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NOTES FROM THE FIELD

When Home is Not a Safe Place: Impacts of Social Distancing Directives on Women Living with HIV

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During the current COVID-19 crisis, countries globally are telling citizens to stay home. But what happens when home is not a safe place? Emerging evidence suggests that 'stay home' regulations for the COVID-19 pandemic results in elevated rates of domestic violence, including elder and child abuse, as well as physical, sexual, and emotional intimate partner violence (IPV) [1, 2]. In China, police reports of IPV during lockdown were three times higher than prior to quarantine regulations [3]. Similarly, reports of IPV in France have increased by 30% since March 17th, 2020 and by 25% since March 20th, 2020 in Argentina [1]. In the United States, which as of June 1st has the largest COVID-19 epidemic globally, police data in a number of different jurisdictions that have implemented 'stay home' regulations have indicated increases in domestic violence reports ranging from 10% in New York City, to 27% in Jefferson County, Alabama [4–6]. Our response to COVID-19 must not repeat the violations to women's sexual and reproductive health and rights that occurred during previous pandemic responses, including the 2014–2016 Ebola outbreak, whereby women were denied access to violence support and sexual and reproductive health services, which overwhelmed the judicial system, and resulted in a 75% increase in maternal mortality [2]. While health care systems face mounting pressure and resource strains due to COVID-19, this must not be the time to divert resources away from essential services that support and protect women who have experienced or are experiencing IPV [2].

COVID-19 will Exacerbate Inequities Faced by Women Living with HIV

We have learned many lessons in the global effort to end HIV/AIDS, including that emerging epidemics such as COVID-19 exacerbate and exploit existing inequities of gender, gender identity, ethnicity, sexuality, income, age, and ability, and disproportionately affect those at the margins [7]. Moreover, we have seen that the social, psychological and economic impacts of the pandemic will be felt for long after the peak of infections have subsided [8]. Women living with HIV disproportionately experience multiple intersecting inequities including high levels of IPV, food insecurity and unstable housing [7, 9], thus there is a particular concern that 'stay home' regulations may be both unattainable and unsafe for many women living with HIV [7, 9].

Global evidence suggests that up to 86% of women living with HIV have experienced some form of gender-based violence in their lifetime [10]. In the US, estimates suggest that the lifetime prevalence of IPV among women living with HIV is double (~55%) that of women not living with HIV [11]. This is concerning, as experiences of IPV among women living with HIV have been associated with barriers to HIV care, including lower levels of treatment adherence, and a reduced likelihood of achieving viral suppression [12, 13]. Previous research has also highlighted the negative mental and physical health impacts of IPV experiences among Women living with HIV [10]. Furthermore, recent Canadian data suggests that historical experiences of severe

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IPV, where women have reported lifetime histories of multiple forms (e.g. sexual, physical and emotional) of IPV, may increase women living with HIV's likelihood of dying [14]. A growing body of literature suggests that experiences of violence may alter women's important immune mediators, thereby increasing one's risk to STIs, HIV, as well as women living with HIV's ability to suppress HIV in the body [15, 16]. Thus, the negative physical health effects of IPV among women living with and at risk of HIV may be in part due to biological responses to violence and trauma.

Current 'stay home' regulations coupled with increased household and economic stressors, as well as elevated fear of acquiring COVID-19 during this time may give rise to opportunities for heightened surveillance and control for abusive partners [1, 17]. As HIV care, research participation, and workplace settings are being transitioned to virtual and telephone-based methods, women living with HIV experiencing violence are less able to connect to critical social and protective networks [18]. As such, necessary social distancing measures have the potential to impact the rates and consequences of IPV, increasing social isolation and mental health concerns, which taken together can hinder women living with HIV's access to, and use of, HIV treatment and violence support, further than they already experience [9, 17].

Implications For Women-Centred HIV Care And Future Research

As part of social distancing requirements in many settings, routine HIV care is being offered via telemedicine [7, 19]. For women who may not have disclosed their HIV status to their partners, this form of care provision, although necessary during these times, may not be a feasible option for many women living with HIV. Virtual care provides greater opportunity for disclosing women's HIV status, reduces women's ability to disclose experiences of violence to providers for fear of their abuser overhearing, thus increasing their risk of further experiences of violence [9]. Our previous research has found that among a sample of women living with HIV in British Columbia, Canada, 59% experienced some form of IPV in their lifetime, of those only 12.4% sought violence support [14]. More recent data from the Canadian HIV Women's Sexual and Reproductive Health Cohort Study (CHIWOS), showed 80% of participants reported experiencing violence as an adult, 42% of whom reported seeking help for violence. Among CHIWOS participants who reported seeking help, the most commonly accessed form of help to cope with violence was through health care providers [20]. In other low-income settings, where telemedicine is unlikely to occur, women living with HIV may still struggle to access medication, as their normal collection points, often far from their communities, are no longer accessible, and male partner surveillance of their movement may have increased. As the health care system, and HIV care, may be the first line of violence support for many women living with HIV, during these unprecedented times, it is especially important that HIV care providers take a women-centred trauma-aware approach, which is led by the needs and priorities of their patients [21, 22]. This can help to ensure privacy and address concerns regarding limited mobility and access to medication.

There is limited research on how to support women living with HIV experiencing IPV [23], and the best approaches are particularly unclear during the COVID-19 restrictions. Future research can learn from the years of community efforts aimed at reducing IPV and HIV [24–26], including ensuring efforts are grounded in community-based responses allowing for the meaningful participation of women in all their diversities [7, 9]. Research is needed to examine how the COVID-19 pandemic is resulting in increased experiences of IPV, the impact of IPV during COVID-19 on women living with HIV, and crucially how best to respond to, and prevent, IPV for all women, and women living with HIV in particular. As social distancing measures limit access to supports, such as family, friends, and health care provides, that help women living with HIV cope with experiences of violence and histories of trauma, research is needed to understand the unique ways in which women living with HIV have developed resilience and coping strategies during COVID-19 restrictions and how these can be best supported. These results can inform future strategies to reduce experiences of IPV during emergency situations and public health crises [23]. This research will be critical to supporting women living with HIV's healing in the aftermath of the COVD-19 pandemic. However, this research will not be easy, and will come with many challenges. For example, virtual data collection while confinement measures are in place may lead to communication being discovered by abusers and thus increase women's risk of violence [23]. And in the global South, virtual technologies, connectivity and data are often incredibly limited. Additional methods to reach those most at risk of violence, including women who use drugs, who are unstably housed, and who live in areas of conflict, need to be explored [18]. As innovative technologies and responses are rolled out, there is a critical need for additional guidance on how to safely collect such data in these circumstances [23].

Conclusion

We have limited evidence on the impact of COVID-19 on people living with HIV [27], and how COVID-19 and relevant responses to the pandemic impact experiences of IPV. The intersections of the co-occurring pandemics

of COVID-19 and IPV are critical to the health and well-being of women living with HIV. As we continue to practice important social distancing measures to reduce the spread of COVID-19, it is vital that efforts are implemented to protect those most vulnerable to the virus and the associated adverse consequences of the public health response. This will include continued and accelerated advocacy for stronger judicial and government policies that ensure the protection of all women, including those living with HIV, who may be at particularly high risk of experiencing violence during global COVID-19 lockdowns. By placing women's safety at the center of the COVID-19 response, we can recommit to the global goals of ending both AIDS and gender-based violence.

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