respondents noted the low value of SRH in women's eyes, and the low motivation to keep themselves healthy. Doctors are more focused on responding to complaints, rather than preventing their emergence.

"As to gynaecology, it is not customary for women to follow this. And more often than not, if a woman is not registered with the AIDS centre and does not receive the therapy, she is not going to see the gynaecologist, either". Russia

"Another point is that this is formal. Any questions? No questions, leave. If I am interested in my health, I will request an examination and also to take additional swabs". Russia

Assisted reproductive technologies for HIV-positive women are either forbidden or available only for a fee.

"We have a trusted IVF specialist; this is a great achievement. But here rather for those who monitor their health, who are planning motherhood. We met the chief physician of the Mother and Child Centre. The Centre promotes the IVF topic for the HIV-positive on a commercial basis". Russia

Access to breast-milk substitutes for women who live with HIV can be complicated if they don't have the necessary documents, for example, as it happens in Uzbekistan. The communities play an important role in enabling access to government support for vulnerable and marginalized women, or they organize such support themselves. They also monitor access to breast-milk substitutes and the procurement conducted using community resources:

"We have a woman, she is an orphan, she grew up in an orphanage. She has an old passport, not a biometric one, dating back to the days of the USSR. When she came to us, she was pregnant with her third child. The government provides infant formula only after you bring the birth certificate. They refused to issue a certificate for her. I made sure that the woman in labour was given a birth certificate, because I knew that she was on therapy and committed to treatment. But it is not an argument for our doctors. I had to tell them that she has nothing to feed the baby with, and that she was going to feed the baby with her milk. After this, they brought the formula to the maternity hospital, and we collected food for her on our own". Uzbekistan

HIV-positive homosexual women face contempt for their sexual orientation and denial of problems and needs on the part of specialized doctors in governmental antenatal clinics. The lack of SRH services for such women is compensated by the NGOs financed by international donors:

"When I came to the gynaecologist and told him that I need a more extensive examination, because my sexual life is different and the infections that are transmitted from a man are not likely to affect me. My doctor said not to bullshit him, to marry and to give birth to children. This is our real sexual and reproductive health in the country". Belarus

"If we are speaking about key groups, about LBT, for several years we have been cooperating with the Alliance for Reproductive Health. We have friendly female gynaecologists; we refer the women to them. During the pandemic, we also cover these expenses". Kyrgyzstan

A broad spectrum of friendly SRH services based on an NGO was available for sex workers in Georgia:

"Tanagdoma is the organization which provides a broad spectrum of services to sex workers. One can get advice from a mammologist, gynaecologist, perform a procedure for gynaecological echoscope of the abdominal cavity and internal organs". Georgia

IMPACT OF THE PANDEMIC ON ACCESS TO SRH SERVICES

The overall assessment of the situation regarding access to sexual and reproductive health services in the context of the coronavirus pandemic, depending on the country, varies from "the services almost stopped" to "the situation has not changed due to COVID-19":

"The situation has worsened significantly, because many hospitals were repurposed for COVID-19. Many women's clinics work only with pregnant women. I can say that all SRH issues have been practically stopped since the end of March". Russia"

"Our hospitals were closed for quarantine, so the services became unavailable. And, in fact, there is no more information about sexual and reproductive health in our city". Kazakhstan

"The needs for SRH did not change due to the epidemic. The women still need diagnostics and contraception. Women get pregnant and give birth. We continue, together with obstetricians and gynaecologists, to train them on family planning, on measures to be taken due to pregnancy and childbirth, to support them in pregnancy and after that, to buy humanitarian help for them". Ukraine

Access to the SRH services is closely connected to the infrastructure and transport links, which have been hit hard by the COVID-19 pandemic. The regulation of movement inside and between the cities by the law-enforcement agencies created additional barriers for women in accessing services, and has also placed them in a position where they had to disclose their HIV status to the police officers. For small towns, where everyone knows each other, this is a very sensitive topic.

In Armenia, due to the quarantine restrictions, HIV-positive pregnant women had a hard time getting to the specialized/maternity hospital (where HIV-positive women in labour are accepted). Negotiations with the police officers at the checkpoints led to the need to disclose the HIV status as they had to present a certificate with their diagnosis. Such negotiations were conducted by the NGO activists by phone:

"There was a case when a woman was not allowed to travel to Yerevan from another city. She was near Sevan, and she was not allowed to go further. I had to negotiate with a police officer for a long time to persuade him to let her through. People did not want to disclose their HIV status to the police officers". Armenia

"Even when women critically needed to see a doctor, we had to find money for transportation, negotiate with doctors, because some health-care institutions were reformatted for COVID patients. We had to look for new trusted doctors, given their HIV status". Ukraine

ACCESS TO ABORTIONS

The study indicated that in many countries of the region, access to abortions has significantly deteriorated or is not available, including in the case of rape, even if pregnancy termination is specified in the relevant medical protocols. Women noted that the topic of abortions is taboo in society. Community activists oversaw and payed for abortion-related services for their clients with NGO resources:

"One bisexual woman was raped at our location, and she got pregnant. She filed an official complaint with the police and there was an examination. When she came with the abortion papers, she was told that she needed to come later as they were not seeing women now, even though she is HIV positive and there is every reason to have the procedure done at any time. This is how it is written in our protocols." Belarus

"We have one woman who decided to terminate her pregnancy, but she got denied the service, they told her to come after the quarantine. After the quarantine, the pregnancy will be too far along, so she has no choice but to give birth. I called her, she said that she didn't know what to do because she has nothing to feed the baby with. She already has three children, she is not employed, she has no husband, and she lives in a rented apartment". Kyrgyzstan

"There were so many problems to resolve for a woman who needs an abortion. We referred her for paid termination of the pregnancy, and we paid for these services". Russia

"Even without quarantine, these services are inaccessible for women – to have a free abortion in an antenatal clinic or a maternity hospital. Some buy Chinese pills and perform abortions on themselves, with all the ensuing health consequences". Kazakhstan

"If the abortion is planned, it was provided in the Mother and Child Centre. The centre was not closed down. They didn't refuse anyone". Moldova

ACCESS TO THE GYNAECOLOGICAL AND CHILDBIRTH SUPPORT

Doctors became one of the groups most vulnerable to coronavirus infection. Because of fear of coronavirus infection, they started avoiding patient visits and recommended the patients not to visit the doctor, and postponed surgeries. The women themselves were afraid to seek medical care and visit medical institutions:

"Women turned out to be more vulnerable to COVID, and they are told that because of COVID it is dangerous for them to visit doctors now, and they offer to postpone the visits until the pandemic is over". Armenia

"Women try not to make any unnecessary visits to a gynaecologist for examinations, or visits for any other service because of the coronavirus. Pregnant women who live with HIV have great fears and increased anxiety. They are very afraid of getting infected with a second infectious disease and harm the unborn child. Instead of calling the ambulance, many call their peer counsellor and talk about their problems, but they won't go to a hospital". Belarus

"All doctors were busy: family doctors, gynaecologists. We asked the women in every possible way, unless the issue they have is serious, not to come to the hospital at this time, so as not to get infected with COVID". Tajikistan

"In March, a second chemotherapy was prescribed for a woman with cancer. One of her breasts was removed, but the disease spread to the second breast. She collected all necessary materials and had to be sent to chemotherapy, but the pandemic started and the doctors refused to treat her until the end of the quarantine". Moldova

The fear around the epidemic was fuelled by the media. Women are afraid to visit healthcare institutions. Pregnant women living with HIV are afraid to give birth or be under medical supervision during pregnancy:

"Pregnant women with HIV are afraid to give birth. On this count, one has to go to hospital, and this is a health care institution, which means there are increased risks. Not all mass media follow the same tactics as NGOs, they created scary headlines that made people hysterical." Armenia

"Women are afraid at the moment to go to healthcare institutions because they are afraid of contracting COVID". Kyrgyzstan

Countries in question have significantly reduced or abolished the consultation of gynaecologists. Pregnant women were given priority. Women were quickly discharged after childbirth:

"Access to the same gynaecologists was limited, only pregnant women or women with cancer were admitted". Belarus

"There was no access to the gynaecologist. Those who were registered in the neighbouring populated area said that the gynaecologist did not work, and it was impossible to register". Moldova

"In our location, the gynaecology department was closed where women received services and underwent in-patient care. It was impossible to get there, even if you had some critical problem. Admission to antenatal clinics has dropped significantly". Russia

"They were accepted everywhere, but very quickly discharged after the childbirth. Literally in 2-3 days, they were discharged". Belarus

"If you need to do an ultrasound, to get tested, then, yes, access has become difficult. The ultrasound office does not work, the doctors do not work". Kazakhstan

In Georgia, the procedures for receiving pregnant women and taking tests became more complicated:

"If you need to see a doctor, you need to call an ambulance. In some cases, waiting for an appointment can take a week, because the queues there, the procedures have become different and this takes longer. If the doctor has ordered tests, then you can't just go to the laboratory, you need to go home, sign up for

the laboratory, and come again. It is not very comfortable for a pregnant woman to travel back and forth". Georgia

In Kyrgyzstan, women were forced to give birth at home. In fact, the activists of the community had to act as an ambulance:

"We had a woman about to give birth, she called me and said that she was giving birth, and there was no one to give her a ride to the maternity hospital, as the ambulance was overcrowded. We brought her to the maternity hospital. What else could we do? Giving birth at home is not an option". Kyrgyzstan

"No maternity hospital accepted a woman who had lost water, and her husband had to take her back home. He brought her home, and by the time the ambulance arrived, she had already given birth to a baby". Kyrgyzstan

A participant of the study from Moldova reported a case of refusal to register a pregnant woman due to the lack of COVID-19 test results:

"A woman, who is not HIV-positive, but she was pregnant, she was not registered because she had no COVID test results. The test is commercial, and she has no money. And the gynecologist is not seeing her, not registering her". Moldova

In the countries covered by the study, STI offices were also closed; doctors either got sick themselves or left to treat the patients with COVID-19.

"Unfortunately, neither an STI disease specialist nor dermatologist can see patients now, they see only pregnant women". Russia

"We cannot offer STI testing to anyone now, we are waiting for the restrictions to get lifted". Russia

"Getting to a doctor at this time – That's simply fiction. To tell you the truth, it was like a war". Moldova

CSOS' ROLE IN MAINTAINING ACCESS TO SRH SERVICES

In a situation of limited access to SRH services because of COVID-19, the personal and partnership connections of the activists and CSOs with doctors are important:

"We have an examination, a trusted gynecologist, she either consulted in the office or I sent her for an examination. We have a contract with the women's health clinic, as they say, personal connections". Belarus

"We just have an arrangement with the hospital administrator. The doctor herself referred the women to me so I could tell them how to take the pills, and some other details that women are too shy to ask the doctor about". Belarus

The CSO-based services of testing for HIV and STIs were reduced in Georgia, the outreach programme for harm reduction was stopped, and women could not use the organizations' services. In this period, pregnancy tests and condoms were in great demand:

"The number of people who visited us has decreased. The testing service was not operating for two months, we had no one to do it for, people could not reach us". Georgia

"In a week, pregnancy tests were already out of stock. No condoms for women, no tests. No organizations had them". Georgia

"Before, we would do outreach events, we distributed handouts, communicated, now all of this is gone. The community is now in a very bad information vacuum". Georgia

NGOs and community-led organizations never stopped their work, they distributed condoms, together with ART delivery, and used the resources of mobile outpatient facilities. Activists in Tajikistan organized a phone line for the issues of COVID-19 and STI for sex workers, who were supplied with condoms as much as possible. They also pointed out that the telephone communication was not always available for women because of lack of money. The community representatives reported a sharp decrease in demand for CSO-based SRH services:

"When the CSO consultants were delivering the ARV medications, they also provided condoms". Kyrgyzstan

"The girls could get condoms, lubricants, first aid kits, because we have a mobile laboratory and the social outreach workers were visiting them". Moldova

"Non-profit organizations distribute condoms and individual hygiene products to certain points. Government institutions, you see, are now repurposed". Russia

"Demand for the SRH services has disappeared. And the women are all lost somewhere". Tajikistan

"We made a phone hotline for sex workers, where they could consulted not only about COVID-19, but also about STI-related issues. Because they had to self-medicate". Tajikistan

"We were limited in many ways. But we tried to supply women with enough condoms". Tajikistan

BREAST MILK SUBSTITUTES

Access to breast milk substitutes and to prevention of HIV transmission from mother to child varied in the countries. Community activists provided social support for pregnant women and helped women to purchase formula using their own resources or the organizations' resources:

"It (breast milk substitute) is distributed in our centre. It was delivered to homes, as was therapy, and also syrup for the children". Moldova

"In the city AIDS centre, it was provided, but not enough for everyone. Very many people asked me to request milk for children. I had some savings, so I was purchasing infant formula at the market, it was help on my behalf, a cheap formula, however, costing 210 soms". Kyrgyzstan

"We always bring it, and also, to the maternity hospitals, they know us. There was no lack of breast milk substitute". Moldova

A SURGE IN VIOLENCE.

ACCESS TO CRISIS CENTRES AND SHELTERS

"If earlier violence was only by clients, now it is violence by family members. She does not work, she does not bring money, she herself is someone superfluous…"

A NEW VIOLENCE SURGE AMID COVID-19

The COVID-19 pandemic has sparked a new surge of violence against women. This is confirmed by both the official statistical data in some countries and by monitoring community representatives:

"Our organization is a member of the Coalition to Stop Violence Against Women. This coalition updates the data on the monthly number of calls to the hotline. So, the number of calls went up by 50 percent". Armenia
"Violence against women living with HIV has also increased". Tajikistan

"Since the beginning of the coronavirus pandemic, the crime rate, the rate of domestic violence, went up". Kazakhstan

"We have a crisis centre in St. Petersburg, and they say that there is, of course, a surge, they have a surge of calls". Russia

Research participants from Moldova noted the increased violence in rural areas, and shared their experience in inspecting calls with district police officers:

"There were a lot of complaints. We have a women's group, 15 girls, even inside our group; we noticed that quarrels start because two people stay at home all the time. We started working with our district police officers, we go with them to villages, to districts. I saw those women, it's scary". Moldova

"Beating means love. Especially in a village. There, girls are 14-15 years old; they leave their homes because their parents abuse alcohol, and start an active sexual life, living with one guy, then with another one. I think it's like that everywhere in the villages". Moldova

The main causes of violence voiced by the research participants during the interviews were socioeconomic, due to a prolonged stay in the same apartment with a man prone to aggression, and with a deteriorating financial situation. This applies to both women from the general population and women from vulnerable groups:

"Women were left in a confined space without money and without work. This, of course, greatly influenced the violence. If we analyse the stories of our clients, then the cases of domestic violence increased by about 30 per cent". Ukraine

"The violence increased against the background of this economic crisis, those are the people who got by on odd jobs. All of them together were isolated in the same space, aggressors became more active, and we had very many cases of violence during the emergency. Women and their children were forced to flee from their homes, from their husbands". Kazakhstan

Sex workers, who experienced systematic violence before the pandemic, and had a low chance of receiving protection from the law enforcement agencies, found themselves in an even more difficult situation after the introduction of quarantine measures.

"We have increased violence here. All these negative emotions collected in those five months, they let it out on whom? Of course, on a sex worker. She is bought, so anything goes". Georgia

"If earlier violence was on the part of clients, now it comes from family. She does not work, does not bring money, so she is superfluous". Tajikistan

"They do not go to the police; they do not see the point. Because in the police departments, they get stigmatized, humiliated. They are automatically subject to huge fines". Tajikistan

Women have lived in situations of violence for many years. The number of violence-related help requests is often related to women's ability to identify situations of violence.

After staying in the shelter, a woman is forced to return to the family where she experienced violence. So, the number of requests for help is only an indirect indicator of the gravity of the problem, and the absence of an increase in help requests does not indicate that the number of violence cases has not increased:

"The problem is that women themselves do not understand that they are being abused. Gritting their teeth, everyone suffers there". Kazakhstan

"Let's say, I am in a situation of violence, my spouse beats me, I am with him in the apartment, I cannot even leave to make a call to the police, to a psychologist, or something else. We are in a confined space. I think, because of this we have fewer calls compared to what we could have in reality". Russia

"We have this mentality, they do not want to offend their brother, relative, because – well, let them beat them, so what?! I already feel better [recovering after an act of violence]. This is the approach". Tajikistan

"Even before the quarantine, the situation was so-so, the quarantine exacerbated all this. Women did not know where to turn, and they still don't". Russia

"The shelters worked as usual, yet I have doubts about their effectiveness. You come there for three months, then you have to return home to the rapist". Georgia

IMPACT OF THE LEGAL ENVIRONMENT ON ACCESS TO PROTECTION FROM VIOLENCE

The response to cases of violence by the police depends greatly on the national legal framework and the legal environment of the country, for example, whether it ratified the Istanbul Convention or if there is a law on domestic violence.

The increased level of violence led to a new wave of discussion of the law on domestic violence, especially in the countries where such a law does not exist. In Georgia, ratification of the Istanbul Convention considerably influenced the quality of police help to the victims of violence:

"Again, they started to discuss, to raise the issue about adopting the law on domestic violence, because the number of help requests increased, specifically for the specialized non-profit organizations, psychologists and attorneys who work with this issue". Russia

"Now we have a hotline on domestic violence, after ratification of the Istanbul Convention. After that, the police started to cooperate very well, the police officers go to the location not only for, say, cases when a husband beats a wife. If before a client was beating a sex worker and the police ignored it, now they come to every call. We have a very good Ombudsperson, she is a woman and she has much empathy for our situation, for all this pain". Georgia

Women lack resources to confront institutionalized violence. In such situations, the support of civil society organizations is very important. The case below demonstrates the vulnerability and defencelessness of a women to the existing government system, and the strength of the community in countering this system:

"Quite recently, a woman from Tolyatti asked for help. She has a husband and two small children, she is pregnant, and he just kicked her out of the house. He was drinking, beating her, kicked her out and even applied for child benefits. Even though they are officially divorced, he is not deprived of parental rights. The woman found herself without any social assistance. She applied to the pension fund, and the officials here told her that he was eligible. No one even started processing her case. I referred her to a local organization, they found a good lawyer and they provided her [access to] a centre where she can receive help and where she can live for some time. She will give birth very soon, and she is afraid that her small children will be left alone, as she has no one to leave children with for the time when she goes to give birth. And our care is not friendly at all. They can just take away the children without even going into the details. In our country, the human factor is what mostly works, not the law". Russia

According to international standards, the government is responsible for securing protection for women survivors of violence, including the opening and maintenance of the crisis centres or shelters. The respondents reported limited access to shelters, including government shelters, and the small number of places in them:

"We do not have a shelter maintained by the government. Only NGO-based shelters, we have a demand for shelters". Armenia

"Based on official data, the country has 24 crisis centres and offices where they provide legal advice, and I know two that are active and operating". Tajikistan

"Some family centres have been converted to provide telephone consultations. And there, psychologists, to the best of their ability, try to help attenuate this level of irritation and aggression. I saw a lot of options where one can call for help and psychological support". Russia

"Literally a week ago, the Kyiv administration published information that two more crisis rooms had opened. This, of course, is still devastatingly too few". Ukraine

ACCESS TO SERVICES AND ASKING FOR HELP UNDER QUARANTINE CONDITIONS

The COVID-19 pandemic has impacted the work of the existing crisis centres/shelters. In Armenia, some centres operated, but they did not accept new clients, while in other centres there was a problem due to the need to isolate new clients:

"As for crisis centres, we have two centres in our country that accept women. During the quarantine, everything was closed – they worked, but they didn't accept new women". Armenia

"Of course, our problem was connected with the 14-day isolation. Taking someone to the shelter right away was very risky, because a woman can also bring the coronavirus to the shelter". Armenia

In Moldova, it was difficult to get to the crisis centre due to the quarantine. One needed to provide the chest X-ray, and to show the results for the tests that were not available to women during the quarantine:

"We were faced with the situation when it was impossible to find a place in a crisis centre for a girl who experienced violence, while there was quarantine". Moldova

National governments' response measures to the COVID-19 pandemic limited women's ability to seek police assistance to protect themselves from violence. For example, a woman was fined for violating self-isolation in Russia for turning to the police after she was beaten by her partner:

"Here is a case, when the woman came to the police, and she was fined. When I read about cases like this, I will start thinking if I should even bother going to the police or not. And, in general, where I could go in such a situation". Russia

The pandemic exacerbated the problem of inaccessibility of services to protect women from violence, but also showed that even under the conditions of quarantine or lockdown it was still possible to provide help using well established cooperation between women's organizations. For example, the activists from Kazakhstan demonstrated a good example of cooperation of a women's NGO with local authorities and police in supporting the women who suffered from violence:

"We took one woman to the centre. The police service brought her to the checkpoint, and at the checkpoint we picked her up, and she still lives with us". Kazakhstan

"We reach out and visit the districts, and we tell the women from the villages, who do not have access to any information whatsoever, about where they can ask for help in cases of domestic violence. We have a crisis centre that works with victims of domestic violence". Kazakhstan

In Armenia, police officers in situations of domestic violence turn to NGOs for help:

"Of course, we had cases when women in house slippers reached the crisis centres or the police station. From there, they called us to work with her". Armenia

The activists noted the work of online hotlines on violence supported by the United Nations agencies, in particular UNFPA:

"In our country, UNFPA together with the civil society sector, responded very well, they opened hotlines where they provided consultations with a psychologist. Their work is really awesome". Uzbekistan

STIGMA AND HIGH THRESHOLD FOR SERVICES AIMED AT PROTECTION FROM VIOLENCE

Stigma and discrimination against HIV-positive and drug-dependent women, as well as against sex workers and transgender women, severely limit their access to help in relation to survivors of violence. The staff of crisis centres or shelters often find reasons to deny admission to such women, or to get rid of them for violating the rules of stay. The provision of assistance to them is also restricted by the existing regulations and norms that do not permit admission of a woman to the shelter if she is under the influence of alcohol or drugs. Women with children have even a harder time receiving help. Community activists have to take on mediation and additional support functions, including mediation with family members. Often, it is the intervention of activists that allows women not to stay on the street:

"The crisis centre is accessible only for women, who have no vulnerabilities at all. Sex workers, women who live with HIV and drug users are not admitted. They are expelled from there immediately". Kazakhstan

"If a woman has an active form of tuberculosis, drug addiction, and she is also in a situation of violence, where should she go? Where should her children go? Let's say, we have an orphanage that can temporarily house the children. But later, how to help that woman take them out of there?" Russia

"These crisis centres are inaccessible to our women, not only those with HIV, but also to sex workers". Tajikistan

"They do not accept drug users and sex workers. If you have anything to do with drugs or sex work, you are already beyond the pale". Georgia

Women living with HIV continue to encounter systemic barriers in accessing crisis centres. The reason for this is HIV-related stigma:

"She went online and called, which was not permitted, she was warned about it, and she violated the rules. She was also pregnant. So, it turns out, that women with HIV that we refer to them later get thrown out onto the street". Armenia

"When we made a special request to the government agencies about the availability of shelters for women with HIV status, we received the following surprising answer: with HIV status – yes, but in the acute state – no". Ukraine

“I think that if an HIV-positive woman gets to this shelter, they will provide their services, but she will not feel at home. This shelter is designed to make people feel at home. But it still will be hard for HIV-positive people to stay there”. Georgia

Sex workers and women who use drugs are often denied access to shelters and crisis centres. The formal requirements, the centres’ office hours and internal regulations of the centres, and, the main thing, the support centre staff’s stigmatizing attitudes towards victims of violence, make these centres inaccessible to women from key populations almost everywhere in EECA countries:

“Sex work is night work. And crisis centres, they live by their own established rules. You can’t go anywhere at night”. Ukraine

“I’m not against women who use drugs, but I do not want our organization to be charged for organizing a brothel”. Kazakhstan

“Women who currently use drugs do not come to us. This is a great stigma, they will not be admitted anyway, and there will be problems with their child”. Kazakhstan

Bureaucratic obstacles create a high threshold for women to receive services from a crisis centre or shelter. They need to collect documents, take tests, visit various institutions and communicate with officials and with the doctors who are not friendly towards them from the outset. For the marginalized and criminalized women, such a “trip for paperwork“ is an almost unrealistic task, and often it is just impossible due to lack of resources, documents, registration, the burden of drug user’s registration, fear to lose parental rights, fear of stigma, discrimination, and disclosure of the secret of their diagnosis:

“The barriers consist in the fact that obtaining a certificate from the doctor is required, but you won’t get this certificate in the evening. One woman did not manage to bring the certificate by 8 p.m., and was not able to get into the crisis centre. She spent the night in our office”. Ukraine

“To get admitted there, one needs to get tested. If I encountered violence here, now, and it’s evening, I will not get anywhere”. Ukraine

WOMEN'S NETWORK AND COMMUNITY-LED ORGANIZATIONS IN THE PANDEMIC

"It is impossible to work, because people are generally not up to the protection of rights. Eating's more important".

All the above sections clearly demonstrate the power of the women's community, its contribution to ensuring the continuity of vital services for HIV prevention and treatment, SRH and protection from violence. The mobilization of efforts of organizations and of individual activists took place against the background of a lack of government support, with imposed restrictions on movement, penalties for "wrong behaviour" aimed at helping people (for example, distributing clean syringes), with total fear, despair and depression among the majority of clients.

The activists and community representatives invested their own resources or were inventing new fundraising strategies to help people in the most dire need: those who were starving, those who were left homeless, those who were not able to call an ambulance for childbirth, who had no money for breast-milk substitutes, who were not able to come for ARV therapy on their own due to the lack of public transport, who could not independently escape the violence, have an abortion, travel to the maternity hospital or to the OST through the checkpoint. Many activists have faced the syndrome of professional burnout, caused by overwork, shock, emotional and mental exhaustion. But it is important to point out that the challenges of the pandemic were perceived by the community through the prism of opportunities, and influenced the development of new initiatives and new work formats.

MOBILIZATION AND MUTUAL SUPPORT. NEW PARTNERSHIPS

With the start of the introduction of lockdown and emergencies, communities of women living with HIV and from key populations and community-led organizations and groups mobilized and started to produce protective equipment against COVID-19 independently, in many cases at their own expense. The activists were motivated to undertake new initiatives and development. The peer-to-peer women's self-help and mutual help groups started developing more actively, including online, to provide psychological support, and the interaction between the organizations of women from key groups improved:

"We have girls, who have been released from prisons. They are professional seamstresses. We just bought the fabric and sewed a lot of masks. They gave them to their clients. Our staff also worked wearing these masks". Belarus

"We grew closer to each other. We became more sociable, more friendly. Some women knew about me, but I didn't know about them. There have been cases when they call and say, 'We've heard a lot about you, we want to get to know you.' We talked a lot. We have a group on Messenger, we communicate, and a lot of women have joined us". Kyrgyzstan

"I am proud that our organization has been very mobilized. Our board has developed an operational workplan. Our secretariat and regional staff meetings became regular, we have started training processes, and the introduction of new methods of providing services". Ukraine

At the beginning of the coronavirus pandemic, many women who worked in the HIV service organizations, were left without personal protective equipment. The organizations that had protective equipment shared it with others:

"Initially, we had no protection, there was a shortage of masks, antiseptics. We thank the "Positivka" [CSO "Positive Movement"] in Minsk, they provided us masks produced from spun bond, they have their own workshop there, and women sew the masks". Belarus

A partnership between the community organizations and professional organizations during the coronavirus pandemic helped to pool resources and to provide help:

"We had access to other civil society organizations that could share resources. We are united into a consortium, and this helps us a lot". Belarus

"We do not have a strong community. Probably, 4-5 organizations, self-formed organizations, that still want to do something... For this reason, we started doing advocacy. We have a contract with the Association of Young Lawyers, whose members do not stigmatize our community, and cooperate with us. They defend our rights in the court, and help with legal problems". Georgia

MEETING THE BASIC NEEDS OF CLIENTS

Community activists helped those marginalized women who were literally starving and had no hope for help and support from anyone. The activists were implementing new fundraising strategies to meet the basic need of male and female clients for food:

"We had stories that made us want to cry, and be glad that we managed to help in time. For example, sex workers were telling us that they were eating dried bread soaked in boiling water, and when we called and offered them food rations, they sat and cried". Kyrgyzstan

"Now, the financial aid has become so inconsiderable that we don't have enough to keep buying food packages. For this reason, we write grants and buy food. And, together with the food, we provide protective equipment". Armenia

WORKLOAD AND ACCESS TO RESOURCES

Due to the pandemic, the workload for women from HIV servicing NGOs dramatically increased. In the beginning of the pandemic, very often, protective equipment was made at people's own expense. There were situations when the organizations stopped operating because most of the staff was ill. The activists had to use their own resources to provide services and to maintain their continuity, for example, personal transportation. They often performed the functions of doctors:

"We worked around the clock. They delivered the pills in their own vehicles". Belarus

"It was impossible to work remotely because we stayed constantly in contact with the patients. We had to go to the AIDS centre to get medications, patients couldn't come, we did this. We were receiving their medications for them and were sending off all medications. It was very intense work". Armenia

"Well, this all takes money, thermometer here, masks, everything should be there. No additional funding at all. We requested it from the Global Fund even before the quarantine, but we still haven't received anything". Kazakhstan

"When the state of emergency was removed, we managed to go and take some STI tests. And the situation worsened again. Almost 90 percent of my employees are sick, we all in self-isolation now". Kyrgyzstan

National organizations had more chances to receive help in response to the pandemic, as opposed to local organizations:

"The republican-level organizations were all talking big and giving thanks that they had received support. And we stayed, the periphery stayed on the periphery". Belarus

The organizations faced additional administrative costs, such as higher rents:

"We also had a problem with paying rent, because the exchange rate went up sharply, and the rent was based on the dollar exchange rate. And it turned out that we had to write official letters. We were supported by our landlord who decreased the rent until autumn". Belarus

RE-PLANNING AND TRANSITIONING TO ONLINE. SHIFTING PRIORITIES

Organizations faced the need to reorganize office work, limiting working hours, because such requirements were imposed by government agencies under threat of fines. This happened simultaneously with changes in workplans of projects and programmes. The activists noted the difficulties of planning and conducting events. Organizations underwent a transition to a new work -- online – which required new knowledge and skills:

"We switched to online training. We rewrote the entire workplan. It was a request from the fund that provided us the grant. All organizations that received a grant rewrote their plans". Georgia

"You need a work permit. As the person in charge I realize that the organization can be fined. For this reason, we try to transition the staff to online work". Kazakhstan

"I said that I remain in self-isolation, because I am concerned about my health, about the health of my mother. I stayed at home for two months, but I arranged with my supervisor to work via my notebook, and she was flexible about this". Kazakhstan

The agenda related to advocacy, gender equality and human rights became a non-priority:

"The situation in our country is so complicated that it's difficult for us to talk about any rights. For that reason, we are looking for other opportunities". Belarus

"When I tell people that advocacy is needed, or some kind of consulting, they are not up to it. People have other things than protecting rights to worry about. They need to eat". Kyrgyzstan

"Advocacy, you know, we worked on this very intensely last year and the year before that, but due to the situation this year, somehow everyone switched to COVID-19". Moldova

ROLE IN SECURING ACCESS TO SERVICES

Community-led organizations played a key role in ensuring the continuity of ARV treatment in the context of the COVID-19 pandemic. This was facilitated by both the trust of male and female patients, and by stable partnership relations with AIDS centres:

"We did not have cases where someone was left without therapy, all this worked expediently thanks to interaction of NGOs, AIDS centres and the authorities". Kazakhstan

"The Ministry of Health Care gave us documents so we could go to a location without a hitch and provide the medication to patients". Armenia

"When checkpoints were established in the country, we received a lot of help from police officers, from road policemen. They passed the medication, the driver brought it. This was a great help". Armenia

"We worked in tandem with doctors and now we are working. Now their activities have intensified even more. Our people were not left out in the cold". Kazakhstan

"The AIDS centres realized that with our help all this can be done effectively, this interaction between the hospitals, a person, and us. They love us very much for this reason". Moldova

Community-led organizations continued their work providing HIV and SRH services during the lockdown. Women's crisis centres, based on community organizations, were forced to close for the lockdown.

The local population continued supporting their activities, which is a testament to the good reputation of the organization.

"We could not stop working, people kept coming to us, how can we leave them?". Kazakhstan

"Our centre was closed because we have women with small children. Citizens come to us, they bring charitable assistance in the form of food or children's clothes. Our social worker went out herself, took this charitable aid and treated it with antiseptics". Kazakhstan

FUNDING AND SUSTAINABILITY

The activists of HIV-service organizations and women-led organizations noted with gratitude the flexibility and sensitivity of donor organizations, which allowed the redistribution of programme funds for social, humanitarian and other support to clients, and also to ensure the safety of staff members during the epidemic of the coronavirus, including the purchase of personal protection equipment. At the same time, some projects stopped their activities. The government, as a rule, remained passive:

"We have reviewed all our programmes. Fortunately, the donors were quite responsive. They have all changed part of our programmes to meet the social needs of these women. And this naturally improved their situation". Armenia

"We have several projects, and not all donors were flexible. UNICEF and AFEW were quite flexible about the situation". Belarus

"We had help from international structures, that's UNAIDS. We had access to masks and to gloves. All employees were supplied with them. But we had no government support". Belarus

"The Global Fund provided the organizations with antiseptics and masks, gloves, respirators. Okay, we'll keep ourselves safe. What next?". Kazakhstan

"Our organization was lucky in this regard. We had some trips planned abroad, which will, of course, not take place this year. We asked the donor to modify the budget. Now, our organization has protective equipment." Kyrgyzstan

The activists are puzzled by the question of what will happen to funding of the organization after the Global Fund programmes are phased out, and they put little trust in the government funding option in the future, and in the capacity of the government for the effective development of the existing services:

"In our country, the Global Fund has been planning to leave for a while now. What will remain, what will the government take upon itself? Formally, they say they will do it. What quality we don't know. Now, the donors are trying to rebuild because of COVID-19, finances are changing, programmes are changing. Hopefully, it will be to the benefit of our beneficiaries, because adherence to treatment is getting worse". Georgia

"I think we will not get governmental funding for many more years to come". Georgia

CONCLUSIONS AND RECOMMENDATIONS

By the end of the research project and the writing of this report, the EECA countries entered a new phase of the COVID-19 epidemic. This new phase was characterized by an increase in the number of new COVID-19 cases in October-November 2020, and, associated with this increase, an overcrowding of infectious diseases hospitals. According to the study, the first stage of the COVID-19 epidemic revealed systemic issues of access to HIV prevention and treatment in EECA countries. Summing up the conclusions of the study, we hope that the experience the countries of EECA region went through at the beginning of the pandemic will be taken into account by the governmental agencies and international donors, and will help prevent the collapse of the system of providing vital medical and social care for women from the most vulnerable strata of the population.

1. Many women from key populations that lived below the poverty line even before the pandemic found themselves without means of subsistence after the lockdown measures were introduced.

The inability to continue the usual economic activities and the total lack of social protection led to disastrous consequences for women from key populations, including hunger and homelessness among most vulnerable women and their children.

Access to governmental social assistance was hampered due to problems with documents, lack of registration, an inability to officially confirm employment or loss of employment, difficulties with Internet access and overcoming bureaucratic complications. In the cases when women's organizations helped women living with HIV and women from the key populations overcome these barriers, the amount of government assistance was insufficient to remedy the financial situation of these women.

RECOMMENDATIONS:

- To the government: designate women living with HIV and women from key populations to a separate category of socially vulnerable citizens in order to provide them targeted social support.
- To the government: establish cooperation with community-led organizations and networks with the goal of reducing the digital divide and ensure access of women living with HIV and women from key populations to digital public services.
- To donors: provide targeted funding to secure food and temporary shelter for women living with HIV and women from the key populations, who at the time of the pandemic found themselves without means for subsistence.
- To community-led organizations and networks: develop partnerships with state and non-state actors and cooperate with them in addressing the social needs of women from key populations.
- To community-led organizations and networks: include food support, housing support, digital skill-building and other services in service packages for women living with HIV and women from key populations.

2. HIV prevention among key populations is no longer a priority for the government, but not for the community.

To obtain permission to continue prevention among sex workers, women who use drugs and LBT people during the pandemic, community organizations independently contacted the municipal authorities and explained how important it is not to interrupt the provision of HIV-prevention services.

The integration of the COVID-19 prevention into the HIV service package happened in many cities immediately, even though community organizations initially received no support from the government sector. The reason for this integration lies in the fundamental principles of the community-led work: flexibility, informal approaches to solving problems and the use of internal community resources.

With the onset of the pandemic, clients of opioid substitution therapy (OST) programmes faced huge challenges in obtaining OST medications, mainly methadone. The reason for these difficulties is that the clients are supposed to get methadone daily when they visit an OST facility in person. In Georgia, Kyrgyzstan, Moldova and Ukraine, thanks to the community's persistent demands, it was possible to obtain the medication on hand for several days.

RECOMMENDATIONS:

- To the government: provide HIV prevention programmes with work conditions during a pandemic (passes, transportation, PPE).
- To the government: ensure OST is handed out to clients for several days/weeks.
- To the donors: maintain the level of funding for HIV prevention programmes among women from the key populations, even with other priority health-care problems during the pandemic.
- To community-led organizations and networks: obtain official permission from state authorities to continue providing services during lockdowns.
- To community-led organizations and networks: provide personal protection equipment for staff, volunteers and clients.

3. The government system was not ready to provide continuous HIV treatment in conditions of strict lockdown measures (self-isolation)

The lack of a system for informing people living with HIV about how and where to get therapy, the inability to secure dispensing of ARV-medication for half a year period (as recommended by WHO), the inability to secure delivery of medications in conditions of idle transport, and roadblocks set up at the entrance to the capital and regional centres - all this could cause many women living with HIV to be left without access to treatment en masse. Deprived of returning to their home country, women migrants found themselves without access to ART for an indefinite period.

This development in the region was prevented through cooperation between community organizations and healthcare workers, often based on personal contacts, and carried out on a volunteer basis. Women's networks and other community organizations were informing women living with HIV about the new rules of diagnostics and dispensing of ART medications, and delivering the medications. This work was done at the expense of the internal resources of the community, using personal transport, years of established contacts within the community and with the medical services, as well as with the support of a number of donor organizations that turned out to be flexible enough to make timely decisions on the need to realign their current projects.

RECOMMENDATIONS:

- To the government: ensure ARVs are dispensed to clients for several months, as recommended by WHO.
- To the government: establish systematic cooperation with the community organizations on informing people living with HIV and on delivery of the medications, and allocate funding, transportation and personal protection equipment for this.
- To donors: envisage financial/technical assistance projects to support community participation in delivery of the medications.
- To donors: provide funding for establishing "ART banks" for migrant women.
- To community-led organizations and networks: continue to document and address HIV treatment interruptions, including through community-led monitoring.

4. In EECA, a serious deterioration in access to sexual and reproductive health services took place, which was lacking even before the outbreak of the pandemic

Access to the sexual and reproductive health services since the onset of the COVID-19 pandemic generally deteriorated. While if in some countries the changes in access were insignificant, in others sexual and reproductive health services virtually stopped. Access to SRH services is closely connected with infrastructure and transport communications, which took a serious hit due to the COVID-19 pandemic. The regulation of movement within and between cities by law enforcement caused additional barriers for women to access services and forced them to reveal their HIV positive status to police officers.

The study found that in many countries in the region, access to abortion was significantly reduced or is absent, even in situations of rape. Pregnant women with HIV are afraid to give birth or be under observation in health facilities during pregnancy. In countries, gynaecologists significantly reduced their working hours or cancelled; many STI clinics also closed.

At the same time, NGOs and community-led organizations did not stop their work and continued to distribute condoms, along with ART medications delivery, through the use of mobile outpatient clinics.

RECOMMENDATIONS:

- To the government: provide uninterrupted sexual and reproductive health services, including access to contraception, to pregnancy and childbirth support and to abortion during a pandemic.
- To the government: establish systematic cooperation with community-led organizations to improve access to sexual and reproductive health services, and to allocate necessary funding, transportation and personal protection equipment.
- To the donors: envisage financial/technical assistance projects to support access to sexual and reproductive health services.
- For community organizations and networks: continue advocating for SRHR and report on SRHR to national human rights instruments and international treaty bodies.

5. The COVID-19 pandemic has provoked a new surge of violence against women, to which government systems were unable to adequately respond.

The main reasons for the surge in violence are socioeconomic in nature. They are related to a prolonged stay in the same apartment with men prone to aggression and with a deteriorated financial situation; this applies to both women from the general population and to women from key and vulnerable populations. The police response to violence strongly depends on national laws. The fact that not all EECA countries ratified the Istanbul Convention and introduced a law against domestic violence before the pandemic negatively impacted women's vulnerability after the lockdown measures were introduced.

The COVID-19 pandemic affected the work of existing crisis centres/shelters: in some places, crisis centres continued working, but did not accept new clients; in other centres, a problem emerged due to the necessity to isolate new clients. Stigma and discrimination against HIV-positive women, women who use drugs, sex workers and trans* women further limited their access to help for violence they experienced even more.

RECOMMENDATIONS:

- To the government: immediately ratify the Istanbul Convention and introduce laws on domestic violence.
- To the government: increase the capacity of crisis centres/shelters, develop recommendations on prevention of COVID-19 for them and provide resources to implement these recommendations.
- To the donors: support the activities of the crisis centres and havens/shelters run by the community-led organizations.
- To community-led organizations and networks: start/continue with systematic documentation of violence against women living with HIV and women from key populations; expand partnerships with local stakeholders to increase the capacity of shelter/crisis centres

6. During the pandemic, community-led organizations and women's networks were at the forefront of the HIV response, becoming the link between HIV-positive women/women from key population groups, and providing them with life-saving services.

When the COVID-19 pandemic began, women's communities and groups mobilized and started producing PPE to protect themselves against COVID-19, including at their own expense, to independently deliver therapy to people living with HIV, to consult on COVID-19 and to provide comprehensive assistance to women from key populations. The activists received and incentive for new initiatives and development. Women's self-help groups and mutual help groups for psychological support began developing more actively; women's organizations from key populations accelerated their cooperation. Partnerships between community-led organizations and professional organizations during the coronavirus pandemic helped in exchanging resources and providing assistance. At the same time, some projects stopped their activities having received neither support from the government nor assistance from donors in reprogramming project activities.

Due to the pandemic, activists had a sudden workload increase. Women had to use their own resources to secure access and to provide services: personal transport, personal finances and -everywhere - their own time. As a result of "wear and tear" work, by the beginning of the pandemic's second wave, many women community leaders found themselves in dire emotional, mental and financial straits. Community resources are depleted.

RECOMMENDATIONS:

- To the government: recognize the importance and financially support the work of community-led organizations including through social contracting; through introducing positions of peer consultants based at the AIDS centres and other government-owned institutions; to stimulate the work of community-led organizations by providing lease discounts for premises, cooperation in securing unobstructed movement of employees (access permits) during the lockdowns and providing personal protection equipment.
- To the government: establish cooperation with community organizations with the goal of reducing the digital divide and to ensure access of women living with HIV and women from key populations to digital public services.
- To the donors: be flexible about the reprogramming of existing donor-funded projects.
- To the donors: provide technical support and calls for proposals for projects focused on improving sustainability of women's organizations, and on prevention of professional burnout among women activists.
- To community-led organizations and networks: increase monitoring, reporting and advocacy capacities through multi-country community-led initiatives in EECA countries and globally.
- To community-led organizations and networks: continue to support each other and seize the moment to recognize the victories of communities, large and small, in these extremely hard times.

ANNEX 1. GUIDE FOR CONDUCTING AN INTERVIEW

Section 1: Information about the participant of the research

- *Age*
- *City and country*
- *Do you identify as a part of the community of women from key groups? Which group or groups do you belong to?*
- *How long have you been involved in HIV activism?*
- *How long have you been providing HIV services?*
- *Name of the organization (can be omitted in the report at the respondent's request)*
- *What services does the organization provide to women from key groups?*
- *Does the organization do local advocacy work? At national level?*
- *Does the organization receive local funding? From national sources? Through grants from international donors?*

Section 2: The context: What changes, overall, took place in your city because of the COVID-19 epidemic?

- *What institutions, whose services are needed by the residents of your city, are closed for the quarantine?*
- *How has public transport changed?*
- *What other restrictions are the residents of your city experiencing due to the COVID-19 epidemic?*
- *Where can people who reside in your city go for psychological help, which they need due to COVID-19?*
- *Were social benefits offered to the population due to the quarantine introduction? If yes, how accessible were they?*
- *What support did the administration of your city give to the people who lost their jobs or temporary earnings due to the emergency situation? Were there difficulties with rent payment for the people who reside in rented houses or apartments? What assistance was provided to such people?*
- *How was assistance rendered to the people without a passport and residence permit, who found themselves in complete isolation in the emergency situation?*
- *To what extent was the information about prevention of COVID-19 and about contact centres, support services related to COVID-19 available?*

Section 3: Access to services for women: How did the COVID-19 epidemic and restrictions on accessibility affect the rights to sexual and reproductive health services, advocacy, HIV treatment and protection from gender-based violence? How did quarantine affect access to HIV treatment for the women who were blocked in other countries/regions of the country?

- *What sexual and reproductive health services for women who represent key population groups affected by HIV were accessible in your region before the COVID-19 epidemic?*
- *Which of the services you mentioned are accessible to women of your region?*
- *Do you and/or your clients have access to information on where they can get the necessary sexual and reproductive health services?*
- *Has the situation with access to HIV treatment become more complicated? (in general, including diagnostics)? If yes, how?*
- *Has access to ARV medications become more problematic for your clients? Why? What is being done to ensure they receive ARVs?*
- *Do women who live with HIV and representatives of the key groups have access to counselling services about violence? What are these services?*
- *Can your clients access information on where they can get help in case of violence? How do they receive this information? If they are informed about the service, have the clients started requesting this service more frequently during lockdown, and by how much? What types of services are in demand?*
- *Do women who live with HIV and representatives of the key populations have access to housing services in crisis centres? If no, please explain, why? How often did they apply for this service during quarantine?*
- *Please share information about the situation with gender-based violence in relation to the epidemic:*

- How frequent are cases of requests of help due to gender-based violence?

- What other types of help do women with HIV/women from key populations need in relation to violence in the COVID-19 context?

- Are there organizations that provide this type of assistance today?

- Have social benefits been provided to the population in connection with the introduction of the quarantine? If yes, how accessible were they for the women you work with?
- What measures are being taken to improve the situation with access to services?
- What other measures do you think need to be taken?

Section 4: The needs of women living with HIV/vulnerable to HIV: Are there any new needs for women from key populations due to the COVID-19 epidemic and restrictive measures?

- What are the needs of women from the key populations in response to the COVID-19 epidemic?
- Which of these needs are being addressed? How does it happen?
- What other help is needed for women from key populations due to the COVID-19 epidemic?

Section 5: Organizing work: What limitations did you encounter when working during the quarantine? Did you encounter situations involving pressure from the authorities after the start of the epidemic and/or when the restrictions were put in place?

- What difficulties do you encounter at checkpoints?
- Did you have to go through interrogations and searches of your vehicles when crossing checkpoints?
- Were you able to get a special pass (for the organization) to move around the city? If not, what difficulties did you encounter when you tried to get a special pass for travels during the emergency?
- Did you have to abandon using the office/drop-in centre due to the quarantine?
- Do your staff members/volunteers have any protective equipment (masks, gloves, disinfectants)? Is it possible to hand them out to your clients? Were these items provided by the city, or did you have to purchase them?

Section 6: Funding and stability: What additional challenges and risks emerged, or could arise, from the epidemic and the restrictive measures?

- Were you able to reorganize your existing funding due to the change in circumstances?
- Is your organization receiving additional assistance from the government, national or international funds/donors due to COVID-19? If so, for what tasks?

LINKS ON THE SOURCES

[1] - For example: Global Fund Survey: Majority of HIV, TB and Malaria Programs Face Disruptions as a Result of COVID-19; Harm reduction International: The impact of COVID-19 on harm reduction in seven Asian countries; UNAIDS: Survey shows that many people lack multimonth HIV treatment in Latin America

[2] - Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic. UNAIDS. 2020

[3] - For example: Shadow Report of Civil Society Organizations on Discrimination and Violence against Women who use Drugs, Women Living with HIV, Sex Workers and women in prison in Kazakhstan. UN Treaty Body Database, Kazakhstan Union of People Living with HIV, Public Foundation for Women Living with HIV in Kazakhstan, Public Foundation «Answer», Public Association «My Home», Public Association “Amelia” and Public Charitable Foundation “Shapagat” (2018); Additional information to the Shadow Report of Civil Society Organisations on Discrimination and Violence against Women who use Drugs, Women Living with HIV, Sex Workers and women in prison in Kazakhstan. UN Treaty Body Database (2019).

[4] - For example: WHO: access to HIV medicines severely impacted by COVID-19 as AIDS response stalls, WHO (2020); COVID-19's impact on HIV vertical transmission services reversed, UNAIDS (2020).