Drogenkonsum in Geschichte und Gesellschaft
Drug Use in History and Society

| 13

Kowalczyk | Steimle | Grabski [Eds.]

Invisible and Ignored

Women and Drugs in Central Asia

Nomos

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Drug Use in History and Society

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Introduction: Women Who Use Drugs in Central Asia – Navigating a Complex Reality

Katarzyna Kinga Kowalczyk, Larissa Steimle, Anna Meryem Grabski

The idea for this book was conceived during the SOLID project. SOLID, which stands for *Social work and strengthening NGOs in development co-operation to treat addiction*, is an international research project coordinated by the Frankfurt Institute of Addiction Research and funded by the German Academic Exchange Service (DAAD) for the period 2020-2024. The project focused on educational and research exchange between five research institutions from Germany, Kazakhstan, Kyrgyzstan, Uzbekistan, and China. Over the course of four years, we had the privilege of exploring the Central Asian region and, most importantly, connecting with its people and hearing their stories. Among them were many women from diverse backgrounds and professions, each facing unique challenges.

Due to the nature of the project, many of the women we encountered were living with HIV and/or using drugs. It was with them in mind that we decided to create this publication. Women who use drugs represent one of the most stigmatized key populations, yet they are often excluded from research and reports. Their experiences remain largely invisible and their voices unheard. This book aims to change that narrative.

In the diverse and rapidly evolving region of Central Asia, the lives of women who use drugs are shaped by a unique set of social, cultural, and legal challenges. Since the collapse of the Soviet Union, countries like Kazakhstan, Kyrgyzstan, Uzbekistan, and Tajikistan have undergone significant transitions in their political and economic structures. However, these changes have often exacerbated the vulnerability of marginalized groups, particularly women who use drugs and women living with HIV (Chapters 2-6). This book aims to shed light on the experiences of these women, exploring the intersections of gender, drug use, and social marginalization in Central Asia.

The social environment in Central Asian countries continues to be influenced by deeply rooted patriarchal norms and traditional values, which often dictate the roles and expectations of women (Chapters 2-6). Despite progress in areas such as education and employment, women in the region

are still predominantly viewed through the lens of family responsibilities and moral guardianship. For women who deviate from these societal expectations – particularly those who use drugs – the consequences are severe. They face heightened stigma, social exclusion, and even violence, which further restricts their access to essential services, including healthcare, harm reduction, and legal protection (Chapters 2-6,9).

The issue of the "Double Stigma"

The situation for women who use drugs is further complicated by what scholars refer to as a "double stigma" - being marginalized not only for their substance use but also for challenging the traditional gender norms that prevail in Central Asian societies. This compounded stigma results in discrimination, both from the public and from within their communities. Women are often perceived as failing in their roles as mothers, caregivers, and upholders of moral values, which exacerbates their social isolation and reduces their access to harm reduction services and treatment (Chapters 2-9).

In Uzbekistan, for example, women who use drugs or are living with HIV face intense social pressures and often remain hidden due to fear of retribution and ostracism. Despite the presence of organizations that strive to support women living with HIV, the services available are limited and often do not cater specifically to the needs of women. In Kazakhstan and Kyrgyzstan, access to opioid agonist therapy and needle exchange programs remains limited, and the requirements for daily visits to clinics pose significant barriers, especially for women with caregiving responsibilities (Chapter 2-4,9).

Barriers to Accessing Services

The barriers that women face in accessing treatment and support services are multifaceted. Legal restrictions, cultural taboos, and the fear of losing custody of their children are significant deterrents. In many cases, women are denied access to shelters and crisis centers due to discriminatory practices that exclude individuals with a history of drug use.

Moreover, punitive drug laws in countries like Kazakhstan and Uzbekistan not only criminalize drug possession but also exacerbate the vulnerability of women who are already marginalized.

Efforts to address these issues have been sporadic and underfunded. Non-governmental organizations (NGOs) have stepped in to fill the gaps left by the state, but these initiatives are often limited by short-term funding cycles and lack of institutional support.

The Role of Advocacy

Activists play a crucial role in supporting women who use drugs in Central Asia, often serving as the first point of contact for those seeking help. This book highlights the efforts of these professionals and the impact of grassroots advocacy in pushing for policy changes. By documenting the experiences of women, this work aims to not only raise awareness but also contribute to the ongoing dialogue about the need for gender-sensitive harm reduction programs (Chapter 4-6).

As Central Asian countries navigate their post-Soviet realities, there is a growing recognition of the need to address the social determinants of health, particularly for vulnerable populations. However, this recognition has yet to translate into comprehensive policy changes that could significantly improve the lives of women who use drugs. The stories and analyses presented in this book underscore the urgent need for holistic, gender-sensitive approaches to harm reduction, healthcare, and social support in the region.

The book consists of 9 chapters: The first chapter is the general introduction, the second: *Invisible and Ignored: Gender-Based Challenges in Drug and HIV Treatment Services in Central Asia* introduces the situation of women who use drugs and/or live with HIV in the Central Asian region, focusing on their access to support services. Next, we discuss the *Socio-Psychological Aspects of Women Living with HIV in Kazakhstan*, examining the specific psychological and social challenges these women face (Chapter 3). This is followed by *three chapters (Chapter 4,5,6)* containing interviews with women from Kazakhstan, Kyrgyzstan, and Uzbekistan, who share their personal experiences and perspectives. We then focus on specific topics related to women, including the *Protection of Reproductive Health and Family Planning (Chapter 7)*, *Women and Smoking in Central Asia*

(Chapter 8), and *Social Work with Women Who Use Drugs in Central Asia (Chapter 9).*

This book reflects what also applies to the entire region. The topic of women and drug use, including their specific needs, has so far received little attention. That includes the scientific perspective, the perspective from people working at support services, and most importantly the perspective of women who use drugs themselves. Therefore, with this book, even though the goal never was to aspire to all the topics related to women and drug use in the region, it was important to us to highlight certain topics and provide a platform for this target group. Instead of only presenting information and data we wanted to give the voice to the women, and therefore we conducted interviews. At this point, we would like to express our heartfelt gratitude to our interviewees for their trust and willingness to share their stories.

The Editors

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1. Invisible and Ignored: Gender-Based Challenges in Drug and HIV Treatment Services in Central Asia

Katarzyna Kinga Kowalczyk

Introduction

Women who use drugs remain largely invisible in society, particularly in low- and middle-income countries. This invisibility is reflected in the limited data on drug use prevalence among women. In Central Asia, the situation is similar, with harm reduction research often overlooking gender-specific issues (AFEW 2015). Although some data are available, primarily from narcological registries, they fail to capture the true number of women who use drugs. For example, in Kazakhstan, 1,498 women were registered in the drug registry in 2023, accounting for 8% of all registered individuals (Prime Minister of the Republic of Kazakhstan 2023). Additionally, women comprised 18% of those enrolled in opioid agonist treatment. However, estimates suggest there are around 22,000 women who use drugs in the country (Vorontsova 2018).

In Kyrgyzstan, there were 479 women in the drug registry in 2020 and 399 in 2025, which accounted for 6 % of all registered people. Among the clients of opioid agonist treatment, 10.5% are women (CADAP 2023; Republican Centre of Psychiatry and Narcology 2025). The estimated percentage of women who use drugs in Kyrgyzstan is 12% (3,000) of the total estimated 25,000 people who use drugs (EHRA 2019).

At the end of 2017, the number of registered drug-dependent people in Uzbekistan was 8,036, of whom less than 2% were women (Gazeta.uz 2018). In Tajikistan, 3%–4 % of people who use drugs are women (Chingin/Fedorova 2014). No data are available for Turkmenistan.

While the prevalence of drug use among women appears low, it's important to recognize that these data are likely underestimated. There are, however, more comprehensive data available on women living with HIV. In Central Asia, the HIV epidemic among women is significant. According to recent Joint United Nations Programme on HIV/AIDS (UNAIDS) data (UNAIDS 2023a, b, c, d), there are approximately 13,000 women in Kazakhstan living with HIV (which accounts for 33% of adults aged 15 and over

living with HIV), 4,700 in Kyrgyzstan (which accounts for 39% of adults aged 15 and over living with HIV), 4,800 in Tajikistan (which accounts for 34% of adults aged 15 and over living with HIV), and 27,000 in Uzbekistan (which accounts for 33% of adults aged 15 and over living with HIV).

In the case of women who use drugs and women living with HIV, it is undoubtable that gender inequality, cultural norms, and oppressive legal systems contribute to the fact that these women are not using treatment and support services. The ethnocultural status of women in society and traditionally established norms of behavior also play a role (Chingin/Fedorova 2014). This is accompanied by a lack of services focusing on women's needs – a serious concern given several reports have noted that, compared with males who inject drugs, women who inject drugs are often at greater risk through unsafe injection practices and unprotected sex (Latypov et al. 2014). Additionally, overall mortality studies of drug users registered in the narcological registers performed in Uzbekistan, Kazakhstan, and Tajikistan found that the highest excess mortality among registered people who use drugs in all three countries was substantially higher for women than men (Latypov et al. 2014).

The aim of this paper is to examine the existing barriers preventing women from using the services available to them and provide recommendations for improving both existing and new services.

The Role of the Woman

Central Asia consists of five separate countries that differ from one another in many ways. However, there are some similarities in the perception of a woman's role and obligations in society. A very strong role is played by national ideologies, which assert that men are the heads of households, the primary breadwinners, and visible in public spaces, while women's roles are largely confined to domestic duties such as child-rearing and caring for the elderly. One of the key roles that women are expected to pursue is motherhood, which was promoted by soviet propaganda as a national duty, encouraging high birth rates. This association between femininity and motherhood still persists, embedding women's roles in notions of purity, chastity, and morality (Cleuziou/Direnberge 2016). Another factor is the concept of 'shame' (*haram*), which further reinforces these gender norms, particularly in regulating women's sexuality and behaviour (Cleuziou/Direnberger 2016).

Gender norms that link women to morality, purity, and household responsibilities sometimes result in women being evaluated more harshly than males in many societies, including those in Central Asia. The idea that women who take drugs are not only going against what society considers to be a feminine standard but also failing in their roles as mothers and caregivers adds to this stigma.

Stigmatization

The literature on the social impact of stigmatization suggests that there is greater stigmatization of female drug users compared to men who use drugs (Lee/Boeri 2017). Studies consistently show that stigma negatively impacts health and contributes to health disparities found among marginalized populations (Chaudoir et al. 2013; White 2002). Social stigma towards alcohol and other drug addictions may be an obstacle to resolving problems or to even coming up with a strategy to solve the issue of addiction. Stigmatization is one of the key factors why women do not use the services available to them.

A significant problem for women who use drugs is the denial of medical services. For instance, essential healthcare services like emergency care or visits to a general practitioner may be refused to them because doctors are unwilling to engage with dependent patients. Another issue is the breach of confidentiality, as healthcare workers may neglect requirements for keeping the medical data of opioid agonist therapy (OAT) patients confidential (Alliance for Public Health 2021). When discussing structural stigma, we have to also acknowledge structural sexism, which refers to the ingrained beliefs, policies, and practices within society or organisations that are based on sex and gender, resulting in inequality and unfair treatment (Kelley/Gilbert 2023).

Gendered Legal Barriers and Human Rights Violations in Health Access

Punitive laws and existing inequalities result in women and adolescents further struggling to access HIV and HR treatment, care and support. In their 2023 assessment, Eurasian Women's Network on AIDS (EWNA 2023) highlighted some of the key gender-based problems in the region:

- Restrictions for women who use drugs preventing them from accessing shelters when they experience violence (Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan).
- Punitive regulations regarding sex work (Tajikistan and Uzbekistan).
- Restrictions preventing adoption and guardianship for people who use drugs (Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan).
- Restrictions of parental rights for people who use drugs (Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan).
- Laws criminalizing the possession of drugs for personal use (Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan).
- Lack of services acknowledging women's needs.
- Insufficient psychological support for women.

A significant concern of women who use or could use the services available to them revolves around the potential loss of child custody. This can affect their motivation for seeking treatment, given that children are a primary reason for undergoing treatment for many women. This is fueled by the belief shared by some that mothers with HIV pose a health risk to their children or that they are incapable of providing proper care.

The human rights of women are frequently violated by the law enforcement system. Reports of police interference and harassment are widespread. Typically, individuals who use drugs frequently experience arbitrary arrests and unjust persecution by law enforcement officials. In countries where opioid agonist therapy is available, such as Kyrgyzstan, drug dispensing points have become a 'hunting ground' for the police. Officers apprehend patients with prescribed methadone (multi-day dose) and arrest them, even if they present documents confirming the legality of their medication. Moreover, patients may be arrested even before they visit opioid agonist treatment sites, as seen in Tajikistan (Alliance for Public Health 2021).

Gender-Based Violence

Across the region, women suffer from gender-based violence, and within the context of the HIV response, women consistently experience marginalization and criminalization, as well as stigma and discrimination (EWNA 2023). Women from key populations, including women living with HIV, are the group most vulnerable to violence (Bessonova et al. 2024). Women

who exchange sex and use drugs (WESUD) are also at higher risk for HIV infection and partner violence (Witte et al. 2023).

There are certain problems in the healthcare system that affect the situation with gender-based violence, for example in Kazakhstan more than 55% of medical workers indicated the lack of private examination rooms, 50% of medical personnel use only local examination instead of a full examination, more than 78% of medical workers do not involve a psychologist in their work when faced with cases of gender-based violence, and a third of medical workers do not register cases of gender-based violence as acts of violence, despite the presence of the necessary codes in the International Classification of Diseases ICD-10 (United Nations Population Fund (UNFPA) 2017). Instead, cases of gender-based violence are recorded as ordinary injuries, and 95% of health workers do not use the World Health Organization (WHO) clinical survey on gender-based violence.

What also contributes to violence is the high level of corruption in the healthcare system and among law enforcement agencies, educational institutions, and service providers. Women become victims of corrupt mechanisms more often than men, especially when applying for social payments and benefits or when applying for a job, because they cannot pay a bribe (AFEW 2015).

Services for Women

In their study on the involvement of women who use drugs in improving the quality of and access to harm reduction services, AFEW (2015) found that women using services in two major cities in Kyrgyzstan (Bishkek and Osh) were least satisfied with government-run services, such as methadone treatment programs. A key issue highlighted was the lack of flexibility, exemplified by the requirement to visit the clinic daily to receive methadone. The lack of flexibility in harm reduction services poses challenges for women, as daily clinic visits can conflict with caregiving responsibilities. Only 25% of women using these services in Bishkek and 15% in Osh were fully satisfied with these services. In contrast, satisfaction levels were higher with syringe exchange programs, where 80% of women using services in Bishkek and 45% in Osh reported being completely satisfied. The highest satisfaction was observed with non-governmental organizations (NGOs) specifically focused on working with women, with 90% of women using services in Bishkek and 40% in Osh expressing complete satisfaction. This

disparity is unsurprising, as in general government services often fail to address the specific needs of women.

The full range of services needed by women is only available at women's centers. At needle and syringe exchange points (NSPs) and opioid agonist treatment centers, there is limited assistance, which does not cover all needs and requirements. The problem is that women's centers are funded exclusively by external, donor organizations on a short-term basis. Thus, there is no sustainability, which is also a barrier to long-term planning and institutionalization.

Some of the other needs mentioned by women in the AFEW study that were not covered in the services provided included material assistance in the form of food, detergents, and medicines, as well as childcare, which would help women to undergo treatment and find and maintain a job. These needs indicted the importance of collaboration with additional services.

What was also missed was access to psychological services, as this was not provided by every service.

Insufficient Psychological Support

Despite significant rates of mental and substance use disorders in the Central Europe Eastern Asia (CEECA) region, there has been a lack of attention paid to the implementation of quality, contemporary mental healthcare services outcomes (Hook/Bogdanov 2021).

A study aimed at assessing the frequency of anxiety and depression among women living with HIV in Kazakhstan (Mishkin et al. 2021) found that among the 410 women living with HIV that were surveyed in Kazakhstan, 15.1% experienced clinically significant anxiety, 12.7% met the criteria for major depression, and 8.5% suffered from both conditions. Overall, nearly one in five participants reported symptoms of either anxiety, depression, or both. Despite the high rates of anxiety and depression, access to psychiatric care was notably limited, with only 4.1% of the women reporting a diagnosis of depression or anxiety by a psychiatrist, and none reported using approved psychiatric medications. This highlights a significant gap in mental health services for women living with HIV in Kazakhstan, pointing to the need for integrated care models that address both HIV and mental health. These conclusions can potentially be generalized to other Central Asian countries.

Physical Health

The effects of psychoactive substances on the body can be severe. Psychoactive chemicals can cause notably different physical reactions in women than men, and women are more vulnerable to certain associated health problems. Moreover, physiological effects, health problems, and gynecological medical demands are associated with substance addiction in women (Peters et al. 2003). Menstrual abnormalities, such as amenorrhea or an irregular menstrual cycle, are experienced by women who use heroin or methadone, for instance (SAMHSA 2015). In the previously cited AFEW (2015) study, the most in-demand medical service among women who use drugs was gynecological consultation and ultrasound examination. Another effect of heroin usage is deficiencies in sexual desire and performance (Llanes et al. 2019).

The literature indicates that women experience heightened symptoms in reaction to many psychoactive substances compared to men. Compared to males, they reported heightened symptoms related to the skin, gastrointestinal system, nose and throat, neurological system, and heart. Women with a history of drug use who experience increased physical discomfort, insomnia, irritability, anxiety, and depression during menopause may face a heightened risk of relapse (Shaw et al. 2022).

These health needs are often times neglected, and healthcare specialists do not have enough knowledge about the problems of women who use drugs and women living with HIV. There is a lack of services focusing on women's sexual and reproductive health. Developing the skills of addiction medicine experts is necessary if they are to provide services that are sensitive to the needs of women and to promote women-focused addiction treatment research and policy.

The Economic Situation

Poverty and a low level of education create significant barriers for women seeking help from services designed for those who use drugs. Women living in poverty often face a lack of access to resources, including transportation and healthcare, which can make it difficult to reach and utilize these services. This is why it is so important to provide comprehensive help focusing on different life areas. In the AFEW study among the participants using services in two main cities in Kyrgyzstan (Bishkek and Osh), wom-

en with only primary, secondary or no education accounted for 69% of respondents, and only 20% had permanent jobs. At the time of the survey in 2015, the majority of women had unstable temporary earnings/jobs.

The results of this study emphasized that women need a wide range of social services to help them with issues such as obtaining documents, education, housing and income, assistance with family and parenting tasks, psychological support, and safety and trust in service providers. Unfortunately, obtaining such a range of services within the existing legal and institutional framework was impossible.

In a study by Witte et al. (2023) with women who exchange sex and use drugs in Kazakhstan, 354 Kazakh women have undergone an intervention that combined HIV risk reduction (HIVRR) activities with microfinance (MF) components, which included:

- Financial literacy training (FLT): sessions designed to improve participants' financial management skills.
- Vocational training: training in skills such as hairdressing, sewing, or manicuring to provide alternative income opportunities.
- Matched savings program: participants were encouraged to save money, which was matched to help them accumulate assets for small business development or further vocational training.

The results of this study demonstrated that integrating economic empowerment strategies like microfinance with HIV risk reduction interventions can be effective in reducing certain forms of violence against WESUD, though the effects may vary depending on the type of violence and the relationship context.

Country-Specific Overview: Kazakhstan

Kazakhstan ranks 65th among the world's countries in terms of gender equality issues. In recent years, Kazakhstan has made significant strides in advancing gender equality and protecting vulnerable populations. Kazakhstan has been a leader in Central Asia in promoting gender equality and combating violence and discrimination against women, including those living with HIV. Despite progress, issues remain, particularly in ensuring access to services in crisis centers for women from key population groups (UNDP 2022). In 2021, the country became an official member of two global coalitions aimed at combating gender-based violence and promoting

economic justice and legal reforms. Legislative advancements include the introduction of a mandatory 30% quota for women and youth on electoral party lists and in the distribution of deputy mandates, as well as the legal cancellation of restrictions on women's employment in certain jobs. Additionally, 31 family support centers have been established across the country regions, and women's entrepreneurship development centers have been opened nationwide. The country has also strengthened its laws and penalties related to violence against children, reflecting a broader commitment to social justice and the protection of human rights (UNDP 2022). The 2020 Code of the Republic of Kazakhstan on Public Health and the Healthcare System guarantees the right of people living with HIV to adopt children. However, some by-laws continue to create barriers for people living with HIV in realizing their right to adopt children.

Despite these efforts, women from key populations, such as those living with HIV, face significant barriers in accessing services. This includes difficulties in receiving support from crisis centers intended for victims of domestic or other forms of violence.

Women living with HIV in Kazakhstan often face high levels of stigma, both from the general population and within healthcare settings. This stigma can prevent them from seeking the care they need, further exacerbating their vulnerability. This stigma is compounded by discrimination in healthcare facilities, where confidentiality concerns and the risk of disclosure prevent women from seeking necessary care outside specialized centers. The specific needs of women in certain situations, such as those in prisons, are not adequately addressed. There is a lack of research and disaggregated data on the conditions and needs of female prisoners living with HIV, which indicates a gap in policy and service provision for this group (Deryabina et al. 2011; Cordingley et al. 2023).

There is insufficient coordination and a lack of a comprehensive communication strategy that integrates gender equality issues with the HIV response. This gap affects the ability to collect and analyses strategic information, which is crucial for shaping social policy that effectively addresses the intersection of gender, public health, and human rights.

Women, particularly those from marginalized groups, face economic and social vulnerabilities that can make them more susceptible to HIV. These vulnerabilities include limited economic independence, lack of access to education, and limited opportunities for employment (UNAIDS 2019).

Country-Specific Overview: Kyrgyzstan

As in many other countries of Central Asia, in the Republic of Kyrgyzstan women are exposed to various forms of gender-based violence from their partners, those close to them, and the police. They also experience stigma and discrimination from healthcare providers in medical institutions (EHRA 2019). These challenges stem from a combination of social stigma, legal discrimination, and limited access to essential services, all of which are further intensified by the country's deeply ingrained gender inequalities (CADAP 2013).

Women who use drugs in Kyrgyzstan are subjected to severe societal stigma. This stigma is compounded by prevailing gender norms that harshly judge women for behaviors deemed to deviate from traditional roles. As a result, these women are often marginalized, both within their communities and by society at large, leading to social isolation and exclusion. The stigma extends to healthcare settings, where women who use drugs are frequently treated with disdain or outright discrimination. This can discourage them from seeking medical help, exacerbating health issues that could otherwise be managed or treated. The stigma also affects their access to services like contraception, prenatal care, and mental health support, all of which are critical to their well-being (Matyushina-Ocheret 2020).

Access to healthcare for women who use drugs is severely limited. The already CADAP quoted report on Women and addictions in Kyrgyzstan highlights that harm reduction services, such as methadone treatment, are often inaccessible to women, either due to discriminatory practices within these programs or because of the presence of law enforcement around treatment centers, which deters women from attending.

The lack of gender-sensitive healthcare services means that women who use drugs do not receive the specific care they need. This includes services for sexual and reproductive health, mental health support, and treatment for co-occurring conditions such as HIV/AIDS and tuberculosis. The healthcare system's failure to address these needs leaves many women without the care necessary to maintain their health and well-being (CADAP 2013; Matyushina-Ocheret 2020).

Violence against women who use drugs is a pervasive issue in Kyrgyzstan. They are exposed to physical, sexual, and emotional abuse from intimate partners, law enforcement officials, and even healthcare providers. In their report on women and addiction in Kyrgyzstan CADAP in 2013 indicates that women are often subjected to police harassment, including

being targeted for arrest or coerced into providing sexual favors in exchange for leniency. 80% of women who use drugs have experienced violence either from law enforcement or intimate partners. This rate is significantly higher than among the general population, where such violence is reported at a lower rate (CADAP 2013).

Discrimination is institutionalized, with women who use drugs facing barriers to accessing justice. They are often criminalized under laws that penalize drug possession, even for personal use, leading to incarceration or other legal penalties that further entrench their marginalization. This legal environment fosters a cycle of violence and exploitation, as women are left with few resources or avenues for protection. The legal framework in Kyrgyzstan is particularly punitive towards women who use drugs. The criminalization of drug possession, even in small amounts for personal use, means that these women are often caught in a cycle of arrest, incarceration, and social exclusion. This approach not only fails to address the root causes of drug use but also exacerbates the social and health problems faced by these women (Matyushina-Ocheret 2020).

Furthermore, there is a lack of legal protection for women who use drugs. Laws that should protect women against gender-based violence and discrimination are either inadequately enforced or do not address the specific needs of women who use drugs. This legal neglect leaves these women without recourse in situations of abuse and exploitation.

Economic instability is another significant challenge. In CADAP's report, 90.4% of women reported that they did not have enough money to buy food in the past 90 days. It is also important to acknowledge that there are virtually no mechanisms in place to encourage businesses to increase employment opportunities for vulnerable people.

Country-Specific Overview: Tajikistan

A study conducted in Tajikistan (King et al. 2016) provided a detailed examination of how deeply ingrained gender norms and roles in Tajikistan influenced HIV risk behaviors and access to services among key populations and incarcerated individuals. The research highlights how men's dominance in sexual relationships often results in women having little to no power to negotiate safer sex practices, such as condom use. For many men, the idea of using condoms is seen as unnecessary or even as a threat to their masculinity, which further diminishes women's ability to protect

themselves from HIV. Women who attempt to negotiate condom use often face violence or accusations of infidelity, reinforcing their vulnerability.

The study also reveals that gender norms significantly restrict access to HIV testing. Women living with HIV encounter additional barriers due to stigma, which not only labels them as immoral but also discourages them from seeking testing or disclosing their status. Although men may have more freedom to seek testing for themselves or their wives, women face substantial difficulties in convincing their male partners to get tested, particularly when those men return from migrant work abroad. For many women, the only time they are tested for HIV is during pregnancy, often when it is too late to benefit from early intervention. The study highlights that counselling services are limited, particularly if a woman is diagnosed during labor, and delays in receiving test results further complicate timely access to treatment.

The legal framework of Tajikistan explicitly punishes people living with HIV. Article 125 of the Tajikistani Criminal Code states that it is illegal to give someone the virus or to put them at risk of getting it. According to this article, law enforcement agencies file criminal charges against individuals who are HIV positive simply because they pose a risk of HIV transmission or are HIV positive (even if the person has an undetected viral load and is not transmitting the virus). Article 162 of the Health Code gives doctors the right to disclose the status of HIV-infected patients at the request of the investigating authorities and does not contain any justification for this (UNAIDS 2022).

The prevalence of gender-based violence is another critical issue. Intimate partner violence is widespread and socially accepted in Tajikistan, with many women believing that their husbands have the right to beat them. This violence often escalates when women try to negotiate safer sex practices or disclose their HIV status. The fear of violence not only increases the risk of HIV transmission but also serves as a significant barrier to accessing HIV services. Police violence is also a serious concern for female sex workers, who are often dehumanized and subjected to abuse, further marginalizing them and limiting their ability to seek help (King et al. 2016).

The study highlights the double stigma faced by women who inject drugs, who are not only marginalized because of their drug use but also harshly judged for violating traditional gender norms. These women are often shunned by society and treated poorly by healthcare providers, making it even harder for them to access harm reduction services.

A significant issue identified in the study is the lack of women-centered spaces within Tajikistan's HIV response. For example, services for female sex workers are often housed in facilities primarily designed for people who inject drugs, where male users have priority. This lack of dedicated spaces makes it difficult for women to access the services they need in a safe and supportive environment. The study also notes that women who inject drugs are a particularly hidden population, making it difficult for outreach services to reach them. The scarcity of female outreach workers and the absence of tailored harm reduction services exacerbate this issue, leaving many women without the support they need.

Economic dependence on men is another critical factor that limits women's ability to access HIV services or leave abusive relationships. Many women in the study reported being financially dependent on their male partners, which reinforces societal norms that expect women to be caretakers of the home rather than active participants in the workforce. The study underscores the importance of building women's capacity and providing income-generating activities as a way to empower them to take control of their health and access services. However, women living with HIV are often not prioritized in government grants and other support programs, highlighting a significant gap in the current HIV response.

Country-Specific Overview: Uzbekistan

In Uzbekistan, the majority of clients in harm reduction and drug dependence treatment programs are men. Current services lack specialized provisions for women and do not offer separate facilities or designated times to address their needs. The societal perception of women who use drugs is shaped by traditional views on gender roles, further exacerbated by negative attitudes towards drug users. This widespread stigma intensifies their vulnerability, putting their health and lives at greater risk (EHRA 2018).

People living with HIV also face high levels of stigma (UNAIDS 2023d). In one of the studies reported by UNAIDS, 76% of women aged 15–49 claimed they would refuse to buy vegetables from a vendor living with HIV and would not allow children with HIV to attend school with other children. This prejudice is largely driven by a lack of knowledge, as only 14% of women in this age group have comprehensive information about HIV (UNAIDS 2023d).

With regards to violence underreporting is still a major problem despite the government's dedication to the fight against gender-based violence and its legislative initiatives. Early and planned marriages are a common practice that further limits women's autonomy by denying many of them access to complete sexual education, as well as limiting their economic and educational prospects. Open dialogue on reproductive health and prevention is frequently impeded by cultural norms, especially in family and school contexts (UNAIDS 2023d).

Examples of Organizations and Initiatives Targeting Women in Central Asia

EWNA—the Eurasian Women's Network on AIDS

The Eurasian Women's Network on AIDS was created to make political declarations on combating HIV/AIDS and human rights a reality for women in the Eastern Europe and Central Asia region. These rights are related to access to health services, including reproductive health, the eradication of violence against women, and the right to be involved in the political and public discussions on which our lives and health depend.

In the summer of 2013, a coalition of women activists from Russia, Kazakhstan, Ukraine, Georgia, and Tajikistan came together to initiate the formation of a regional association for women affected by HIV. Six months later, representatives from Moldova, Armenia, Uzbekistan, Kyrgyzstan, Estonia, and Belarus joined their efforts. In 2013, the founding meeting of the organization was held in Tbilisi, Georgia, with women leaders from eleven countries across the EECA region in attendance. The EWNA was legally registered in Tbilisi in 2015, and over time it has become a powerful regional women's public movement, placing women's leadership at the center of the HIV response in the EECA region.

The Public Foundation Revanche

Opened in 2018, Revanche, an NGO based in Almaty, Kazakhstan, provides help to many marginalized groups, such as people who have left prisons, people who use drugs, people living with HIV, people with socially significant diseases (HIV, tuberculosis, hepatitis), children from orphanages, sex workers, and women who cannot go to a crisis center. Among the services

Revanche provides is HIV testing, medical and psychological services, social work and legal help, and psychosocial education.

Special attention is paid to women, especially those released from the colonies (a place where prisoners are sent to live far away from the rest of society, in a distant area.), to help them to start a new life. Revanche uses a 'peer-to peer' model in which the consultants have their own lived experience of the issue; for example, women who have been living with HIV for many years counsel women who have only recently learnt about their diagnosis.

As a part of its activities, the organization put on a performance consisting of monologues from the lives of people living with HIV, ex-prisoners, and women survivors of violence. The creative initiative grew into the idea of creating a social theatre aimed at preventing HIV, drug use, and other social problems.

Women's Centers in Kyrgyzstan (Asteria Public Foundation and the Public Foundation Podruga)

Women's centers are specialized social services aimed at providing a comprehensive package of social services for women, whose staff members are from the community of women who use drugs, formerly incarcerated women, and women living with HIV.

Asteria Public Foundation

Asteria Public Foundation was founded in 2006 by a group of women with a history of substance use. Asteria is a community-based organization that provides social services and psychological support to women who use drugs, sex workers, formerly incarcerated people, and women living with HIV, as well as their partners and relatives.

The Foundation is a unique place where a woman can receive a comprehensive package of supportive services all at once, including temporary housing, food, medicines and hygiene products, and legal support, as well as social referrals and access to self-help groups.

Asteria also conducts advocacy activities to improve the living conditions of women substance users. The Foundation works closely with physicians, law enforcement officials, and crisis centers to reduce discrimination and stigma against people who use drugs.

The Public Foundation Podruga

The public foundation Podruga (meaning 'girlfriend') was founded in 2001 and is based in Osh, southern Kyrgyzstan. The organization provides comprehensive social, psychological, and medical support to women engaged in risky behaviors within key populations. The organization focuses on educational initiatives, promoting social rehabilitation, and supporting the adaptation of vulnerable individuals into society. Additionally, Podruga works to raise awareness among state and public institutions about the challenges faced by high-risk groups, while actively engaging in the prevention of human trafficking and addressing critical gender issues.

Programs and Projects focusing on Women

Living with Dignity, Tajikistan

The aim of the Zindagii Shoista ('Living with Dignity') Program in Tajikistan (2015–2018) was to prevent violence against women and girls (VAWG) in four rural villages. Utilizing a family-centered approach, the program worked with 80 families to transform attitudes and social norms, strengthen relationships, and empower women economically with a view to reducing VAWG. At the end of the intervention, the proportion of women experiencing violence from their husbands and in-laws had fallen by 50%. The program demonstrates that a dual approach focused on social norms change and economic empowerment can have a gender transformative impact and significantly reduce violence against women (Shoista 2018).

Wings of Hope, Kyrgyzstan

In 2019, crisis centers in the cities of Osh ('Ak Zhurok'), Bishkek ('Shans' and 'Sezim'), Karakol ('Ayalzat—Women's Initiatives Development' and 'Meerman'), and Naryn (Public Association 'Tendesh') began working on implementing a pilot project in Kyrgyzstan aimed at establishing a 'one-stop' service model for assisting women who have experienced violence. This initiative was supported by the GLORI Fund and the Crisis Centers Association (Glori 2019), with financial backing from the United Nations Development Programme (UNDP) in the Kyrgyz Republic.

The project was modelled after South Korea's 'Sunflower Centers', which have operated since 2004 and provide a comprehensive support system for women who are victims of gender-based, sexual, or domestic violence. These centers offer integrated services, including counselling, psychological, medical, and legal support, and assistance with legal investigations - all within the same facility. This approach was expected to reduce the risk of repeated violence and help women return to normal life more quickly, while also avoiding secondary victimization.

The six crisis centers involved in the project in Kyrgyzstan followed a unified methodology for providing initial counselling and support to victims. This methodology was based on the WINGS model (Women Initiating New Goals for Safety), developed by researchers at Columbia University in the United States. Key components included educational sessions on the specifics of different types of gender-based violence, assessing the risk of re-victimization, psychological support, and social reintegration, and developing safety plans and setting future goals. Women were referred to medical facilities for services that cannot be provided by the crisis centers, with services tailored to the specific needs of each woman based on the severity and nature of the violence they have experienced.

The project primarily served women with below-average income levels, who often face financial constraints. These women sought help after experiencing gender-based violence, usually at the hands of their husbands, partners, or former spouses. Psychological violence, such as insults and threats, is in general the most common form of abuse, but other forms, including isolation and economic violence, are also prevalent. Economic violence, a common tool for suppressing women, involves restricting their access to financial resources or exploiting their trust by creating debt obligations in their name.

Alongside experts and civil activists, efforts were being made to select medical institutions with experience in preventing gender-based violence or assisting victims. These institutions were adapted to offer one-stop services that meet international safety and quality standards. The goal was to create comfortable, private conditions that also facilitate effective investigative procedures. Facilities had to be equipped with Wi-Fi, audio-video equipment, and a two-way mirror, allowing for private testimony collection and remote specialist consultations. The medical institutions should have established protocols for cooperating with law enforcement and women referrals.

The evaluation of the project revealed that after the intervention, the number of young women experiencing violence from both their husbands and in-laws was reduced by 50%. Additionally, reports of physical intimate partner violence (IPV) among women over the past year decreased significantly, dropping from 45% to 16.5%, while incidents of sexual IPV fell from 29% to 4%. Women's earnings increased fourfold, and the proportion of women with any savings grew tenfold. Furthermore, there was a significant decrease in depression rates and suicidal thoughts among both women and men.

Implications for the design of services for women

To conclude the chapter, several recommendations are presented drawn from various reports and surveys on how to improve services for women (AFEW 2015; Matyushina-Ocheret 2020; EMCDDA 2023; Center for Justice Innovation 2023; EWNA 2023).

Collect Data

One of the major recommendations is to collect comprehensive, gender-specific data on the prevalence of drug use, HIV, violence, and other related needs. The data in these reports should be disaggregated by gender to address specific issues more effectively. It's difficult to create services and address the needs of women without knowing the provenance of the problem.

Assure Basic Standards in Women's Treatment Services

Care should be given in settings that are suitable, safe, stigma-free, and accessible to both pregnant women in particular and women in general, and other especially vulnerable groups such as people with disabilities.

Women ought to be able to choose whether to have a female key worker or take part in group sessions just for them (without the presence of men).

Trainings should be organized for health and social workers on gender-sensitive service delivery, as well as for law enforcement officers.

Be Flexible

The working hours of the services should be flexible. Women should also be able to change their appointment times to fit in with other obligations, such childcare or employment.

Provide Support for Childcare

For many women, access to therapy is severely limited by a lack of childcare. Childcare should be supported by services so that women, particularly single mothers, can attend therapy.

Improve Personnel's Ability to Handle Gender-Specific Needs

Women's services should include trauma-informed care principles. It is important to teach key personnel how to identify and handle warning indicators of sexual and domestic abuse.

Make Sure Substance Use Does Not Prevent Access to Crucial Services

Receiving essential recovery treatments shouldn't be hampered by women's use of drugs. These programs include, among other things, social housing, mental health services, and shelters for abused women. Trauma-focused therapies must be easily accessible.

Collaborate or Integrate Services

The help provided should focus on different areas: physical, mental, legal, and social. This is why cooperation between different services is highly important, as is implementing the 'one-stop-shop' model in which all services are provided in one place.

Integrate Health Services

The focus should not only be on blood-borne diseases. Other health issues are also important, such as menopause, sexual health, reproductive health,

and smoking cigarettes. It is crucial to ensure that women have access to services that provide this support.

Include Women in the Creation of Services and Promote Community-Led Harm Reduction Programs

To make sure that services appropriately fulfil the needs of women who use drugs, including former users, it is crucial to actively seek out their thoughts - they should be involved in the process of designing, monitoring, and evaluating services.

Women should be encouraged to participate in working groups at all levels in the development and amendment of legal or subordinate acts (state programs, clinical protocols, service standards, etc.).

Community-led programs are seen as crucial for building trust and linking women with essential health services in a way that reduces stigma.

Conclusion

Acknowledging women's needs when designing and offering services for women who use drugs and women living with HIV is crucial for several reasons. Women who use drugs often face unique challenges, including higher rates of trauma, domestic violence, and caregiving responsibilities, which can significantly impact their substance use and recovery experiences. Services that are specifically designed to meet these needs guarantee solutions that are more sympathetic and caring, in addition to being more successful. For example, offering childcare and establishing secure, accepting environments might facilitate a woman's ability to ask for and receive assistance. Given the fact that funding for harm reduction programs is mainly provided through limited donor funds, advocacy efforts are needed to ensure that additional gender-sensitive services are provided through public funding.

Advocacy for women-focused services goes hand in hand with supporting women using drugs and living with HIV in general, which is crucial to improving their lives. There are other areas that need reforms too. First and foremost, ending the cycle of arrests and incarcerations that exacerbates women's social and health problems requires the decriminalization of drug possession for personal use. Ensuring better access to healthcare is also

crucial, with a focus on gender-sensitive services that address the special needs of women, such as mental and reproductive healthcare and harm reduction initiatives. Legal changes are also required to shield these women from discrimination, abuse, and harassment by the police. Advocacy groups lobby for the extension of services like needle exchanges and supervised consumption locations, arguing that harm reduction is the most successful strategy. To support these activities, legislation must be changed to shift the focus from criminalization to damage reduction and public health.

To provide effective help and care, it is essential to develop programs specifically targeted towards women since women who engage in drug use encounter distinct obstacles, including systemic sexism, violence based on gender, and intersectional oppression, which greatly influence their experiences with drug use and their need for treatment. Gender-specific difficulties are typically disregarded by traditional addiction programs, resulting in gaps in care and worse outcomes for women. Healthcare professionals can deliver more effective, gender-responsive treatment that addresses the many biological, psychological, and social issues affecting women and ultimately improves their health and well-being by developing programs that are focused specifically on women.

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2. Socio-Psychological Aspects of Women Living with HIV in Kazakhstan

Oksana Ibragimova

Introduction

As of early 2024, there were 32,659 people living with HIV in Kazakhstan (with an estimated total of 40,000). In 2023, 3,862 new HIV cases were identified, 686 of which were due to injection drug use (Kazakh Scientific Center for Dermatology and Infectious Diseases 2024). Overall, HIV incidence in Kazakhstan showed improvement compared to the previous year, slightly decreasing from 19.6 per 100,000 population in 2022 to 19.5 per 100,000 population in 2023. Men account for 67.8% of all new HIV cases, while women represent only 32.2% (National Centre for Public Health of the Republic of Kazakhstan, 2023).

This chapter focuses on the social and psychological needs of women living with HIV in Kazakhstan. It begins by describing the general situation of women living with HIV, the legal barriers they face, and the available services, including the prevention of mother-to-child transmission of HIV and support for mothers and children facing stigma and discrimination. The chapter also emphasis the various forms of violence encountered by women living with HIV in Kazakhstan.

General Situation of Women Living with HIV in Kazakhstan

Women living with HIV in Kazakhstan have the same legal rights as other women, according to the Constitution of Kazakhstan. These rights include access to education, protection, dignified treatment, non-discrimination, and healthcare.

In 2021, the Joint United Nations Programme on HIV/AIDS (UNAIDS) country office released a report on gender analysis in Kazakhstan (UNAIDS 2021). According to this report, the gender inequality inherent in this cultural context exacerbates the socio-economic challenges faced by women. Inequality, sexual and gender-based violence, and lack of access

to services due to cultural norms, homophobia, and transphobia are significant obstacles to achieving the goals set out in the Sustainable Development Goals and the UNAIDS Global Strategy.

Legal Barriers for Women Living with HIV

Kazakhstan is a party to over 70 multilateral universal international human rights treaties, including the Universal Declaration of Human Rights and eight United Nations (UN) human rights conventions. In cooperation with the UN, Kazakhstan regularly submits periodic national reports on reforms and achievements to the relevant UN treaty bodies. These reports emphasize Kazakhstan's efforts to implement recommendations from various UN Conventions, including those addressing the elimination of discrimination against women, the prevention of torture and ill treatment, and the protection of children's rights, as well as civil, political, economic, social, and cultural rights.

During the 76th session of the UN General Assembly in New York, Kazakhstan was elected to the UN Human Rights Council for 2022–2024, which recognized its active and responsible role in promoting international human rights standards. Kazakhstan's priorities include promoting gender equality and women's empowerment, the universal abolition of the death penalty, fighting against all forms of intolerance, freedom of religion and belief, ensuring inclusive and universal education, and respecting human rights during the Covid-19 pandemic.

According to the 'Assessment of the Needs of Women with HIV in Kazakhstan' (2022), services for people living with HIV in Kazakhstan often do not consider gender, creating barriers for women to access specialized legal, social, psychological, and medical support. Despite progress in improving the socio-economic status of women and girls at the national level, internalized stigma and discrimination against women living with HIV, women who inject drugs, and transgender women remain serious issues. These barriers significantly hinder their access to harm reduction, HIV prevention, sexual and reproductive health services, mental health support, and protection from violence services (CCMKZ, 2022).

HIV transmission is criminalized in Kazakhstan, ostensibly to protect women from infection by their partners. However, this can increase violence against women and exacerbate gender inequality. Women living with HIV can be penalized for breastfeeding, which contradicts their rights.

Patriarchal norms can lead to relationship violence and prosecution of women for HIV transmission, even if they were unaware of their status. The criminalization of HIV transmission creates obstacles for women to access medical and social services, as they may face prosecution for HIV-related behavior.

In 2022, Kazakhstan removed legal barriers for people living with HIV to adopt children. However, the country criminalizes the endangerment and transmission of HIV (Article 118 of the Criminal Code). Until 1st July 2023, women living with HIV were legally restricted from accessing crisis centers according to the standard for providing special social services to victims of domestic violence (Chapter 2, Clause 13, sub-clause 2 of the Criminal Code). In the new standards for providing special social services in the field of social protection, there is no basis for refusal of admission due to the presence of an infectious disease.

HIV is included in the list of socially significant diseases eligible for free medical care (the so-called Guaranteed Volume of Free Medical Care). However, people living with HIV who have not paid insurance contributions do not have access to other medical services in the state healthcare system.

In Kazakhstan, in case of rights violations, individuals can contact the Commissioner for Human Rights, as well as human rights non-governmental organizations (NGOs) that provide assistance in protecting and restoring violated rights. Kazakhstan also has a Commissioner for Children's Rights.

Prevention of Mother-to-Child Transmission of HIV

According to the 'Country Progress Report—Kazakhstan Global AIDS Epidemic Monitoring—2022' (Kazakh Scientific Centre of Dermatology and Infectious Diseases, 2022) and the legislation, including the Code of the Republic of Kazakhstan 'On People's Health and the Healthcare System', a standard for organizing midwife and gynecological care has been approved. Under this standard, medical care for pregnant women, mothers, and women of all age groups is provided within the framework of the Guaranteed Volume of Free Medical Care (GVFMC), Mandatory Social Health Insurance (MSHI), or voluntary health insurance.

Medical services, including anonymous HIV testing, are available to young women from the age of 16. Abortion is available from the age of 18

without parental or legal guardian consent. Prior to this age, consent from parents or legal guardians is required.

To prevent HIV transmission, mandatory double HIV testing is conducted for pregnant women under medical supervision in primary healthcare institutions. Prevention of mother-to-child transmission of HIV is included in clinical HIV protocols, which do not prohibit mothers from choosing to breastfeed. Women with HIV are provided free breast milk substitutes as part of a comprehensive approach to prevent vertical HIV transmission.

In 2022, 99.6% of women in Kazakhstan were registered in primary healthcare facilities and underwent timely free HIV testing. If HIV infection is detected, women are referred to regional HIV prevention centers, where they receive laboratory monitoring and HIV treatment (International Group for Best Practices in Healthcare, 2022).

In recent years, the coverage of pregnant women with antiretroviral (ARV) therapy has increased, reaching 98.7% in 2022. The coverage of children with preventive treatment is 100%. In 2022, there were 469 deliveries among HIV-infected pregnant women. Of these, 463 women received antiretroviral therapy during the reporting period, covering 98.7%.

Due to the availability of preventive treatment, the birth rate among HIV-positive women in the country is increasing, and the number of abortions among women living with HIV has decreased by 1.2 times over the past five years. The 'Code on People's Health and the Healthcare System of the Republic of Kazakhstan' addresses the issue of patronage and treatment of children with an unknown diagnosis born to mothers with HIV (Kazakh Scientific Centre of Dermatology and Infectious Diseases, 2022).

Stigmatization of People Living with HIV

According to the Stigma Index study (Central Asian Association of People Living with HIV, 2021) the level of self-stigmatization among women is higher than among men.

- 20% of women reported mental health problems (anxiety, depression, insomnia, post-traumatic stress);
- 78% of women find it difficult to disclose their HIV status to others;
- 26.69% of women feel dirty because of their HIV status;
- 52.98% of women feel ashamed of their HIV status.

Stigma in Society and Among Healthcare Workers

Stigma from society and healthcare workers is a major barrier to accessing services for women with HIV. The lack of peer-to-peer counselling services exacerbates this situation. Trained women living with HIV can serve as effective counsellors, providing knowledge, support for adherence to ART, and psychosocial assistance. Psychological support, especially outside of the capital city, Astana, is often unavailable, as are support groups for women (Central Asian Association of People Living with HIV, 2022).

Women with HIV are not always aware of their rights during diagnosis and treatment and are not protected from illegal actions by employers and healthcare workers. One of the main concerns for women with HIV is the loss of custody of their children due to their status. Caring for their children is often a significant motivating factor for adhering to regular medical check-ups and taking ART.

According to the HIV Stigma Index (Central Asian Association of People Living with HIV, 2021), healthcare workers who do not provide HIV services exhibit high levels of stigmatization and discrimination against women, almost double the level compared to men in all aspects.

Social and Psychological Aspects

Women living with HIV primarily need social and psychological support. While the medical aspect is crucial, social issues often arise earlier. These issues include social isolation, discrimination, and societal stigmatization. Women often experience intense emotional pain upon learning of their HIV-positive status. They worry about their ability to have a family and children or adequately care for their existing family and elderly parents.

One of the most serious family issues for many women living with HIV is disclosing their HIV status to relatives and those close to them. The fear of not being understood, accepted, or being rejected by family is the main reason for hiding their HIV status. In family relationships, misunderstandings, tensions, and suspicions frequently arise when one partner hides their HIV status. Delayed disclosure can further exacerbate conflicts within the family, especially for women. Feelings of loneliness are intensified by isolation when women most need support and the opportunity to discuss their fears and concerns.

The psychosocial problems that women living with HIV may face include a wide range of emotional challenges such as anxiety, loss of confi-

dence in the future, family disagreements, feelings of loneliness, hurt, and disappointment, loss of control, guilt or unjust accusations, helplessness, fear of death, and social isolation.

Equally important are social problems like the threat of job loss or unemployment, temporary or permanent disability, lack of social support from family and close associates, increased medical expenses amidst a lack of or insufficient social benefits, and others.

Sexual issues are also significant. The fear of infecting a loved one and concerns about relationship breakups if their HIV-positive status is disclosed are common problems. Therefore, access to psychological support should be one of the key interventions.

Mental Health

Women living with HIV in Kazakhstan face several limitations when it comes to accessing mental health services.

In most cities in Kazakhstan, there is a notable lack of qualified psychologists within AIDS centers. These specialists play a crucial role in providing support and counselling to women living with HIV, helping them cope with the psychological challenges associated with their HIV diagnosis and its consequences. The absence of psychologists in AIDS centers creates a barrier to accessing appropriate services for patients who may experience emotional difficulties, stress, and anxiety due to their health. This can negatively impact their psychological well-being and ability to manage long-term treatment and care. Therefore, having qualified psychologists in AIDS centers is essential for providing comprehensive psychological support and improving the quality of life for women living with HIV in Kazakhstan.

Within the healthcare context of Kazakhstan, there is a lack of systematic screening for depression levels among women living with HIV. The absence of regular screening means that many women with HIV may remain unnoticed in terms of their psychological state and emotional well-being. Depression is a serious psychological disorder that can severely impact the quality of life, social adaptation, and treatment adherence of women with HIV. Regular screening for depression is not conducted.

For several reasons, the motivation of women living with HIV to seek psychological help is often low. Firstly, the stigma associated with HIV can create barriers to acknowledging their emotional difficulties and seeking

help. Women may fear stigmatization and discrimination from society, including fear of losing their jobs, social status, or relationships with family and friends if their HIV status becomes known.

Secondly, some women may not recognize the importance of psychological support or see a direct connection between their mental state and HIV infection. They may priorities medical treatment over their emotional well-being.

Additionally, some women may feel fear or discomfort openly discussing their emotional problems with a stranger, even if it is a licensed psychologist. They may feel vulnerable or fear judgment from others.

Thus, the motivation to seek psychological help among women with HIV can be weakened by a combination of stigma, insufficient understanding of the importance of psychological support, and emotional barriers related to openly discussing their problems.

Despite the importance of psychological support for women with HIV, not all NGOs have sufficient resources to staff psychologists or provide access to free psychological assistance. This may be due to limited funding, a shortage of specialists, or prioritization of other types of support, such as medical care or social services.

This problem can be especially relevant for NGOs operating outside of major cities, where access to psychological services may be even more limited due to a lack of resources and specialists. As a result, many women with HIV may be deprived of the opportunity to receive the necessary psychological support due to limitations in NGO activities.

In society, there are stereotypes and prejudices that can become obstacles to seeking psychiatric help. Mental disorders or requests for psychiatric help are often associated with negative stereotypes such as 'weakness', 'abnormality', or 'undesirability'. These stereotypes can lead to fear of being judged or rejected by others.

Some women fear negative reactions from their social environment, colleagues, friends, or even family if they learn that they are seeking psychiatric help. Additionally, fear of psychiatric diagnoses or treatment can be a reason for refusing to seek help. It is also important to note that both women living with HIV and their children require special attention due to the stigma and stereotypes they face in society. This can affect women's adherence to antiretroviral therapy (Central Asian Association of People Living with HIV, 2022).

Given these issues, efforts in HIV support should focus particularly on the social and psychological aspects for women living with HIV. This is

highly relevant and important as adequate social and psychological support plays a key role in everyday life. The well-being of future generations and the formation of their moral and social values are closely linked to the health of families and the health of women. It directly influences the development and well-being of children, as well as the formation of their values and norms of behavior. Therefore, caring for the health of mothers acquires the highest significance in the context of national policy as it affects the stability and sustainable development of society as a whole.

Gender-Based Violence

Kazakhstan is one of the first countries in Central Asia to establish a national body dedicated to promoting gender equality (UN Women, nd). Additionally, the Constitution of the Republic of Kazakhstan guarantees equal rights and freedoms for all citizens and prohibits discrimination based on gender (Article 14).

However, discrimination, stigmatization, or prohibition of discrimination is not separately defined in any legal act, except for 'discrimination on the basis of sex', provided by the Law of the Republic of Kazakhstan 'On State Guarantees of Equal Rights and Equal Opportunities for Men and Women'. Meanwhile, several laws contain a prohibition on discrimination, including the Criminal Code of Kazakhstan. The Criminal Code does not criminalize homophobia or transphobia, limiting itself to a closed list of national, racial, and religious hatred, which makes it impossible to investigate crimes committed on the basis of sexual orientation and gender identity (SOGI) as hate crimes. The Criminal Code also does not contain a definition of hate crime; an aggravating circumstance is recognized as 'the commission of a criminal offense based on national, racial, and religious hatred or enmity' (Article 54 of the Criminal Code of Kazakhstan, Government of Kazakhstan, 2014).

In 2021, Kazakhstan joined two Action Coalitions of the Global Equality Forum committing to combat gender-based violence and ensure economic justice and rights. This led to the removal of the list of prohibited professions for women. At the 76th session of the UN General Assembly in New York, Kazakhstan was elected a member of the Human Rights Council for 2022–2024, with a focus on gender equality and women's empowerment. Kazakhstan actively participates in the work of the UN Commission on

the Status of Women, which reviews the implementation of international standards for the protection and promotion of women's rights.

On 11th April 2024, the Law of the Republic of Kazakhstan 'On Amendments and Additions to Certain Legislative Acts of the Republic of Kazakhstan on Ensuring the Rights of Women and the Safety of Children' and the Law 'On Amendments and Additions to the Code of the Republic of Kazakhstan on Administrative Offenses on Ensuring the Rights of Women and the Safety of Children' were adopted, amending seven codes and eight other regulatory acts concerning women's rights and child safety.

Kazakhstan has also ratified several international conventions, including the Beijing Declaration and Platform for Action (1995), the Convention on the Elimination of All Forms of Discrimination Against Women (1998), the Convention on the Political Rights of Women (1999), the Convention on the Nationality of Married Women (1999), eight fundamental conventions of the International Labour Organization (ILO), and the 2030 Agenda for Sustainable Development.

According to the Sample Survey on Violence Against Women, 17% of women aged 18-75 who have ever had a partner reported physical or sexual violence by an intimate partner in their lifetime, and 5% in the past 12 months (UNFPA, 2017). Sexual violence increases women's vulnerability to HIV infection. One in three women living with HIV (34.4%) face abuse, including beatings by their husbands/partners or other relatives. Among them, only 21.6% sought help, while 12.8% did not. This means that about a third of women who experienced physical violence did not seek help or protection. Additionally, 20.3% of respondents did not want to answer this question, likely due to feelings of shame or fear of talking about the abuse (UNFPA, 2017). Women living with HIV are deprived of the opportunity to reside in crisis centers for female victims of domestic violence as HIV infection is listed in the medical contraindications for residing in these organizations (adopted at the sub-legal act level).

There are certain problems within the healthcare system that affect the situation with gender-based violence (UNFPA, 2017): More than 55% of healthcare workers indicated the lack of private examination rooms, 50% of the medical staff carry out a local examination instead of a full one, more than 78% of healthcare workers do not involve a psychologist when dealing with cases of gender-based violence, and one third of healthcare workers do not register cases of gender-based violence as acts of violence, despite the presence of necessary codes in the International Classification of Diseases (ICD-10). Instead, cases of gender-based violence are registered

as ordinary injuries, and 95% of healthcare workers do not use the WHO clinical survey on gender-based violence in their work (UNFPA, 2017).

Conclusion

In conclusion, we wanted to highlight both the progression that has been made and the challenges that remain in providing medical care to women living with HIV in Kazakhstan.

Firstly, significant achievements of the Kazakh government in the healthcare sector, especially in providing accessible medical services for women with HIV, should be noted. The introduction of standards for organizing obstetric and gynecological care, the expansion of access to anonymous HIV testing for young women, and mandatory testing for pregnant women significantly reduces the risk of vertical transmission of the infection and improves the quality of life of this population group.

However, the problems related to stigmatization and discrimination are still serious. The high level of self-stigmatization among women with HIV, as well as stigmatization by society and even medical personnel, create barriers to receiving the necessary help and support. The lack of available psychological services and support groups deprives these women of important sources of support and information.

It is also important to pay attention to foreign migrant women who are deprived of access to free antiretroviral therapy, creating inequality in healthcare access based on nationality.

To successfully address these issues, it is necessary to continue developing educational programs to overcome stigma and discrimination and expand access to psychological support and counselling. Moreover, it is important to ensure equal access to all types of medical care regardless of social status or nationality. Only in this way can a decent quality of life and health for women living with HIV and their children be ensured.

Additionally, attention should be paid to social aspects such as the threat of job loss, financial difficulties, and lack of social support. Developing community and state-level support programs can significantly ease the burden on women facing HIV.

Ensuring access to psychological support and counselling in the field of sexual relations is also crucial, where the fear of infecting a partner and concerns about revealing one's HIV status can become obstacles to healthy and trusting relationships.

In general, combining medical care with psychosocial and social support is key to ensuring a full life and well-being for women. Statistics on domestic violence and sexual crimes indicate the severity of the problem and the scale of this problem in society.

The adoption of the Law of the Republic of Kazakhstan 'On Amendments and Additions to Some Legislative Acts of the Republic of Kazakhstan on the Issues of Ensuring Women's Rights and Children's Safety' in April 2024 was an important step towards protecting women from violence and ensuring their rights. This law introduces changes to several legislative acts, improving the system of protecting women and children.

However, despite the measures taken, there remains a serious gap in the support system for women facing violence. The lack of crisis centers and shelters, especially outside of major cities, creates barriers for those who need help and protection. For women living with HIV, the situation is exacerbated by the fact that medical issues prevent them from accessing shelter in crisis centers.

Thus, it is important to develop an integrated approach to protecting women, including strengthening the legal framework, expanding the network of crisis centres and shelters, and training and preparing personnel working in this field. Special attention should be paid to women living with HIV, considering their vulnerability and specific needs. Only in this way can a safe and dignified existence, free from violence and discrimination, be ensured.

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3. Interview with Oksana Rusnak

conducted by Katarzyna Kinga Kowalczyk

Katarzyna Kinga Kowalczyk: Can you introduce yourself?

Oksana Rusnak: My name is Oksana Rusnak. I am from Uzbekistan and live in the city of Tashkent. I turned 48 on September 11th, 2024. I am a woman living with HIV and a woman who uses drugs. Nowadays, I use drugs less than I did in my youth, mainly because of work and because I lead a very active lifestyle. With my open and active stance on both drug use and HIV, I am also an activist in this field.

Katarzyna Kinga Kowalczyk: Can you tell me about your work?

Oksana Rusnak: Currently, I work as a peer consultant for HIV and tuberculosis at Ishonch va Hayot. Since I've personally experienced tuberculosis, I also receive support. We consult people on how to accept their HIV status and continue living. For example, we help [HIV-positive] women who have given birth. We have a service that guides them through pregnancy until their child reaches one and a half years of age. Once a month, after the last PCR test, we deliver formula milk to them. Right now, I'm the driver in our organization, delivering the formula to women on specific days. It's difficult for these women to travel with a newborn, and many can't afford a taxi or even the bus fare. Some can afford delivery services like Yandex Taxi, but not all of them. I deliver the formula to women who can't visit the center, whether they are sick, have no one to leave their child with, or face other challenges, such as a broken leg. So, I handle deliveries for women in such situations.

Additionally, I live openly with my HIV status and try to show those around me that we are not dangerous or contagious. We provide psychosocial support, and we have a psychotherapist in the project to consult women, especially those dealing with psychological issues. We also offer legal help, as many people don't know their rights.

Our organization, which is a NGO, focuses a lot on supporting women, especially those living with HIV, but there are no specific state services for women who use drugs. Even in shelters, women who use drugs are often not accepted, even with our recommendation.

The NGO "Ishonch va Hayot" in Uzbekistan is a prominent organization focused on supporting people living with HIV (PLHIV) and key vulnerable populations. The organization's activities are centered on reducing stigma and discrimination, providing psychosocial support, and advocating for the rights of PLHIV.

Key activities include:

- Comprehensive Care and Support: Providing emotional, legal, and social support to PLHIV; helping to improve their quality of life.
- Advocacy and Public Education: Raising public awareness to reduce the stigma against PLHIV; Fighting for policy changes that promote the rights of these individuals.
- Legal and Social Services: Legal consultations to help PLHIV understand and protect their rights.
- Community Mobilization: Uniting PLHIV and other vulnerable groups through self-help groups and advocacy initiatives to strengthen community support.

Ishonch va Hayot also works in partnership with organizations like UNAIDS and the Global Fund to expand access to HIV treatment and care, aiming to improve the quality of life for those affected by the epidemic in Uzbekistan.

Work also includes specialized projects for women and addressing barriers faced by people who both use drugs and live with HIV www.plwh.uz

We also have trust rooms available to the public where people can get tested or consult with a narcologist. We try to refer people to both free and paid services so that they can get help.

Trust rooms (кабинет доверия) are facilities or services where people, especially from key populations like people who use drugs or those living with HIV, can receive support without judgment. These rooms often offer harm reduction services, such as providing clean needles, psychological

consultations, and access to HIV testing. Trust rooms are crucial in reducing the spread of infectious diseases like HIV and hepatitis and providing a space where individuals can receive medical and social support (Zakhidova 2024).

Most people here don't openly disclose their HIV status. They tend to only trust certain people [with this information]. Our organization is the only one in Uzbekistan that specifically works with people living with HIV. We're the only one so, naturally, everyone eventually turns to us. We rely a lot on word-of-mouth.

That's why, even now, in different settings, I openly say that I am a former drug user and that yes, I am HIV-positive. However, in order to avoid reinforcing the stereotype that HIV-positive people are drug users, I've started to hide it from casual acquaintances. I realize that by hiding it, I can change their perception. However, when I meet someone I think is ready to understand, I openly say, "Look, I'm living, I was a drug user, and I'm HIV-positive. I'm alive because I started treatment on time. What's stopping you from starting treatment?" I was an HIV denier myself for many years, now when I meet people like that, I try to give them more attention. I know what it's like to be in denial about HIV.

We have successes. For example, there was a person in the community who was HIV-positive but refused to take antiretroviral therapy (ART). No one could convince him, so he was sent to me. I usually handle cases like that. [I convinced him to start.]

I am also an outreach worker. Currently, we are running a testing project. Outreach workers go to locations where women engage in commercial sex work. We provide them with materials and information on where they can seek help if they face issues like drug addiction, abuse, and so on. This is all part of our outreach work. We conduct testing among sex workers, but we also provide screening for tuberculosis and sexually transmitted infections (STIs). While we do more STI testing during outreach work in the trust rooms, screenings for tuberculosis and HIV are more common in the testing centers.

We also have our own website and Telegram groups where we try to spread awareness and let people know these services exist. The services are there, but unfortunately, none are specifically designed for women.

Nowadays, even narcologists will reach out to us if they find out someone is HIV-positive. [This shows] our work isn't just a drop in the ocean. I've been reflecting, and there have definitely been [positive] changes. We now have

strong contacts with both the tuberculosis and narcology services, even if it's only at the doctor level, not at a global scale yet. But it's a start and it's already working. They now see the value in our work. If before they questioned us, saying, "What are you doing here? We've been studying this for centuries," now they're starting to say that much less.

Katarzyna Kinga Kowalczyk: What is life like for women in Uzbekistan?

Oksana Rusnak: I wouldn't say it's particularly difficult for us to live here. Every country presents its challenges. On one hand, women are somewhat revered, for example, as mothers or in other roles that grant them a certain status. However, on the other hand, it feels like there's actually no real respect for women. It's all just words because, in practice, true respect is lacking.

I'm of an age where I remember what it was like before, and I see how things have changed since the collapse of the Soviet Union. Yes, things have become harder; I can say that women here face something close to violence. It's one of the many problems women deal with. For example, if your husband beats you, older women might say, "It's nothing, don't take this outside the home, it's normal." Society - especially mothers-in-law and mothers - are largely okay with this. About 90% of people have this mindset. We don't live in a European society where, if you're beaten at home, you can go and complain. Even when women do report it, they are often told, "It's family, you fought today, you'll make up tomorrow."

We've encountered situations where wives later come back and withdraw their complaints. Why do they withdraw them? Because when their husbands find out that they reported them, they get beaten again. The husband's mother might also interfere, saying, "Why are you airing our dirty laundry?" So, yes, there are difficulties in this regard, especially within traditional families. While I believe this also happens in other countries, our mentality doesn't allow for problems to be taken outside the home.

According to the Uzbek Ministry of Internal Affairs, approximately 14,800 protection orders were issued in 2020 to protect individuals, usually victims of domestic violence, from their abusers. The majority of violence against women occurs within families, with husbands identified as the perpetrators in 82% of the 13,230 domestic violence cases reported the same year (Eurasian Women's Network on AIDS 2023).

We do have some services available, and shelters have opened where a woman can go and stay for a while. However, if you are a woman who uses substances, you won't have access to these shelters.

Katarzyna Kinga Kowalczyk: Are there HIV or drug treatment services for women only?

Oksana Rusnak: We don't have separate state services for women living with HIV or women using psychoactive substances. In general, only NGOs provide support to women living with HIV who also using drugs. These NGOs specifically focus on key populations. While there are some government services, such as the narcological dispensary and the Mahalla Committee, which help resolve family conflicts, their approach is often conservative. For example, they often tell women to endure their situation for the sake of their families, children, and societal expectations, imposing many restrictions on women while men face fewer consequences. Our NGO has held lectures with these organizations because they are the first ones to spread information about someone's diagnosis which leads to stigma and discrimination. The neighbors don't understand what HIV is, for example. People who use drugs are not even considered human beings. They aren't considered being people.

A mahalla (district, quarter, ward, or neighborhood) in Uzbekistan is a traditional neighborhood or community organization. It plays an important role in daily life, where people living in the same area can come together to support each other. Mahallas are responsible for organizing social events, providing help to families in need, and solving local problems. They also help with things like distributing welfare, managing local disputes, and maintaining community values.

Katarzyna Kinga Kowalczyk: What is the attitude toward using mental health support among people living with HIV?

Oksana Rusnak: When someone is told they need to see a psychotherapist, they often respond with, "I'm not mentally ill." People don't understand that mental health is also part of overall health. A psychotherapist is just like any other doctor, like a general practitioner or a pediatrician for children. When they prescribe something, people often refuse, saying they won't take the medication because they don't understand its importance. We even had a lawyer once, someone with multiple degrees, and when we hired him, he

said, "What mental health? Why are you girls bothering with this?" It's then you realize that even well-educated people don't grasp the significance of mental health.

It's difficult, but it's so necessary. I've personally gone to a psychotherapist because I realized I couldn't handle my emotions anymore. I was burning out at work, and sometimes there's no feedback or recognition for all the work you do. You keep working and working without getting anything in return.
My principle is to "do good and let it be." But after a while, it's not just physical exhaustion—you can't even open your eyes in the morning or face going to work. You start hating people. For example, when someone living with HIV comes in and says they're disabled, you feel like hitting them because they don't seem like they're disabled at all.
I realized I couldn't keep working with people in this state. I had to see a psychotherapist and eventually left my role as a peer consultant. I didn't leave because of that, but I had lost empathy. When I looked at someone, I didn't feel sorry for them anymore. And you can't work in this field without empathy.

Burnout and mental health challenges are highly prevalent among activists and healthcare workers in the HIV and drug use fields. Several studies highlight the unique stressors faced by these professionals, including frequent exposure to trauma, resource limitations, and the emotional toll of working with marginalized populations. In Eastern Europe and Central Asia, according to studies conducted in the region, burnout is often exacerbated by underfunded programs, a lack of mental health support, and limited organizational resources (Central and Eastern European Harm Reduction Network 2006; Sarata n.d.).

Katarzyna Kinga Kowalczyk: What should be changed to help to support women?

Oksana Rusnak: If I had a magic wand and could do whatever I wanted, I think it would go beyond just helping women with HIV. The main issue here is stigma, which is deeply ingrained in our society. Stigma and discrimination go hand in hand, like twins. If we could eliminate that, things would already be better.
However, beyond HIV, I think women in general need more support. I would create shelters, real places where women could go. There should

be separate shelters for drug users, where a woman can go and reach her lowest point or find a safe space, surrounded by people who understand her struggles. A place where - like returning to your parent's house - you can always return when needed.
And this should be the case for all women, not just those living with HIV or using drugs, especially here in Uzbekistan. It's like trying to turn a huge ship around, but with a magic wand, I'd want equality, where everyone has the same rights and isn't restricted by their status. For example, women with HIV or who use drugs, especially in rural areas, endure so much humiliation. Even from their own in-laws. I remember staying with a woman who had just given birth. She had stitches from a difficult delivery, and her mother-in-law came in and told her to get up and clean. When the woman explained she was in pain, her mother-in-law replied, "So what? I worked in the fields right after giving birth." There's no compassion, even from woman to woman.

Katarzyna Kinga Kowalczyk: On a more personal note, what are your dreams?

Oksana Rusnak: I've been living with my status for a long time, and I've accepted it as a consequence of my past lifestyle. What hurts me the most is children born with HIV. I hope that by the time they grow up, there will be a vaccine. I want children to have access to the newest vaccines and thorough screenings.
I've seen children brought in almost lifeless, and it takes years for them to recover, learn to speak or walk again. It's heartbreaking. I've seen many deaths, and although I consider myself a tough person, I wish there were no diseases at all.
I hope I live long enough to receive that magic cure. Even if drugs exist in the world, everyone should at least have the chance to avoid suffering.

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4. Interview with Valentina Mankiyeva

conducted by Katarzyna Kinga Kowalczyk

Katarzyna Kinga Kowalczyk: Can you introduce yourself?

Valentina Mankiyeva: I am the director of Central Asian women's network "Amal," I represent the Central Asian region in the Steering Committee of the organization. This is relatively new. I also represent the community of people who use drugs in the Country Coordinating Committee. I was recently elected. So now - for the next three years - I will represent my community, and I will focus more on women's issues, since we have, of course, been very focused on women's rights. Since 2009, I have been working on non-profit projects related to the prevention of socially significant diseases. And since 2015, my work has been closely related to advocacy, human rights, and mental health. Leadership and activism are also key areas of my work. That's a brief summary. I have a daughter, and I'm raising her on my own. I live in a small town in Kazakhstan.

Katarzyna Kinga Kowalczyk: What is life like for women in Kazakhstan?

Valentina Mankiyeva: In Kazakhstan, the status of women in society is somewhat in-between, as it's in Asia it's influenced by both traditional and modern factors. In some regions, traditional values are more dominant. Women play an important role in the family, but they also bear a lot of responsibility in society.

However, the status and gender roles of women can vary, depending on the region and socio-economic conditions. Traditionally, women in Kazakhstan take on major responsibilities such as managing the household and caring for children. In terms of societal development, women are active in the workforce, taking up important positions - but there's still the issue of the "glass ceiling" factor where women can't advance to a higher position. Despite this, many women today aim to balance both career and family.

When talking about women's status, and specifically their position in society, our legislation strives to provide equal rights for both men and women. In recent years, the government and NGOs have worked to improve the status of women. Consequently, new gender policies have been adopted.

However, gender stereotypes are still prevalent. Observation and research show that men often don't relate to or identify with gender issues, seeing it as "not about us, but about them."
While we have adopted policies and strive to meet international conventions, in reality, the situation for women in Kazakhstan is more complicated. Despite formal gender equality, women still face discrimination, particularly in the professional sphere. Women are paid less than men and they face barriers to promotions and access to certain professions because of these persistent stereotypes.
However, younger generations are increasingly rejecting these stereotypes and fighting for their rights. Education and the spread of key information play an important role in this shift.

Among the countries of Central Asia, Kazakhstan is a leader in progressive gender equality, ranking 76th out of 146 countries in the Global Gender Gap Index 2024, a report designed to measure gender equality (World Economic Forum 2024). Kazakhstan has been a pioneer in Central Asia in promoting gender equality, as well as establishing the National Commission on Women, Family, and Demographic Policy early on. The country's Constitution ensures equal rights and freedoms for all citizens, explicitly prohibiting gender-based discrimination. Furthermore, Kazakhstan's Gender Equality Strategy (2006-2016) laid the groundwork for improving gender-related legislation, and its updated Concept of Family and Gender Policy includes ambitious goals like increasing women's representation in decision-making roles by 30% by 2030 and tackling issues such as domestic violence, the gender wage gap, and asset ownership by women (National Democratic Institute 2005; Government of Kazakhstan 2016).

Kazakhstan has ratified key international conventions, including CEDAW, the Beijing Declaration, and several ILO Conventions. The country also adopted its first National Action Plan aligned with the UN Security Council's "Peace, Women, and Security" resolution, leading to women's participation in UN peacekeeping missions (Peace & Freedom n.d.). In 2021, Kazakhstan joined global efforts to combat gender-based violence and advance economic justice through the Generation Equality Forum, and in 2024, a Kazakh representative was elected to the CEDAW Committee — a first for both Kazakhstan and Central Asia (UN Women 2021; 2024).

Kazakhstan's commitment to gender equality is further reinforced by its election to the UN Human Rights Council (2022-2024) and active involvement in the UN Commission on the status of women (The Astana Times 2021).

Katarzyna Kinga Kowalczyk: What is life like for women who use drugs or live with HIV in Kazakhstan?

Valentina Mankiyeva: When discussing this, we can talk about women who use drugs, both together with and separately from those living with HIV, as these issues often intersect. Women who use drugs are particularly vulnerable, as they often fall victim to punitive drug policies.

In recent years, statistics have shown an increase in drug use among women, and the prisons are overcrowded. Many of those incarcerated are involved in drug-related activities, including trafficking. While both men and women are involved, I want to draw attention to the fact that many of the women involved are young, aged 18 to 30.

According to research conducted by the Eurasian Women's Network on AIDS, women who use drugs are two to five times more likely to experience violence compared to women in general. In the context of HIV, the situation for women who use drugs and live with HIV is multifaceted, touching both the medical and social aspects. As I mentioned, drug addiction among women has increased, and they make up a significant portion of this group.

However, official statistics don't fully reflect the reality because many women don't seek help due to discrimination and stigma. Women face severe stigma and societal judgment. For women with HIV, this stigma is even more pronounced as they experience a "double stigma."

Access to medical care is critically limited, especially for those without health insurance or registration, and people often struggle to access medical services. This can also be linked to a lack of information about available treatment programs or financial limitations.

Overall, in Kazakhstan, there has been a rise in HIV infections among women who inject drugs. However, research in this area is lacking because many women do not seek help.

Katarzyna Kinga Kowalczyk: How about services for women?

Valentina Mankiyeva: The services are not gender-sensitive at all. However there are programs run by non-governmental organizations (NGOs) that implement a range of gender focused projects. For example, there is men-

torship support for women living with HIV. Here women can receive legal assistance, and there are support groups and peer groups. But these programs are also facing difficulties. For instance, before we spoke, I contacted one of the program's mentors in one of the regions. There are difficulties within the project and in the overall ability to implement it.
For example, there's the self-help group component. The women she works with are all in correctional facilities. Some of them have been released, but they don't even have basic communication access. She said, "How am I supposed to conduct a self-help group if they're incarcerated and only get 15 minutes to call once a day or once a week and under surveillance? They have to choose between joining my group or making a call home." So, she told me she needs to go there and arrange some memorandums with the penitentiary system, but she can't because there's no funding. She said, "I don't even understand what I'm doing in this project." It was a cry from the heart. People say we should tell good stories, but I tell them we need to share the bad ones too. It's great that there's a project and support, but it's also important to recognize the challenges.
As for government support, it's not available. Crisis centers don't accept women living with HIV, but there is ongoing work to change the legislation. Soon, amendments to regulatory acts will allow people living with HIV to be accepted into hospices and crisis centers.

Katarzyna Kinga Kowalczyk: Can you describe your personal experience with drug use and how it has affected your journey with HIV and addiction recovery?

Valentina Mankiyeva: When I was 18, I was diagnosed with HIV. Around the same time, I started using drugs. It was unclear what was happening. I believe my partner knew, because when we went to get retested, they told him to retake the test. I understood. By then, I already had symptoms. The HIV came before I started to use drugs, though.
I disappeared for a while, and for five years, I went through a terrible period. During my time of using drugs, at least once a year, sometimes twice a year, I would end up in a drug rehabilitation center. I also went to various rehabilitation and spiritual centers, always looking for a way out. I kept trying to find solutions in our addiction treatment and psychiatry systems. I ended up in psychiatric wards. The drug rehabilitation center wouldn't take me more than twice a year so at some point I was placed in a psychiatric facility where they had nothing but tramadol for me. They gave me pills secretly. Imagine, I was there with about 100 mentally ill women,

and I was there too with my addiction. It was awful. They knew something was wrong with me and, for two weeks, they treated me differently because of my "yellow cup" and the fact that I had HIV. Some people knew.

The use of yellow cups to identify people with HIV has been reported in some parts of the world, usually as part of hospital or institutional practices. This approach has been criticized for being stigmatizing and discriminatory. The idea behind these practices is to signal to healthcare workers that certain patients may need extra precautions. However, this method raises several ethical and privacy concerns.

Regarding spiritual centers (run by Charismatic Movement), I stayed at one in particular for about three years, on and off. When I first went there, I was waiting for a certificate from the AIDS center. From 1996 to 2005, I returned again and again to places like these spiritual centers. In 2005, I decided to go back to rehab. It was a radical place where I had to tell everyone I had HIV. There were about 60 people and I don't know how they felt about me. They told me that Jesus would heal me from HIV. It was a strict place too, where you couldn't wear certain clothes, and no medications were allowed. There was no talk of treatment.

The Charismatic Movement is an interdenominational Christian movement that emerged in the mid-20th century, emphasizing the manifestation of the gifts of the Holy Spirit, such as speaking in tongues (glossolalia), prophecy, healing, and other supernatural occurrences. In Kazakhstan, the charismatic movement became actively involved in drug rehabilitation in the 2000s, establishing centers offering spiritual healing through prayer, Bible study, and participation in community life. The common method of treatment was using prayer and scripture study to strengthen faith to overcome addiction and creating an environment where participants support each other on the road to recovery. The approach has been criticized emphasizing the lack of scientific evidence for the effectiveness of such approaches and emphasizing the need for professional medical care. In addition, some have reported cases of coercion and human rights violations in such centers.

A year and a half later, I went back to the AIDS center for a check-up, but I had a relapse again, a hard one that lasted for four years. During that time, I kept trying to get into addiction treatment centers just to maintain myself, not to reduce doses. I just wanted to stop using drugs. I was tired.

In 2009, I went to the Republican Scientific and Practical Center for Medico-Social Problems of Addiction in Pavlodar. I completed a year-and-a-half program there. After that, I got married. There was psychotherapy, rehabilitation, and social reintegration involved. It was rehabilitation after rehabilitation.

I am a woman who uses drugs and I have HIV. It's scary. I went through such terrible years, but even now, not much has changed. I live in a city in Kazakhstan that had a significant HIV outbreak. There's a famous Russian film about it. It was tough, and I felt like I wanted to die, like I had this sign on me, that I am infected. It was terrifying. I developed paranoia. I didn't understand what was happening and I couldn't cope with my feelings.

In rehabilitation, I didn't understand myself. After it, at some occasion, I met people who had gone through the program with me. They said, "Valya, you became a lawyer!" I replied, "A lawyer? Did I want to be a lawyer?" I didn't even remember what I had wanted [six months ago].

They told me I used to cry constantly. Rehab was so hard for me. I was scared that I would never have children. Everything changed when I met the [INPUD] community in 2009. Something shifted in my mind, but it was still difficult. I had lived for nine years expecting to die, and now I had to figure out how to live.

So that was my long journey in addiction treatment. Around 2011-2012, I had several severe relapses, especially after my husband died in 2015. I was left with a small child. I had another breakdown a year later, but I recovered. Since 2016, I've been trying to move forward without putting my body through more substance abuse shocks.

The turning point was when I met the INPUD community and Olya Belyaeva. She embraced me with such warmth and I finally felt acceptance. It was at a drug policy meeting in Moldova. It was 2016, and I had just come out of a relapse. I had always been taught that everything had to be radical, that there should be no substitution programs, no marijuana - everything had to be strict.

It was hard for me to live like that. I was always told, "You're a drug addict, you had a relapse, so you're a total failure". It was all or nothing. Meeting the people in Moldova made me realize that you can live and work without substances controlling your life. You can even take methadone for life, why not? Before, I thought you had to go through therapy and then get off it [completely]. But after meeting this community, my perspective shifted. It's wonderful that there is such a network and support system. It changed my life.

Katarzyna Kinga Kowalczyk: Can you tell me more about your work?

Valentina Mankiyeva: Right now, I'm involved in conducting a gender assessment for INPUD, and I'm one of the interviewers, so I'm also working on transcribing the interviews. Lately, I've been more engaged in research, which I find fascinating because I believe that research holds power - it opens up a whole new community. I also want to apply for sociology programs, although it didn't work out this year. I'm aiming to get another degree because I'm no longer interested in being a lawyer. I've always wanted to do psychotherapy, and people often ask me if I'm a psychologist. In some ways, I suppose I am, and it's something closer to my heart, though it requires a lot of energy.
I'd also like to move forward with sociology, to understand it more deeply and be able to influence things from that perspective.

INPUD – International Network of People who use Drugs, is a global network of people who use and have used drugs. A key role of the organization is to support people who use drugs to access and take part in international policy processes.

I'm currently managing a project for the Global Fund, and I've recently taken on a five-month outreach project, where I'm the lead outreach worker. I'm proud to be part of that because, honestly, we would be doing harm reduction work for people using psycho-stimulants even without this project. I was the first to start this and I'm proud of it. It took a lot of courage to do this back in 2019. Our team was supportive and encouraging, saying, "Go ahead" After a few months, I went through a crisis from the whole situation and ended up in a terrible depression. I got rid of everything, but then I met with Yasun. We had a meeting and a good evening together, and I returned renewed.
Now I'm back in and we're continuing our work. Also, the organization I'm currently leading, AMAL, won grants from the Eurasian Women's Network for the Feminism School project. This fall, we will organize an international school with participants from three countries.

Katarzyna Kinga Kowalczyk: Can you tell me more about the Feminism School project?

Valentina Mankiyeva: These will be for women activists to meet in all their diversity, including transgender people and women who do not use drugs

but are living with HIV. Furthermore, Natalia Sidorenko will be one of the trainers, and I'm very happy about that because she's fantastic.
We also run the program "Foundations of the History of Feminism." Currently, the women participating are completing assignments. We've already watched two films, and the trainers are actively preparing us. The goal is to introduce our amazing women to the themes of feminism and narcofeminism (Chapter 5).
This is very interesting for a number of reasons. First, feminism is still a controversial topic in Central Asia, it's a taboo. Second, it's interesting because it shows there's support out there and that there are many women who feel the same way you do. They are out there, and you can meet and learn from one another. But most importantly, this ties back to mental health. That's where the real strength lies, as I see it.

Katarzyna Kinga Kowalczyk: Why is mental health so crucial?

Valentina Mankiyeva: Mental health is fundamental. If you don't have that balance in your head and around you, you can't build anything. Back when I had a lot of mental health issues, addiction, hepatitis, HIV, and everything else, it was impossible for me to make the right decisions because I didn't even understand how to sort out my thoughts. I had so much trauma and I felt sorry for myself.
I liked it when we did individual psychotherapy, which was also provided by the Women's Network. If we talk about resources, I liked it when Natalia told me, "You couldn't have acted any differently back then because you were truly ill. You acted that way to survive." And sometimes, just simple sentences like that can turn your world around.
But there's a tendency - well, not a concern, but a pattern - that when I offer women this kind of support, saying, "Look, you can reach out here, go there," they say, "No, I'm fine just talking to you."
These are women who use drugs. They talk to me and act like everything is okay. But I tell them, "Wait, I need help too. I can't be your therapist for various reasons - including time - and it's not my role. I'm telling you, here are the tools, go, it's free." But they refuse.
This might be the result of some kind of external or internal stigma. Men say the same thing when I suggest they talk to a specialist. They say, "How can I speak with them through a camera? It just doesn't feel right." Men and women alike avoid using these resources. This is a topic worth researching.

Katarzyna Kinga Kowalczyk: How do you take care of yourself?

Valentina Mankiyeva: Well, first of all, my organization has different groups, like expert advisory groups. We can organize such a group upon request. Right now, as part of the gender assessment, we also have psychological support available with female psychologists for women and male psychologists for men. I will reach out soon and accept that support.

I practice meditation, and you know, I listen to a lot of mantras while working. I do yoga, too. And I also have various little massage balls and gadgets. These are things I got from our girls' meetings and peer meetings. They really help keep me grounded.

Psychotherapy helps me personally, as does talking to colleagues and friends. You know, sometimes you call someone - everything feels overwhelming. It's good to have people you can openly talk to. I might say, "I've been out of it for two weeks. I can't do anything; everything has stopped." And after talking things through, you feel like you can get back on track.

But the difficulties are real, especially for women in social and financial crises. I'm a mom, as well as a woman who uses psychoactive substances, and I'm raising my child alone - it's hard. You go from project to project and there's no stability. You are constantly wondering where the next support will come from.

There is also another important topic: doctors. Recently, I went to a neurologist. So, when they asked me about chronic conditions, I mentioned that I have HIV. The doctor, a young man, maybe around 26 or 30 years old, was supposed to examine me. But instead of a proper examination, he just touched me with his gloved finger. My daughter, Rumina, was with me, and he asked, "The child doesn't have AIDS, right?"

I wanted to tear him apart inside. But outwardly I kept my composure and started educating him on what HIV is. I even had to explain to him how I contracted it, as if that's important to people. And I felt ashamed to say it. After all, I have a child, and I couldn't admit that I used drugs. So, I said I contracted it sexually. I made up a whole story, saying my husband didn't use drugs, that my child was born healthy, and that it's possible to live a healthy life if you take your therapy.

After leaving, I thought, "What is happening?" I called the head of the clinic and explained the situation. She said, "Valya, people change all the time. Come in, we can arrange a training for them if you want."

But my desire to keep educating them is fading. I've been going to doctors less because I don't want to waste my energy on this. Just recently, I went

to a gynecologist - a lovely young woman, warm and seemingly competent. But again, she asked, "How did you get HIV?" I thought, if I say drugs, her attitude will change. People seem tolerant of HIV but not of drug use. I said, "sexually," and left the appointment feeling the same frustration. Why do I have to explain how I contracted HIV? Why is it relevant to a gynecologist? It feels like pure curiosity, not something that helps with medical care. And again, it brings us back to mental health.

Structural stigma against people who use drugs (PWUD) and live with HIV is a significant issue in Central Asia. It manifests in both formal policies and informal social practices. This type of stigma often creates barriers that prevent individuals from accessing essential health services, such as harm reduction programs, HIV treatment, and psychosocial support.
In countries like Kazakhstan, Tajikistan, and Kyrgyzstan, legal frameworks often criminalize drug use and HIV transmission, contributing to stigma and fear of legal consequences for seeking treatment. This results in a lack of engagement with health services because of fear of prosecution and discrimination. Furthermore, societal stigma—including negative perceptions from healthcare providers—reinforces this marginalization, discouraging individuals from accessing both HIV and addiction treatment services.

Katarzyna Kinga Kowalczyk: If you had a magic wand to change whatever you wanted, where would you start?

Valentina Mankiyeva: I'd create many shelters. Yes. I think this is the most pressing need women face: having that female support system, staffed by specialists who can offer comprehensive care, including support for children. From there, women can receive [more] help if they want it.
We've already raised the issue of accessibility of services. Many programs aren't designed with women in mind, which is why they don't address the issue well enough. This isn't just about government programs, but also international ones and the grants that are implemented here. They don't target women who use drugs.
Perhaps shelters or other temporary housing options, like specialized centers, could provide a safe and supportive environment for women to get the necessary help. I believe that's an important task. Additionally, we need to improve advocacy work to change the existing situation. To do that, we need to gather data and conduct research to understand women's needs

and better formulate demands. The reports we submit to international committees - Kazakhstan actively participates in this - can serve as a tool to show where the system is failing to meet modern needs. That's why shelters are so foundational. When you feel safe, when you have a roof over your head, then, of course, you can start to think more clearly.
And when you sleep in a clean bed and have something to eat, you can think. What can you do when you're hungry or homeless?

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5. Interview with Nazik Abylgazieva

conducted by Katarzyna Kinga Kowalczyk

Katarzyna Kinga Kowalczyk: Can you introduce yourself?

Nazik Abylgazieva: I am Nazik and I live in Bishkek, Kyrgyzstan, where I was born and raised. Currently, I identify as a queer human rights defender and activist, and as a pansexual individual. I'm also deeply aligned with narcofeminism, a concept that Alla Bessonova introduced me to. I actively use natural psychoactive substances, enjoy smoking cannabinoids, and have had various experiences with other substances.

Queer is an umbrella term used by individuals whose sexual orientation or gender identity falls outside the traditional norms of heterosexuality and cisgender identity. It can refer to people who are gay, lesbian, bisexual, transgender, non-binary, or other gender and sexual minorities. The term is broad and flexible, and its use can vary from person to person.

Pansexual refers to someone who is attracted to people regardless of their gender or gender identity. Unlike bisexuality, which is sometimes understood as an attraction to two or more genders (though this definition can vary and often includes attraction to people of all genders), pansexuality encompasses attraction to people across the full spectrum of genders, including non-binary and transgender individuals.

Narcofeminism is a movement at the intersection of feminism, harm reduction, and drug policy advocacy, specifically focusing on the experiences and rights of women who use drugs. The core idea of narcofeminism is to challenge both the patriarchal structures and oppressive drug policies that disproportionately affect women.

The movement began in 2016 through the European Harm Reduction Association's collaboration with AWID (Association for Women's Rights in Development) during a meeting in Brazil. This partnership continued with a follow-up meeting in Berlin in 2018, titled "Strengthening Feminist

Movement-Building and Engagement of Women Working in Drug Policy in Eastern Europe and Central Asia," where discussions focused on how feminists and women-who-use-drugs movements could support each other. Subsequent global meetings took place in Barcelona and Portugal in 2019, bringing together representatives from women-who-use-drug networks worldwide. These gatherings also included visits to harm reduction services focused on women. Naming the movement posed challenges, but the term "narcofeminism" was embraced in the EECA region because of its lack of negative connotations. In Kyrgyzstan, the local branch launched in 2019 by joining the "16 Days Against Violence Against Women" campaign (Bessonova et al. 2023).

By profession, I'm a teacher and a former professional athlete. I hold the title of Master of Sports in football and rugby. I graduated from a sports academy and taught for some time, but I wasn't satisfied with the salary, so I had to explore other areas. That's how I ended up in human rights and activism. I spent over 10 years working in an LGBT organization, one of the first in Kyrgyzstan, Labrys.

Katarzyna Kinga Kowalczyk: How is life for women in Kyrgyzstan?

Nazik Abylgazieva: It's fun, not boring, to say the least. Of course, patriarchy is strongly entrenched here, and I've faced this since childhood. Patriarchal attitudes are very prevalent in Kyrgyzstan and the Central Asian region, including neighboring Uzbekistan, Tajikistan, and Kazakhstan. Turkmenistan is more like North Korea, a closed-off country, but the other four countries have similar contexts. Even with the independence of Kyrgyzstan, which we just celebrated recently, women continue to face stigma and discrimination.

Starting from birth, the living conditions depend heavily on the region. The capital, Bishkek, is more modern, while rural areas are much more traditional. In some regions, there's still no electricity, and women have to walk long distances to get drinking water. There's a lack of access to essential needs, education, jobs, or even basic resources.

In 2024, some women in rural regions still lack access to water, electricity, and proper living conditions. Regarding reproductive health, women are expected to bear children and often denied contraception, as men often forbid it, mixing religion into it, claiming, "Allah said to give birth to as many children as destined." Women endlessly give birth, leaving them physically exhausted. By the time they're 40, they look like they're 60 due

to the toll of having multiple children, financial hardships, and no access to basic needs like food and education for their children.
When it comes to security, physical, psychological, and economic violence against women is common. The saddest part is that many women don't even realize they're experiencing violence from their partners.
I am not sure if you have heard about Nikah; it's a type of marriage which takes place in Islam [meaning] you don't have to register it. It's more common in Kyrgyz families than in Russian or other ethnic groups. Husbands migrate to Russia or another country, leaving these [legally unmarried] women with children. And they have no education, because they are often still young, 16-17 years old, when they are married off.

Nikah is a form of Islamic marriage ceremony that is common in some regions. Unlike civil marriages that require official registration at a registry office (ZAGS), *Nikah* marriages are conducted in religious settings, often without legal documentation. This can leave women vulnerable, particularly in ethnic Kyrgyz families where the practice is more prevalent.

We also have the issue of kidnapping women, even though it is legally prohibited. In these cases, brides are kidnapped and married off without their consent by their parents or the groom. Again, there's no way of romanticizing it, someone chooses you and steals you away. There are cases of rape and sexual violence against women. And, of course, there are cases where such situations lead to fatal outcomes.

Ala kachuu is a traditional practice in Kyrgyzstan that translates to "grab and run." It refers to the act of bride kidnapping, where a woman is abducted by a man and his friends with the intent of forcing her into marriage. Although it may be portrayed as an old tradition, in many cases, it still happens against the woman's will, and she is often coerced into marriage due to societal pressures, fear of stigma, or familial shame. While this practice was outlawed in Kyrgyzstan in 1994 and the penalties increased in 2013 to a criminal offense, it still persists, especially in rural areas (Kleinbach & Salimjanova 2007; UN Women 2013)

The [COVID] pandemic period caused a surge and revealed all these problems, which I think happened in many countries. But in Kyrgyzstan, I remember the figure showed a 64-67% increase in domestic violence. In these confined conditions, in isolation, men were showing their aggression and violence to the fullest, and there were horrific and shocking cases

of male partners torturing their wives or girlfriends. And it continues to happen now. You might have heard about that notorious case that gained public attention involving the former Minister of Economy in Kazakhstan and his wife, there was a trial in Astana.

> The former economy minister Kuandyk Bishimbayev was sentenced to 24 years in prison for the brutal murder of his wife, Saltanat Nukenova. The case sparked nationwide outrage, with demands for stricter laws. In response, a new law ("Saltanat's Law") now criminalizes domestic violence, but activists argue it doesn't go far enough in addressing issues like legal loopholes and societal tolerance. With hundreds of Kazakh women killed by partners annually, this trial marked a step toward justice, but significant gaps in protections for women remain (24.kg 2024).

There's always this notion that violence only happens in marginal families and that the intellectual class is somehow protected from it. This case gained a lot of public attention, and the trial was conducted publicly. And it was just a nightmare. The authorities in Kazakhstan then started talking about introducing a law to protect women from domestic violence. But why does this only happen when something becomes public? Every day, even as we're talking right now, in some families, someone's ears are being cut off, someone is being raped, and children are being beaten.

I will be open and honest: I was subjected to physical and psychological abuse by my father for a long time. Our father is a tyrant, and he abused my mother, and my family – my sister and me – have lived through this psychologically, though we try to move on. Now I'm grown up and no longer a little girl. I have the right to talk back to my father. And there are many families like ours. Based on conversations and reflections from support groups with women of different ages, the stories are all very similar. What happened 20 years ago, 10 years ago, 30 years ago, and what's happening now – these stories are eerily alike. Only the actors, and the people involved, are different. That's the conclusion I've drawn, from what I see.

Now you have access to devices, phones, and the internet – everything spreads quickly. These tools weren't available before. If we go back even 15-20 years, there was no Istanbul Protocol, no signed conventions. But Kyrgyzstan signed the CEDAW convention to eliminate all forms of discrimination. At one point, Kyrgyzstan was seen as a beacon of democracy. The government was working on these documents and initiatives, which was great. But in practice, nothing changed. Implementing these things

requires massive resources – human and financial – to make them work and to monitor them.

The Istanbul Convention, officially known as the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence, is a human rights treaty adopted in 2011. It aims to protect women from all forms of violence, prevent violence, prosecute perpetrators, and eliminate domestic violence. The convention emphasizes gender equality and requires states to adopt comprehensive legal frameworks and support services for survivors (Council of Europe 2011).

The CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) is an international treaty adopted by the United Nations in 1979. It aims to eliminate all forms of discrimination against women by ensuring women's rights to equality in all aspects of life, including political, economic, social, cultural, and family life (United Nations 1979).

Now, I don't understand why there's been such a strong rollback. The things that are happening in Kyrgyzstan right now are complete madness. I see so many women covered up in traditional clothing. It's scary sometimes to walk in the center of the city, not to mention the outskirts. You don't know what might happen to you. Will someone come after me because I look non-traditional, with short hair and tattoos? I notice the attention I get. When it's kind and positive attention, that's fine. But when it's aggressive or carries a criminal undertone, it's terrifying.

Katarzyna Kinga Kowalczyk: And how is life for women who use drugs?

Nazik Abylgazieva: Similar to how they've always lived - terribly. If you're a woman and a drug user, society immediately condemns you. There's no support - only judgment and further psychological abuse. If we talk about public opinion, it's much stronger than any law or court. The presumption of innocence, I think, just doesn't work here in Kyrgyzstan, from what I observe.

The situation for women now is tragic, especially considering the drug scene. There was a time when women used heroin and now, the drug scene has changed, with all these synthetic drugs. Synthetics influence is immediately visually noticeable – a person changes in appearance without a doubt. It's not just about appearance but mental as well. There's a very

strong psychological dependence, and there are also some accompanying disorders.

Once I accompanied a girl, a young girl, who had been using synthetic drugs, mephedrone, for a long time, and experienced sexual violence, to the district police department to file a report. The violence was committed by her brother, a close relative. Of course, law enforcement agencies are reluctant to accept such reports, but because I was sitting next to her and presented myself as a human rights defender representing her interests, they were like, "You have no right to be here." And then there was this strange dialogue. I said, "You see what condition she's in, I just don't want to leave her alone with two investigators." Then a third investigator came, and I said, "What's this committee of investigators? You see the state of the girl, now you're going to question her about the events that occurred, and the three of you are here like it's some kind of circus. Even right now, I see clear violations."

"Where is the female investigator?" I asked, "The one who could at least examine her properly and follow the necessary legal procedures?" I told them, "This is a complete violation, what is this?"

Finally, a female officer came to examine her, and they started the questioning. I asked if the extra men could leave the room. "This is not a concert or a performance; serious things are happening here," I said. "The fact that you're used to doing things this way doesn't make it acceptable." While she [the female officer] was questioning the girl, they simultaneously called her brother and mother, who subsequently arrived. She had a breakdown, saying she didn't want to go back home. So I took her away. The investigator wanted to send her back to that abusive home environment with her brother and mother, who were emotionally pressuring her.

Later, I referred her to a crisis center called AELZAD. It's a crisis center funded by international grants and by state funding. It positions itself as open to all women, without any specific requirements.

It took a long time to explain and negotiate before I could bring the girl to the center. But in the end, it didn't work out for her because she was going through withdrawal, and her psychological state wasn't stable. In such crisis centers, priority is given to women with children, women from rural areas, and women being pursued by husbands, abusers, or aggressors. As for women who use drugs or work in the sex industry, or if they're lesbian, bisexual, or transgender – if all of these identities intersect – then it's goodbye. "We don't want to deal with you."

People are afraid because they don't know better. Fear stems from ignorance. There are many stereotypes, and many factors influence decisions. If a person is more empathetic, like a good social worker, then that's great. But overall, the system works against women who are vulnerable to HIV, especially women in key populations.

Sadly, there are currently no shelters, a lack of space, and no proper services or conditions. While they exist in certain places, there is no comprehensive solution. This is similar to how we talk about aiming for "one-stop" services, comprehensive services. It all looks nice on paper, in proposals, but in practice it does not exist.

So, again, in Kyrgyzstan, there are sufficient numbers of non-governmental organizations, some of which have been registered for a while, because all these grant funds started pouring in during the early 90s. There are specific ones that work and are active, while others exist nominally. Due to the law on foreign agents, as of today, some organizations have self-liquidated. Two LGBT organizations have already self-liquidated. There is also a large organization that has worked with human rights defenders for more than 20 years, and they had to rebrand. They closed the old organization and opened a new one because they are already under close scrutiny. And even if they do not declare themselves as foreign agents, they are still subject to tax audits or visits from government representatives at their events. These are the realities we are facing.

Kyrgyzstan's "foreign agent" law, signed into effect in April 2023, imposes strict regulations on non-governmental organizations (NGOs) that receive foreign funding. These NGOs must now register as "foreign representatives" and are subject to extensive financial reporting and auditing requirements. The law was inspired by similar legislation passed in Russia in 2012 and has sparked concerns about increased scrutiny of civil society (Library of Congress 2024).

If we talk about services regarding HIV prevention then, of course, there is testing. Many projects have even introduced express testing with results in 15 minutes, and it's 90-something percent accurate. And there are immediate referrals, of course, to AIDS centers, but now they've rebranded as hepatitis-HIV bloodborne contact centers. They try to present themselves better because the term "AIDS center" and the acronym "AIDS" still scare people. Many people still hold distorted and incorrect beliefs about HIV, despite all the awareness campaigns and countless videos. A

massive amount of money has been poured into HIV prevention and public awareness campaigns in Kyrgyzstan. While there has been some progress, many still think of it as "the plague of the 20th century" and have strange misconceptions about how it's transmitted – like thinking a mosquito bite or sharing a cup can transmit it.

Condoms are distributed, but there are no female condoms. This is especially problematic if we are talking about vulnerable women like sex workers or trans women. There is a significant lack of access to psychological support. Mental well-being is only just now being discussed. Before, it was like, "What mental health? Let's deal with the basics first." But mental well-being is indispensable. Even when talking about harm reduction, you treat the body with detox, and clean out the substances, but what about the mind? It's all psychological dependence. Sure, you've treated the body and brought it back to order, but the mental aspect is inseparable. How can we ignore that and say we'll deal with mental well-being later?

There are still strange discussions such as, "Men don't need a psychologist or psychotherapist, so why do you women?" It's strange thinking because it's obvious that there's a need. Women say it, and even some men have started talking about it. But when it comes to women, all of them say they need psychological support, whether it's peer-to-peer support, group support, or any other form that works for them. But there's no one specific model. People are different. There isn't one universal great psychotherapist or psychiatrist who suits everyone. These are different characteristics. It's all very complex. People often hire one psychologist or psychotherapist for a project and then say, "That's it, spread the word." But not everyone likes that specialist. So, yes, there is a service, but not everyone likes the specialist offering the service.

It's strange because people come to you with a request and you're trying to "set them on the right path" based on your own beliefs and convictions. You're not approaching your work professionally; instead, you're trying to change their orientation or their life decisions. Whether we're talking about drug use or sex work, or even about leaving a husband and someone says, "Maybe you should reconsider"—that is shocking and incidents like these occur. People think, "Why do I need such help?" and many become disillusioned with therapy and psychological support. They get traumatized and think, "Maybe people are right, why should I go to a psychologist? I'd rather turn to alcohol, substances, or other accessible antidepressants to balance my condition." That's how it is.

Katarzyna Kinga Kowalczyk: How about 12-step programs?

Nazik Abylgazieva: The 12 steps Minnesota program was originally developed for Alcoholics Anonymous, but later it was adapted for people with various substance dependencies. This is, of course, a preferred therapy in prisons, correctional facilities, and so on. However, various pieces of evidence show that it doesn't suit everyone. This is especially true for those using new psychoactive substances. It's absolutely irrelevant. It doesn't fit at all.

I worked for three months at a private rehabilitation center that used the 12-step program. It didn't work at all, no. Especially when there's a mixed group – one person with alcohol addiction and another with mephedrone or amphetamine addiction, synthetic drugs. They're just in completely different realms. When sitting with them and talking, they don't understand each other at all. They're not even interested in it. So, I think, why is that? It's clear – it's just business. They take enormous amounts of money from people, but provide no real help. It seems to me that people don't even make it past the third step. I honestly think so. Does anyone actually reach the twelfth step? I think nobody gets past the third step. Stay sober every day and that's it. That is my experience.

Katarzyna Kinga Kowalczyk: Could you tell more about your work as an activist?

Nazik Abylgazieva: For the past two to three years, I've been working with Alla Bessonova and Sergey Bessonov specifically on the Harm Reduction program. In 2019, Alla and I co-founded the Women's Network for Key Populations in Kyrgyzstan, specifically for women in key populations. We realized that many organizations provide basic service-related assistance, and we didn't want to duplicate those efforts. Why should we? Our focus became mental well-being and psychological support for activists, leaders, women who have used drugs or are currently using, or those in remission.

Addiction is something fluid; it's not as if today I say, "I'm an addict," and tomorrow I say, "I'm not." It's like sexual orientation, which I think is very fluid and flexible. Today, I might feel bisexual, tomorrow a lesbian. That's how people feel. I identify as pansexual. But I accept and understand that people are diverse, and they explore themselves. And I think that's fine.

Mental well-being and access to various forms of psychological support became something very important to me and Alla and we decided to move in this direction. We've already held two retreats for women who use drugs.

We also organized two off-site retreats with experts and psychologists. I don't have the academic background to call myself a psychologist, but as someone with lived experience, I enjoy speaking with women from different walks of life, including those with experiences of drug use.
Addiction is just one part of who these women are. They might also be actresses, homemakers, businesswomen, or travelers. Substance use is just one part of their lives, but there's so much more to them. I don't want to focus solely on substance use as the primary thing that unites us. However, we must highlight its importance. We offer group psychological support and individual sessions, though this requires funding because no one can provide this help for free indefinitely.
Alla and I realized that we also have our own needs. We can't volunteer endlessly. We need to cover our basic needs too. So, while I haven't fully stepped away from LGBT activism, I prefer not to work directly in LGBT organizations anymore. In 2021, I closed that chapter, saying I would pursue research and international forums. Recently, I attended the fifth Central Asian LGBT Platform in Almaty.
The topic of safety is something I'm passionate about - physical, digital, and psychological safety. I've completed two ToTs (Training of Trainers) with Frontline Defenders, a Dublin-based organization that supports human rights defenders. They help in urgent situations, such as those involving government persecution or threats to life, by providing relocation or evacuation support. I've also conducted safety workshops for LGBT organizations and their partners. These topics - mental well-being and safety - are highly relevant today.

Katarzyna Kinga Kowalczyk: How do you take care of yourself?

Nazik Abylgazieva: Good question. I do take care of myself. Speaking of external interventions, I occasionally allow myself to use - to smoke marijuana. Episodically, once a year or every six months, I go on a psilocybin journey, which involves using mushrooms or LSD. But I don't mess around with it; it's very philosophical for me, but it has to be [practically] beneficial. Yes, sometimes what occurs is unexpected, but it's a good experience.
Otherwise, I found that music always saves me. I love music in different formats, and I love to listen to music. I also move around by bike a lot. I visit nature, go out, read books, talk to good people. So, I have my own little set of practices that help me keep going and holding on.
And even, like, when it comes to my father, with [questions like] "why is he like that?" I have practices now. He has an alcohol addiction, and he

used to go on binge-drinking sprees. When he's intoxicated, he can be very aggressive. Well, it's more controlled now, more manageable, but still, I have to suppress it, and then I need an outlet. At least I can use my bike for that.
I also love nature and going out. New experiences, new bright impressions – they create new neural connections in the brain and prevent me from sinking back into darkness, into someone else's scenarios, like my family's. I don't want to fall into other's scenarios; I want to live my own life. How long can I keep living the lives of my parents or someone else? It feels like a waste of time.
Time flies fast now, like seasons changing – spring, summer. Years fly by. I want to allow myself to love myself and direct resources toward myself. Otherwise, I'll fall apart mentally and physically, crumble into pieces, and I won't be able to provide support to anyone else. I've already been in that state. I was in a deep depression. I've been through it, and the recovery was hard, and I don't want to go through it again.
Self-care has to be a priority; otherwise, how can you help others? Of course, there are times - without a doubt - when I feel powerless, like I just want to say, "That's it, I can't anymore, enough," and go off into the woods or mountains, into a little hut, and say, "Leave me alone, I don't want to see anyone. I just want birds, animals, plants. Yes, I'll grow carrots and eat leaves and I won't want to see a single person, not anyone at all." But then I allow myself to go off to some quiet place, like our Karagach Grove. We have places like that where you can retreat and restore yourself, and then I think, "Well, things aren't that bad after all, Nazik, not so bad."
There are, of course, emotional swings, naturally. This is because I love helping people. But there are times when, honestly, I hate people. I hate them because you think, "Why even bother?" when things don't go as you hope. Then you start devaluing yourself, digging deep, and thinking, "Why am I doing this? It's all useless." I think you're familiar with this, right? Walking through the maze of your thoughts, having these internal dialogues and monologues.

Katarzyna Kinga Kowalczyk: If you had a magic wand and you could immediately change whatever you want, then where would you start?

Nazik Abylgazieva: I wish, on a global scale, that there would be no conflicts and wars at all. I don't want people to fight, to show aggression. Ideally, everyone would just love it. If I had a magic wand, I'd make sure people just loved each other and there was no aggression.

Violence in families is a micro-conflict. And then you have clans fighting clans, cities against cities, nations against nations, and then it escalates globally. It's all the same. People. It's just people.
Whether you call it wars or special operations, it's all about competing for resources. These are all just human ambitions; it's all about people. Some just have more resources. I feel like if we could change that, if we could instill in people that there's no need to fight and compete, but instead just love each other and focus on creating, then people would have more time to enjoy life, to improve, and to get educated.
Why aren't women educated? Because their whole day is taken up with cooking, washing, and dealing with endless children. When is a woman supposed to have time for herself? She might want to get educated, but she simply doesn't have time.
Now we just need to invent that magic wand, Kasia.

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6. Protection of Reproductive Health and Family Planning

Galina Grebennikova, Natalya Rakhalskaya

Introduction

Sexual and reproductive health is a crucial but often undervalued component of overall well-being. It involves not only good physical health but also the ability to have safe and satisfying sexual relationships, the opportunity to have children, and freedom from coercion and violence. For women living with HIV and using drugs, access to information and services in this area is often complicated by stigma and discrimination from various sides, making it imperative to address their unique needs, reduce health risks, and empower them to make informed decisions about their reproductive health.

Living with HIV and dependence on psychoactive substances presents unique challenges, especially concerning reproductive health. Many women face prejudices from family, society, and healthcare professionals, leading to various adverse outcomes.

Strategies for harm reduction are related to reproductive health, especially for women who use drugs and those living with HIV, as these populations confront particular and compounded health hazards. Accessing reproductive health treatments can be extremely difficult for drug-using women due to a variety of factors, such as stigma, discrimination, and a lack of specialised programmes. As a result, requirements for prenatal care, contraception, and the prevention of sexually transmitted infections (STIs) like HIV may not be met. Ensuring women living with HIV have access to comprehensive reproductive health treatments is crucial for both their personal health and the prevention of HIV transmission from mother to child. By offering non-judgemental, holistic care that covers sexual and reproductive health, harm reduction strategies that incorporate reproductive health services can close these gaps and empower women. This will eventually improve health outcomes and slow the transmission of HIV.

Reproductive Health

According to the World Health Organization (WHO), reproductive health is defined as "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions, and processes" (WHO 1994). This definition, proposed by WHO and agreed upon at the International Conference on Population and Development, includes sexual health as well (WHO 1994).

All these elements together form the basis of reproductive rights, which are an integral part of human rights and social justice. These rights include:

- the right to universal access to modern contraceptives
- opportunities for safe pregnancy and the protection of maternal and child health
- the right to education and information on sexual and reproductive health
- opportunities for safe abortion.

These rights guarantee every person the right to health, safety, and autonomy in making decisions regarding their body and reproductive choices. Addressing the fundamental principles that define the foundations of health and freedom for every person, it is important to note that reproductive rights mean guaranteed access to modern contraceptives for all members of society. This access ensures the ability for each person to choose and control their reproductive path, regardless of social status, age, or gender.

The Right to Universal Access to Modern Contraceptives

Modern methods of contraception offer a wide range of options, allowing people to choose the method that best suits their needs and preferences. These can include condoms, contraceptive pills, intrauterine devices (IUDs), injections, patches, subdermal implants, and others. Guaranteed access to contraceptives not only helps prevent unwanted pregnancies but also contributes to public health improvement. Family planning allows parents to decide when to have children and how many to have, which in turn helps reduce inequality in access to education, employment opportunities, and economic resources.

Moreover, access to contraceptives plays a key role in reducing the risk of transmission of infections, including sexually transmitted infections (STIs).

This is important not only for individual health but also for public welfare, as preventing the spread of STIs helps reduce healthcare costs and improve quality of life.

Thus, guaranteed access to modern contraceptives is an essential element of reproductive health and one of the rights of every person. It contributes to the realization of an individual's rights to health, freedom, and self-determination, as well as to creating a more equitable and prosperous society.

Opportunities for Safe Pregnancy and the Protection of Maternal and Child Health

The realization of reproductive rights undoubtedly includes another important aspect of a prosperous society – the protection of maternal and child health, which allows future parents to prepare properly for childbirth, receive timely medical care, and monitor their health throughout the pregnancy.

The protection of maternal and child health also includes access to quality medical services during pregnancy, childbirth, and the post-partum period, screening for potential complications, necessary medical procedures, and support from qualified healthcare professionals.

The Right to Education and Information on Sexual and Reproductive Health

The right to education and access to information on sexual and reproductive health is also an integral part of reproductive rights and freedoms. It provides individuals with knowledge about their bodies and sexuality, helps prevent unwanted pregnancies, protects against sexually transmitted infections, and promotes the creation of healthy and responsible relationships.

It is necessary to take into account the social and cultural contexts in which reproductive rights operate. This includes respect for the diversity of cultural beliefs and practices, as well as consideration of the individual needs and life circumstances of each person.

Opportunities for Safe Abortion

Finally, reproductive rights include the possibility of safe abortion when necessary. It is important to understand that the decision to have an abor-

tion is often made under complex and individual circumstances, which may include social, economic, medical, and psychological factors. Guaranteed access to safe abortion services provides women with the opportunity to make decisions about their reproductive path in a safe and supportive environment. Providing access to qualified medical abortion services helps prevent complications and risks associated with unsafe and illegal methods of pregnancy termination, which contributes to reducing maternal mortality and disability, as well as preserving women's physical and psychological health.

Freedom of choice and control over one's body are inalienable rights of every person. Reproductive rights ensure the ability to make informed decisions about sexual and reproductive health, including access to contraception, abortion, and quality medical care.

Factors Affecting Reproductive Health

Reproductive health is influenced by a variety of factors that are interrelated and impact individuals in different ways. The main factors affecting reproductive health include:

- *lifestyle*: chronic stress, low physical activity, poor diet and, as a result, being overweight or underweight, risky sexual behaviour, and sexually transmitted infections
- *harmful habits*: alcohol abuse, smoking, drug use
- environmental factors: the consequences of nuclear test sites, environmental pollution;
- *social environment*: low living standards, inadequate nutrition, unemployment.

Lifestyle is a major determinant of reproductive health, whereby chronic stress, low physical activity, and poor diet can significantly disrupt reproductive functions. Chronic stress, for instance, can lead to hormonal imbalances that affect menstrual cycles and fertility, while a sedentary lifestyle often contributes to obesity, which is linked to conditions like polycystic ovary syndrome (PCOS) and infertility. Additionally, poor nutrition can result in deficiencies that affect reproductive health, while being either overweight or underweight can disrupt normal reproductive processes, making it difficult to conceive. Risky sexual behaviors, such as having multiple partners or engaging in unprotected sex, increase the risk of STIs,

which can lead to infertility and other serious reproductive health issues if left untreated.

Harmful habits like alcohol abuse, smoking, and drug use also have detrimental effects on reproductive health. Excessive alcohol consumption can disrupt hormonal balances and reduce fertility in both men and women, while smoking is linked to a range of reproductive problems, including a higher risk of miscarriage and reduced sperm quality. Drug use further complicates reproductive health by causing hormonal disruptions and increasing the likelihood of infertility and pregnancy complications. The formation of harmful habits (smoking, alcohol, and drug use) negatively affects not only the individual's health but also the health of future children. Alcohol abuse leads to an increase in the number of children with congenital physical and mental disabilities. It is now proven that pregnancy is incompatible with alcohol or drug use, as it increases the risk of pregnancy loss, infertility, and the likelihood of giving birth to a sick or impaired child. Early on, nicotine, alcohol, and drugs result in the death of the fertilized egg and embryo, delayed foetal growth and development, organ and system malformations, spontaneous abortions, and stillbirths. Alcohol use increases the risk of early sexual activity, HIV infection, and sexually transmitted infections. Women who misuse alcohol, marijuana, and other illegal drugs are more likely to report not using condoms, having more sexual partners, getting STIs, abusing contraceptives, engaging in non-consensual sex, and experiencing violence from their partners (Hall et al. 2013).

Additionally, environmental factors are crucial. For example, genetic abnormalities, infertility, and an increased incidence of birth deformities and miscarriages might result from radiation exposure from nuclear test sites. By altering hormonal balance and raising the risk of reproductive malignancies and birth defects, environmental pollution – which includes exposure to pesticides, heavy metals, and chemicals that disrupt endocrine function – can also have a negative impact on reproductive health.

Finally, an individual's social surroundings also have a large influence on their reproductive health. Low living standards, which are frequently accompanied by financial difficulties, can make it more difficult to get necessary medical care, result in poor nutrition, and raise stress levels, all of which have a detrimental impact on the health of the reproductive system. Deficiencies in vital nutrients that are critical for reproductive processes can arise from inadequate diet, which is frequently associated with poverty. In addition, joblessness can worsen stress and depression, limit access to

healthcare, and encourage unhealthy lifestyle choices, all of which can have a negative impact on reproductive health.

The Role of Parents

The foundations of reproductive health are laid in childhood and adolescence, so it is crucial to care for one's health from this age onwards. Parents need to be aware of the main stages of their children's physiological development, the reasons for consulting healthcare professionals, and the intervals for preventive visits. Regular monitoring by a doctor from birth will help identify any problems early, including delayed or premature sexual development, allowing for timely medical intervention, if necessary.

The process of puberty begins in the child's body at six to seven years of age. Parents must ensure that the child is developing according to their age, and a doctor can help determine this. Mothers should definitely take their daughters to a gynecologist when they are nine to ten years old, as this is the period in which girls develop secondary sexual characteristics, such as breast development and the appearance of pubic and underarm hair.

For boys, sexual development is assessed at twelve years old by a doctor to determine whether the child has entered puberty. The development of body hair, genital size, Adam's apple size, and other external signs are evaluated.

The next visit to the gynecologist for girls should occur with the onset of menstruation, as this is one of the most important moments in a girl's development. It is considered normal for menstruation to begin when a girl is about twelve and a half years old, although it can occur a little earlier or later. However, if by fourteen years old a girl has no secondary sexual characteristics and by sixteen years old has not started menstruating, parents should be concerned and immediately take their daughter to a gynecologist.

For boys, a repeat visit should occur at 14 years old. The doctor will determine how the child is progressing through puberty and whether there is a delay in sexual development. Twelve to 14 years old is the most common age for the onset of varicocele (enlargement of the veins of the spermatic cord), which should be ruled out as it can be a cause of infertility in the future.

In addition, parents should seek medical advice if their child has any complaints, such as itching, pain, burning in the genital area, unusual discharge or very painful menstruation in girls, or other concerns.

The adolescent period is crucial for forming healthy lifestyle habits. A lack of information on reproductive health protection due to the absence of a comprehensive sexual education system for children and adolescents leads to early sexual activity and risky sexual behavior, resulting in high rates of teenage pregnancies and abortions, the spread of sexually transmitted infections, and, in the future, potential infertility.

Developing a healthy lifestyle should involve the acquisition of specific knowledge and skills that exclude harmful habits and unsafe sexual behavior. Thus, reproductive health is a reflection of an individual's quality of life in childhood and adolescence.

It is well known that reproductive behavior determines the quality of reproductive health. Reproductive behavior includes reproductive attitudes (when and how many children to have), sexual behavior, and contraceptive behaviors. Acquiring the necessary behavioral skills is crucial. If young people positively perceive the need for healthy behaviors, their relationships will be as safe as possible.

In Kazakhstan, several gradual steps are being taken towards protecting the reproductive health of the entire population, the most important of which is the 'Concept of Family and Gender Policy in the Republic of Kazakhstan until 2030', approved by the President's Decree. There is also a state program aimed at reducing maternal and child mortality in the Republic of Kazakhstan within the framework of the overall Concept of Healthcare Development in the Republic of Kazakhstan for 2020–2025. These programs and activities aim to reduce inequalities in access to reproductive services, reduce maternal and child mortality, improve the quality of life for women and children, and create public awareness of the importance of caring for reproductive health.

A significant contribution to this effort is made by the Kazakhstan Association for Sexual and Reproductive Health (KMPA), which, over the last 30 years, has implemented numerous projects aimed at raising youth and adolescent awareness and promoting the realization of reproductive rights and freedoms in Kazakh society.

Risky Sexual Behavior

Risky sexual behavior increases the risk of contracting and spreading STIs, including HIV. STIs are bacterial or viral diseases, and the primary route of infection is sexual contact. STIs include syphilis, gonorrhea, chlamydia, trichomoniasis, cytomegalovirus, herpes simplex virus, hepatitis B, human papillomavirus, HIV, and several other infections. If infected with STIs, both men and women face risks of complications. For men, these include inflammation of the prostate gland, seminal vesicles, testes, and epididymis, which can lead to infertility. For women, these include inflammatory diseases of the ovaries, uterus, and fallopian tubes, which can impair reproductive function.

If left untreated, some STIs, such as gonorrhea and chlamydia, can lead to infertility or pregnancy loss in women and sexual dysfunction in men. Human papillomavirus infection can lead to cervical cancer.

Risky sexual behavior remains a significant public health issue, especially among key population groups. These groups include, but are not limited to, youth, sex workers, people who use drugs, and men who have sex with men.

Youth are often at risk due to a lack of information, access to reproductive health services, and decision-making skills. They may face peer and societal pressure, leading to unprotected sex, multiple partners, and other risky behaviors.

Preventing teenage pregnancies remains one of the most pressing issues in reproductive health. According to sociological studies conducted by United Nations Population Fund (UNFPA 2017) in the Republic of Kazakhstan, the average age of first sexual intercourse is 16.5 years. About a third of youth aged 15–19 are sexually active, with 21% having had their first sexual contact before the age of 18. On average, three out of 100 girls aged 15–19 become pregnant, and 15% of them terminate their pregnancy through abortion. Therefore, safe sexual behavior, which includes the use of barrier contraceptives (condoms) that prevent pregnancy and protect against sexually transmitted infections, including HIV, is of great importance.

Female sex workers confront particular difficulties in preserving their reproductive health, but there are various tactics that can support them in taking care of their health. Frequent health examinations are essential, including gynecological exams such as pelvic exams and Pap screenings to detect problems like cervical cancer early on, as well as routine testing

for STIs like HIV. Furthermore, since the hepatitis B virus can be spread through sexual contact, being vaccinated against it is crucial (WHO 2012; UNAIDS 2014).

Having safe sexual practices is yet another crucial component of reproductive health. Whether using male or female condoms, using them correctly and consistently is one of the best methods to avoid STIs and unintended pregnancies. To protect their clients, sex workers should also be equipped and trained to discuss condom use.

It is essential for sex workers to have access to a range of contraceptive methods in order to avoid unwanted pregnancies. In addition to having access to emergency contraception, like the morning-after pill, in the event of unprotected intercourse or contraceptive failure, sex workers ought to be given the freedom to select the type of contraception that best meets their needs.

In order to maintain reproductive health, knowledge and awareness are essential. Continuous education regarding safe sexual practices, STI prevention, and reproductive health should be provided to sex workers. It's also critical that they understand their legal rights to healthcare, safety from abuse, and protection from exploitation.

Another crucial element is support for mental health. Counselling services are available to assist sex workers in managing the psychological stress and trauma that may come with their job. Peer education and community assistance can also be very successful. Joining or starting support groups, as well as participating in peer education programs where sex workers teach one another about reproductive health, can offer emotional support and safety and health-maintaining techniques.

Promoting better working conditions is crucial to lowering health hazards. This entails pushing for the decriminalization or legalization of sex work, which can increase sex workers' access to healthcare and legal safeguards, as well as supporting the provision of condoms and hygienic amenities in their places of employment.

Harm reduction initiatives, including needle exchange programs, can lower the risk of infections and other health problems for drug users. Providing assistance in controlling or minimizing substance use can also enhance general health results.

Reproductive and general health are dependent on having access to clean water and sanitary facilities. Last but not least, aiding advocacy initiatives that seek to enhance the social and legal landscape for sex workers may result in increased access to healthcare and abuse prevention.

Family Planning

Family planning is one of the key preventive measures in maintaining reproductive health. According to the United Nations definition (1994), "family planning is the ability of couples and individuals to freely and responsibly decide on the number and timing of their children's births, and to have the information and means to do so consciously, using the full range of safe and effective methods".

Family planning can also be called parenting planning. There are specific principles of family planning aimed at the birth of desired children at optimal times with minimal risk to both the mother's health and the health of the future child.

Thanks to family planning, individuals and couples can anticipate and have their desired number of children, as well as determine the timing of their births and the intervals between them. This is achieved through the use of contraception and infertility treatment.

It is important to know that the risk of maternal and infant mortality increases with pregnancy before the age of 18, short intervals between births, and pregnancy against the background of other concomitant diseases.

Pregnancy before the age of 18 is associated with a 35% higher mortality rate for children born to women in this age group compared to women aged 20–30, and maternal mortality increases by 34%. Girls under 15 years old are five times more likely to die during childbirth than women at 20 years old.

Pregnancy at the age of 35 or older also carries a higher risk of maternal and infant mortality. Additionally, there is an increased incidence of children born with congenital neural tube defects (NTDs), particularly Down's syndrome. It is noted that the incidence of congenital defects increases fortyfold in women aged 40 and above.

If the interval between births is less than two years, the child mortality rate increases by 2.5 times (with a higher risk of stillbirth, spontaneous abortion, and the birth of low-weight children). The risk of maternal mortality, pregnancy complications, and bleeding also doubles.

Multiple births (from four to seven births) increase the risk of maternal and infant mortality by 40%.

Pregnancy with concomitant diseases (such as cardiovascular diseases, kidney diseases) increases the risk of maternal and infant mortality.

Considering all of the above, thorough preparation for pregnancy is necessary. Couples planning a pregnancy should undergo laboratory exam-

inations and consult with a physician. To prevent congenital defects, it is recommended to take 400 micrograms of folic acid three months before conception and continue taking folic acid during the first twelve weeks of pregnancy.

If pregnancy is not currently planned, it is advisable to use contraceptive methods, also known as contraception methods. Modern contraceptives are effective and reliable methods of family planning. A trained health-care provider can help choose the safest and most effective contraceptive method, but the final decision on which method to use is made by the woman or man themselves. Consultations provide individuals with the opportunity to ask any questions they have regarding contraceptives.

When choosing a contraceptive method, factors such as reproductive plans, the impact of contraception on concomitant diseases (if any), the reliability of the method, the way it is used, protection against STIs (including HIV), and its other positive effects on the woman's body are considered.

Given the wide range of contraception methods, it can sometimes be difficult to make a choice. If pregnancy is not part of the immediate plans and contraception is needed, the following questions may help in deciding on a method:

- How reliably does this method protect against unwanted pregnancy (effectiveness)?
- Does the method prevent infection with sexually transmitted infections, including HIV?
- How difficult is the method to apply (ease of use)?
- Is the method comfortable to use?
- Is the method affordable and available (availability in pharmacies)?
- Is a doctor's prescription required to obtain the contraception?

The most common contraceptive methods
Birth control pills: These are known as combined oral contraceptives and contain low doses of the same hormones that are produced by the female body. The pills help prevent pregnancy by stopping ovulation (the release of an egg from the ovary) and thickening the cervical mucus, making it difficult for sperm to enter the uterus and reach the fallopian tubes. Women who use oral contraceptives take one pill every day, regardless of whether they have had sex or not. The pills work most effectively when taken at the same time every day. With consistent, regular, and correct

use, the effectiveness of oral contraceptives in preventing unwanted pregnancy is 99%. However, the pills do not protect against STIs or HIV.

Depo-Provera: This is an injection of a dose of female hormones that prevents unwanted pregnancy by stopping ovulation (egg production by the ovaries) and thickening the cervical mucus, making it difficult for sperm to reach the uterus and fallopian tubes.
Women using Depo-Provera need to get injections in the shoulder or buttocks every three months. The effectiveness of Depo-Provera is 99,7%, but only if the injections are received regularly. The injection does not protect against STIs or HIV. Depo-Provera can only be obtained after consulting with a doctor, and the injection must be administered by a trained healthcare professional in a clinic.

Spermicides: These come in the form of suppositories, cream, gel, foam, and film. They contain a chemical substance that destroys and/or impairs the movement of sperm.
Women who use this method insert spermicides into the vagina before each sexual act. With consistent and correct use, the effectiveness of spermicides in preventing unwanted pregnancy is 82%. Spermicides do not protect against STIs or HIV. A doctor's prescription is not required to purchase spermicides.

Female condoms: These are soft rubber pouches with a ring at both ends. The ring at the closed end is inserted into the vagina, while the other ring and open end remain outside. Female condoms protect against pregnancy and STIs, including HIV.

Implants: An implant is a thin plastic rod inside which there is a small dose of the hormone progestin. The rod is inserted by a doctor under the skin on the inner surface of the arm for three to five years (depending on the type). The implant prevents unwanted pregnancy for three years. It is a hormonal method of contraception that does not protect against STIs or HIV.

Intrauterine device (IUD): An IUD is a small device that a doctor places inside the uterus. It remains inside for five to ten years (depending on the type) and continuously prevents unwanted pregnancy. A doctor can remove it at any time. Like the pill, an IUD contains hormones that

prevent pregnancy. More than 160 million women worldwide use this method. This indicates that IUDs are the most widely used reversible contraception method worldwide. They do not protect against STIs or HIV.

Emergency contraception: This is the only contraception method that can be used after vaginal intercourse to prevent unwanted pregnancy. A woman can use emergency contraception if she and her partner forgot to use other methods, the method used failed (e.g. a condom broke), or there was sexual violence. A woman who needs emergency contraception takes pills that can act differently depending on the phase of the woman's menstrual cycle at that time. Emergency contraception can prevent the release of an egg by the ovaries, hinder the meeting of sperm and egg, or prevent a fertilized egg from attaching to the uterus. Emergency contraception works most effectively if taken within the first 72 hours after unprotected sexual intercourse or failed contraception. Emergency contraception reduces the risk of pregnancy by 75%–89%. This method does not protect against STIs or HIV.

Condom: This is a latex pouch worn over the erect penis. During ejaculation, sperm remains in the condom, preventing fertilization. It is important to know that condom and female condom use is the only method of preventing most sexually transmitted infections, such as gonorrhea, chlamydia, syphilis, hepatitis, HIV, and others.

Withdrawal: This method occurs when the man withdraws his penis from his partner's body before ejaculation. Withdrawal is a contraceptive method with a high failure rate, as it can be difficult to control the process. However, practicing withdrawal is better than doing nothing, but it's worth remembering that there are highly effective and reliable contraception methods available. The withdrawal method does not protect against STIs or HIV.

Family planning and the use of safe contraception methods help maintain reproductive health and help women give birth to healthy and desired children.

Pregnancy and Living with HIV

There are a lot of myths around pregnancy and living with HIV, around mother-to-child transmission of HIV, and around breastfeeding. The effectiveness of antiretroviral therapy has led to the normalization of pregnancy among women living with HIV, significantly reducing the risk of perinatal HIV transmission (Moseholm et al. 2022). According to WHO (2024), in Kazakhstan in 2021 there were 475 women living with HIV who received antiretrovirals to prevent mother-to-child transmission. Another misconception is around breastfeeding. In some settings, breastfeeding is recommended if the mother is on effective antiretroviral therapy (ART) and maintains an undetectable viral load. The risk of HIV transmission through breastfeeding is very low in these circumstances. However, recommendations may vary based on local guidelines and access to safe alternatives like formula. In Kazakhstan, the prevention of mother-to-child transmission of HIV is included in HIV clinical protocols that do not prohibit mothers from choosing to breastfeed. Additionally, breast-milk substitutes are provided free of charge to women with HIV as part of a comprehensive approach to preventing vertical transmission of HIV.

What is absolutely crucial is support from healthcare providers regarding ART and prevention of mother-to-child transmission (PMTCT) practices as this helps to reduce women's fear of death and perinatal transmission, which in turn enhances their participation in HIV care and leads to the birth of children free from HIV (Akinsolu et al. 2023).

Conclusion

Reproductive health is an integral part of the overall well-being of every person. It includes not only physical well-being but also the right to safe and satisfying sexual relations, reproductive choice, and freedom from violence and coercion. By guaranteeing access to information and services in the field of reproductive health, we affirm our commitment to protecting the rights of every person, regardless of their social status or life situation. Therefore, it is important to continue efforts to combat stigma and discrimination, ensuring equal opportunities for everyone to take care of themselves and their health.

Reproductive health is an important but often disregarded topic, particularly for women who take drugs, work in sex, or living with HIV. Stigma,

prejudice, and restricted access to necessary health treatments are among the many obstacles that these women must overcome. As a result, needs for contraception, antenatal care, and the treatment and prevention of STIs may go unmet. Reproductive health treatments are often underutilized or insufficiently provided for these disadvantaged individuals, despite the critical role they play in ensuring their overall well-being and lowering the risk of future health difficulties. Reproductive health must therefore be incorporated into HIV and harm reduction programs in order to provide comprehensive treatment that takes into account the special requirements of these vulnerable women.

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7. Women and Smoking in Central Asia

Meryem Grabski

Introduction

Smoking is the biggest preventable cause of death and disease burden worldwide. Smoking affects almost every part of the body negatively (WHO 2023). It is not only responsible for the majority of lung cancers but has been linked to cancers in the larynx, oral cavity, oesophagus, pancreas, bladder, stomach, colon, rectum, liver, and other organs. It is also responsible for many cases of ischaemic heart disease and increases the risk of heart attacks and strokes. Smoking during pregnancy significantly increases the risk of pre-term delivery and stillbirth and is linked to low birthweight, increased birth defects, and birth complications (Bernstein et al. 2005; Hackshaw et al. 2011; Jaddoe et al. 2008). It is also associated with negative long-term health outcomes for the baby, such as asthma, breathing problems, and learning difficulties in later life (Banderali et al. 2015). In addition to the smoker's offspring, smoking also negatively affects everyone in the proximity of the smoker: at least 1% of all deaths worldwide are cause by second-hand smoke (Öberg et al. 2011).

While tobacco use is declining globally, this decline is especially steep in certain parts of the world, while there is little decline in others and within certain populations. More specifically, in the past two decades, the steepest decrease in smoking levels has been seen in high sociodemographic index (SDI) countries, whilst the decline has been much smaller or non-existent in low and middle SDI countries. According to the World Health Organization (WHO), today around 80% of the 1.3 billion tobacco users worldwide live in low- and middle-income countries. The decrease in smoking levels in high SDI countries has mostly been driven by a decrease in male smoking, whilst the decrease in female smoking has been less pronounced (WHO 2021).

Smoking behavior is strongly patterned by gender: it is more common in males than in females in all regions of the world. This has arguably led to the problem of female smoking flying somewhat under the radar of public attention and healthcare efforts (Amos 1996). However, smoking is a

high-risk behavior for women: the annual number of female deaths caused by smoking-related diseases is more than two million. The viewpoint that female smoking is a significant health hazard that warrants specific and tailored research and intervention has been a topic of public interest for a while, with the WHO calling for 'a tailored approach to tobacco control that engages with the challenges faced specifically by women' (WHO 2008). However, the implementation into health care is slow. This slow-rising interest in female smoking from the public health sector is in stark contrast to the long-standing activities of transnational tobacco companies to recruit women as customers using targeted strategies (Amos/Haglund 2000). Especially in the light of decreased smoking rates in high SDI countries, the tobacco industry is believed to view women and girls in low-income countries as a largely untapped market and a primary target group (Feeny et al. 2021).

In the context of Central Asia, this poses questions about the current state of smoking in women in the region and how the risk of female smoking might develop in the coming years. Given the limited amount of in-depth data on smoking behaviors in the region, especially in women, we are going to approach this topic by illustrating: 1) the specific risks smoking poses to the health of women; 2) known tobacco industry tactics on how to establish and enhance female smoking in a population; 3) the current state of female smoking in Central Asia, using the framework of the Tobacco Epidemic Model; and 4) a summary of current tobacco control efforts in the region.

Smoking and Women

Women have a higher risk of dying from tobacco smoke-related diseases than men. This is due to both sex and gender factors. In the following we will refer to 'sex' as the biological sex that is assigned to a person at birth based on recognizable physical characteristics, and to 'gender' in terms of social gender or gender identity and social gender roles. Both play a role in the increased risk for women who smoke cigarettes or are subjected to cigarette smoke.

Firstly, women are believed to have a higher biological sensitivity to the toxic substances contained in tobacco smoke than men, both from direct and second-hand smoke. This means that the same amount of nicotine might lead to greater risk of harm in females than in males (Prescott

et al. 2002). Female smokers also are believed to possess a higher risk of developing cardiovascular disease as well as certain cancers, such as bladder cancer, than male smokers (Castelao et al. 2001; Gallucci et al. 2020). The negative effect of nicotine on estrogen production has been suggested to be responsible for some of these findings, given the differences in function of this hormone in women compared to men (Ruan/Mueck 2015). Furthermore, women have a greater risk for a worse prognosis and higher mortality for tobacco-related cardiovascular diseases than men (Gao et al. 2019).

In addition to these biologically determined risks, gender-specific factors often lead to poorer treatment for women. According to the World Health Organization (2021), healthcare systems are geared towards treating men, which means that women are less likely to receive treatment tailored to their needs (WHO 2021). For example, due to their lack of representation in clinical trials, women have a higher risk of developing adverse reactions to most smoking cessation medications. Another example of an increased risk due to gender-specific factors is the fact that contraception is still mainly seen as a woman's responsibility: the contraceptive pill usually contains estrogen and the risk of suffering a stroke increases sevenfold and the risk of a heart attack twentyfold in smokers who take additional estrogen (Bousser/Kittner 2000).

In addition to greater direct health risks from smoking, women who smoke often have greater difficulty to quit than men. This applies to both unassisted attempts to quit smoking as well as attempts with therapeutic or pharmacological support (Smith et al. 2016). The reasons for this are still unclear. Some studies have shown that women are more likely to smoke in order to cope with stress, which could be an additional barrier to quitting if no alternatives for dealing with stress are offered (Torchalla et al. 2011). Research also suggests a lower physical dependence on nicotine and a stronger dependence on smoking-related stimuli in women compared with men, such as the smell of smoke or the ritual act of smoking itself. In this case, classic nicotine replacement therapy, such as a nicotine patch or gum, would not substitute the main drive for smoking and would thus be less effective (Perkins 2001). Furthermore, women are more likely to suffer from depression than men, which is known to be a barrier to successful smoking cessation.

It is clear that women need tailored methods to change their smoking behavior (Smith et al. 2017). In terms of medical treatment, some achievements have been made: it was found that while there is no major difference

in efficacy between the drugs bupropion and varenicline for smoking cessation in men, the efficacy of varenicline in women is significantly greater than that of bupropion (Smith et al. 2015). This finding is now part of smoking cessation guidelines in many countries. It furthermore shows that the targeted investigation of gender-specific differences in smoking cessation can have important real-world consequences.

Smoking during pregnancy bears a high risk for both the baby and the mother. It can increase the risk of ectopic pregnancy, miscarriage, birth complications, stillbirth, low birthweight, and sudden unexpected death in infancy, as well as potentially cause cognitive and developmental disability in later life in the offspring, thus adding to the risks associated with female smoking. Apart from this, probably no other group of smokers experiences greater stigmatization than pregnant women who smoke (Flemming et al. 2013; Loyal et al. 2022; Wigginton/Lee 2013). Discriminatory behavior towards pregnant smokers, however, has the potential to cause distress and hinder smoking cessation (David et al. 2023).

The Tobacco Industry and Women

Since the 1920s, women have been on the radar of the tobacco industry as a desirable consumer base. Before this time, smoking was long considered a behavior of morally loose women in North America and Europe, closely associated with prostitution (Greaves 1996). The introduction of mass-produced cigarettes at the turn of the twentieth century changed the tobacco market and the importance of the tobacco industry entirely and led to a rapid increase of smoking in men. Tobacco companies started advertising their products aggressively, often using images of attractive young women. At this time, however, this was mainly to entice male customers, rather than to attract females to take up smoking, even though showing women in the advertisements without marketing directly to women might have already been a way to raise the interest of females in smoking (Brandt 1996).

An overt interest in females as potential customers only started to develop when, during World War I, women began to challenge traditional gender roles anyways. In the context of women trying to achieve voting rights, labor equality, and the right to be able to partake in (at the time) male-only everyday privileges such as playing sports and wearing trousers, smoking also became a symbol of previously male-only privileges that women were now claiming for themselves. The tobacco industry responded

to this trend by providing potential (female) customers with new, and in some ways opposing, images of female smokers, and rebranding female smoking away from loosely moral behavior to more desirable properties: one was the idea of branding smoking as a means to increase beauty and youthfulness, for example as a weight control measure. One of the first targeted ad campaigns was Lucky Strike's 'Reach for a Lucky instead of a sweet' in 1925 (Amos/Haglund 2000). After this, Lucky Strike became the bestselling brand for several years. Even the invention of the filter was originally to make the cigarette more appealing to women (Houghton et al. 2020). Later on, red filters were invented to hide potentially embarrassing lipstick stains. This was followed by slim cigarettes, slim cigarette packages, and scented cigarettes, all to make the cigarette more appealing to the female consumer.

The other major strategy was to brand smoking as a new symbol for female independence. The most famous campaign selling this idea was the 'Torches of Freedom' campaign that was launched by Edward Bernays in 1929, when women were hired to publicly smoke during the Easter Day parade in New York City (Amos/Haglund 2000). Whether the actual campaign caused as much of a media frenzy as Bernays claimed later is debated today; however, at this point it would have been obvious to anyone in the industry that adapting advertising strategies to specific target audiences works especially well for selling cigarettes (Topić 2021). And indeed, the two strategies detailed above seem to be the blueprint for many of the female-targeted smoking campaigns that were to follow worldwide: smoking as a way to be more attractive (to men) and smoking as an expression of personal freedom.

The latter was especially obvious in post-Soviet Union countries throughout the 1990s. Tobacco companies quickly zeroed in on women in the region with targeted advertisements alluding to the freedom of a Western way of life, with slogans such as 'Test the West' or 'Lady's first' in Hungary, or connecting smoking with Western imagery associated with freedom, such as motorbikes for women in the Czech Republic (Amos/Haglund 2000). In much of the region, smoking rates doubled in women during the 1990s. Similar strategies - linking smoking with empowerment and other aspirations - are still used today, for example in India and numerous African countries (Feeny et al. 2021).

Apart from being quick to adjust to monumental societal changes in different countries and benefitting from this as detailed above, the tobacco industry is also quick to adjust to slower changes within markets. In the

1980s, with growing concerns about the negative health effects of cigarettes, the number of more highly educated smokers was declining the US and other higher SID countries. This is a trend that has continued until today, with the biggest proportions of smokers in higher SDI countries having a lower socio-economic status (SES). A meta-analysis found that the specific targeting of lower SES women in the US started as early as the 1970s. Strategies to expand within this customer base included lowering the price of cigarettes, the use of non-tobacco products to gain access to new markets (i.e. coupons and the like), and even financial service products: Phillip Morris invented a prepaid debit card for the 'unbanked', who were mainly female and with a below-average education (Brown-Johnson et al. 2014).

Apart from promoting female empowerment through slogans, the tobacco industry also has a history of inserting itself into empowerment projects, gender equity campaigns, or anti-youth smoking campaigns (Feeny et al. 2021).

It needs to be stressed that the industry uses many, often contradictory strategies to advertise their products to women. Next to female empowerment, stereotypes and gender norms are often at the core of the messaging, such as the alleged female desire to not embarrass oneself with the unpleasant smell of cigarette smoke or a preference for sweet flavors and floral packaging.

Even though there is good evidence of the strategies the tobacco industry uses to target women in some post-Soviet Union countries, little is known about these strategies in Central Asia. In the following sections we are going to try to gauge whether the tobacco industry might view women in the region as a potential target, by looking at the prevalence of smoking using the Tobacco Epidemic Model.

The Tobacco Epidemic Model

The most widely accepted model of the temporal development of the tobacco epidemic is the Tobacco Epidemic Model, developed by Lopez et al. (1994). The model was originally based on the development of the smoking epidemic in high-income countries over the 20th century but has since been adapted to incorporate evidence from low- and middle-income countries (Thun et al. 2012). Lopez et al. proposed that the tobacco epidemic develops within a population over the course of decades in four distinct stages and presents differently in males and females. The first stage (also called

the 'incipient stage') is marked by very low smoking rates in a population (less than 5% in females and less than 15% in males) and the widespread uptake of the smoking habit in males. Smoking-related deaths are very low. In the second phase, smoking uptake in men increases to a prevalence of anywhere between 15%–65% and within this phase does not decline by more than 10%. Women start taking up smoking too, and prevalence for women increases to anywhere from 5%–45% and does not decline by more than 5% within this phase. An increase in smoking-related death is seen but awareness of the dangers of smoking might still be underdeveloped. Stage three is considered the turning point, where smoking rates in men start declining by at least 10% or more, since knowledge about the health risks of smoking might be well known and smoking-related deaths will have risen to about 25%–30% of all deaths in men. Smoking rates among women start declining towards the end of this phase by at least 5%. In the fourth stage, smoking-related deaths in men peak early, peaking a couple of decades later in women. Smoking rates in males are under 25% and decline by at least 10%. In women, smoking prevalence is under 20% and decline by at least 5%.

The Tobacco Epidemic Model illustrates the difficulty in communicating risks associated with smoking due to the time lag between the widespread uptake of smoking and its full effect on the population's mortality.

In the following section we will classify the development of female smoking behavior according to this model in Kazakhstan, Kyrgyzstan, and Uzbekistan. We will furthermore summaries how transnational tobacco companies gained a foothold in the region after the collapse of the Soviet Union and what tobacco control looks like in these countries today.

Kazakhstan

The Tobacco Industry in Kazakhstan

As with other newly independent states after the collapse of the Soviet Union, Kazakhstan ended up with a state-owned tobacco industry that was on the verge of collapsing as centrally funded subsidies for growers and producers were not available anymore. This provided an opportunity for transnational tobacco companies to expand, which they swiftly took advantage of. The tactics used by British American Tobacco (BAT) in particular to enter the new markets of former Soviet Union countries, first

by establishing imports and then by setting up a manufacturing presence, are clearly detailed in two studies (Gilmore/McKee 2004a; Gilmore/McKee 2004b). In Kazakhstan, Phillip Morris managed to establish a market share of 70% between 1990 and 2000. During this time, 4% of all foreign direct investments (FDI) to Kazakhstan were made by the tobacco sector and the production capacity for cigarettes doubled.

Currently, the Kazakh cigarette market is dominated by Phillip Morris and Japan Tobacco International, both of which have factories in the Almaty region. In 2016 20 billion cigarettes were produced in Kazakhstan (Drope et al. 2022).

Women and Smoking in Kazakhstan

According to the 2023 WHO report on the global tobacco epidemic, 38.5% of males and 7.7% of females were smoking cigarettes (WHO 2023). Smokeless tobacco use and e-cigarette use was below 3% in both males and females. Between 2000 and 2020, the prevalence of cigarette smoking decreased by less than 10% in males in Kazakhstan and did not change significantly in females (Dai et al. 2022). A further study comparing results from two representative surveys in 2001 and 2010 came to the same conclusion (Roberts et al. 2012). However, a survey of 1,201 adults conducted in 2021 found a prevalence as high as 10% among female smokers (Glushkova et al. 2023). According to the Tobacco Epidemic Model, Kazakhstan is in the second stage of the epidemic. There is a lack of research investigating smoking among Kazakh women, which needs to be addressed. This is especially important given the potential increase measured in the most recent survey.

Tobacco Control Policies in Kazakhstan

Kazakhstan has implemented a range of tobacco control policies, more than its neighboring countries, but important policies are still missing. The following areas are mandated to be smoke-free: healthcare facilities, educational facilities, universities, government facilities, and indoor offices, as well as public transport. However, there are no smoking bans in bars and restaurants. Furthermore, there are no funds designated to enforcing these bans. Nicotine replacement therapy (NRT) and other smoking cessation

aids are available and partially covered by public healthcare. There is no national smoking quit line (a nationally advertised and funded telephone hotline that smokers interested in quitting can get advice from). Tobacco packaging regulations mandate a graphic label and coverage of 65% of the package. Kazakhstan is the only country of the three countries discussed here that has run national mass media anti-tobacco campaigns including target audience research, process evaluation to assess implementation, etc. The overall score of Kazakhstan on the Tobacconomics Cigarette Tax Scorecard is 2.63 out of five possible points. The Scorecard assesses the price, change in affordability, tax share, and structure of cigarettes in a given country. According to this rating, the price of cigarettes is too low, the change in affordability is moderate, the tax share of the price is moderate, and the tax structure is good (e.g. reliance on uniform specific excise taxes that are adjusted to outpace growth and inflation). The overall ad ban compliance for tobacco advertising is 65% (Drope et al. 2022).

In July 2024, the sale and distribution of e-cigarettes, vapes, and liquids was banned, as was the use of them in undesignated areas.

Kyrgyzstan

The Tobacco Industry in Kyrgyzstan

Transnational tobacco companies also managed to gain footing in Kyrgyzstan after the collapse of the Soviet Union. By 2000, the tobacco company Reemtsma had secured a position as one of the country's major investors. Cigarette production capacity increased tenfold in this period (Gilmore/McKee 2004a; Gilmore/McKee 2004b). However, in 2014, Reemtsma decided to close production in Kyrgyzstan. This was partially due to its capacity being in excess of its production needs, but also due to Kyrgyzstan joining the Eurasian Customs Union, which freed cigarettes imported from the Union of customs duty. Today the biggest exporters of cigarettes to Kyrgyzstan are Kazakhstan, Russia, the United Arab Emirates, and Uzbekistan (Drope et al. 2022).

Women and Smoking in Kyrgyzstan

According to the 2023 WHO report on the global tobacco epidemic, 2.7% of females and 48.2% of males are smokers in Kyrgyzstan (WHO 2023).

Smokeless tobacco use and e-cigarette use was almost non-existent in females (0.1%) and at 10% in males. There is some evidence for an increase in smoking rates among women in the past decades. Dai et al. present changes in age-standardized prevalence, drawing from a meta-analysis of population data, which show a significant increase for females and males in Kyrgyzstan between 2000 and 2020 (Dai et al. 2022). Given the overall low prevalence of female smoking, the magnitude of this increase needs to be considered small. Still, it is one of the very few countries worldwide in which, during this time frame, female smoking has significantly increased at all. One study comparing results from two surveys in 2001 and 2010 also found an increase in female smoking from 4.5% to 5.9%; however, this was not significant (Roberts et al. 2012). According to the Tobacco Epidemic Model, female smoking is in the incipient stage in Kyrgyzstan, as prevalence is still below 5%. However, male smoking is much higher than 15% and thus can be considered to be in the second stage of the Tobacco Epidemic Model.

Tobacco Control Policy in Kyrgyzstan

Although Kyrgyzstan has implemented tobacco control policies, many avenues for curbing tobacco use are still untapped. The following areas are mandated to be smoke-free: healthcare facilities, educational facilities, universities, and government facilities. There are specific funds in order to enforce these bans. However, there are no smoking bans in indoor offices, restaurants, pubs and bars, or public transport. NRT and other smoking cessation aids are available and partially covered by public healthcare. A national tobacco quit line has been established. Tobacco packaging regulations mandate a graphic label and coverage of 50% of the package. No tobacco control mass media campaigns have been run in Kyrgyzstan. The overall score of Kyrgyzstan on the Tobacconomics Cigarette Tax Scorecard is 3.50 out of five possible points. According to this, the price of cigarettes is relatively low, the change in affordability can be considered good (less affordable), the tax share of the price is moderate, and the tax structure is good (e.g. reliance on uniform specific excise taxes that are adjusted to outpace growth and inflation). The overall ad ban compliance for tobacco advertising is 45% (Drope et al. 2022).

As in Kazakhstan, the parliament passed a bill banning the sale and distribution of e-cigarettes, vapes, and liquids, as well as the use of them in undesignated areas in 2024.

Uzbekistan

The Tobacco Industry in Uzbekistan

British American Tobacco managed to achieve a market share of 70% by 1999, securing a monopoly position in Uzbekistan. Its investment at the time accounted for one third of all FDIs made in Uzbekistan. How BAT managed to achieve monopoly status and the favorable treatment of the government is laid out in detail by Gilmore/McKee (2004a/b). Locally produced cigarettes are most commonly used in the country. The share of imported cigarettes is only around 5%. In 2016, 11 billion cigarettes were produced in Uzbekistan (Drope et al. 2022).

Women and Smoking in Uzbekistan

According to the 2023 WHO report on the global tobacco epidemic, less than 1% of females and 13% of males are smokers in Uzbekistan (WHO 2023). The prevalence of cigarette smoking did not change significantly in females or males between 2000 and 2020 (Dai et al. 2022). However, in Uzbekistan, smoking cigarettes is not the only major way to consume tobacco. The traditional use of Nasway, a chewing tobacco made of tobacco, butter, and slaked lime, is likely as prevalent or even more prevalent than cigarettes. A study from 2011 estimated Nasway use among 1,795 men at 22% and cigarette use at 20% (Usmanova et al. 2012). Co-use of the two products was found to be common, too. There is a lack of research on smoking in females, mainly because smoking prevalence is estimated to be very low. The authors furthermore suggest that it could be the use of Nasway that keeps prevalence of cigarette use relatively low, despite strong efforts from the industry to target the Uzbek market. According to the Tobacco Epidemic Model, female smoking is in the incipient stage in Uzbekistan, as prevalence is still below 5%. However, male smoking is at around 20% and can thus be considered to be in the second stage of the Tobacco Epidemic Model.

Tobacco Control Policy in Uzbekistan

Uzbekistan has implemented some tobacco control policies; however, many of the common tobacco control policies have not been implemented yet. There is only one area that is mandated to be smoke-free, which is public transport. Healthcare facilities, educational facilities, universities, government facilities, indoor offices, restaurants, and pubs and bars do not have smoking bans. There are furthermore no specific funds allocated to enforce smoking bans. NRT and other smoking cessation aids are available and partially covered by public healthcare. A national tobacco quit line has not been established. Tobacco packaging regulations mandate a graphic label and coverage of 40% of the package. No tobacco control mass media campaigns have been run in Uzbekistan. The overall score of Uzbekistan on the Tobacconomics Cigarette Tax Scorecard is 1.88 out of five possible points. According to this, the price of cigarettes is too low, the change in affordability can be considered good (less affordable), the tax share of the price is moderate, and the tax structure is considered bad (e.g. little reliance on uniform specific excise taxes that are adjusted to outpace growth and inflation). The overall ad ban compliance for tobacco advertising is not known (Drope et al. 2022).

Discussion

Drawing all the preceding evidence together, it becomes clear that data on smoking in Kazakhstan, Kyrgyzstan, and Uzbekistan is scarce, especially in women. The data we do have show that female smoking in the region has historically been—and continues to be—uncommon, with all countries being at the first stage of the Tobacco Epidemic Model for females. This is likely partially due to the relatively strong conformity to traditional gender roles in the region and the idea that smoking is not for women. However, there is some evidence that this might be changing in both Kyrgyzstan and Kazakhstan as some data is suggestive of an increase in female smoking. In a recent meta-analysis of population data, Dai et al. described Kyrgyzstan as one of the few countries where smoking rates in women had actually increased (Dai et al. 2022). This increase was likely of small magnitude, but it is an alarming finding nonetheless as an increase in female smoking was only found in nine other countries worldwide in this meta-analysis during that time. In Kazakhstan, a survey conducted in 2021 found a smoking

rate in women of 10%, which is higher than the generally estimated 7% (Glushkova et al. 2023). Both of these findings indicate that smoking in females might become more common in these countries. In Uzbekistan, considered the most conservative of the three countries, female smoking rates do not seem to have changed, but it should also be taken into account that data on this are also very hard to come by.

It is hard to estimate at the current point in time if and in how far female smoking will increase in the region. However, if the opportunity presents itself, be it because of a change in the traditional role of women or a trend towards novel tobacco products, the tobacco industry will not wait to capitalize on this. Anti-tobacco laws exist in all three countries but leave out some important measures, and only in Kyrgyzstan is a specific budget allocated for the enforcement of these laws.

The fact that an outright ban of e-cigarettes was decreed in both Kyrgyzstan and Kazakhstan in 2024 is a potentially alarming indicator of an increase in smokers, including women. It is currently not easy to judge what determined this decision, but there are several explanations at hand: it could point to a fairly strong involvement of the tobacco industry in political decision-making, as banning tobacco-free e-cigarettes will likely tie their consumers more closely to their tobacco-containing products. Evidence in this direction could be seen in the fact that while e-cigarettes were banned, smokeless tobacco heaters - arguably the more dangerous of these two relatively novel nicotine delivery devices, as tobacco is still involved - are not subjected to this ban. Another explanation might be the fear of the initiation of smoking in groups in which smoking rates are currently still relatively low, such as children and women. There is indeed some evidence that e-cigarettes are more appealing to women. However, in this case, it is still unclear why tobacco heating devices do not fall under this ban. The official explanation is the fear of dangerous counter banned products currently flooding the market. But again, this cannot explain the exclusion of tobacco heating devices from this ban.

This recent development is a stark reminder that we cannot assume that the current low smoking rates mean that tobacco control is unnecessary in a population or, as Dai et al. put it in their 2022 paper on the evolution of the global smoking epidemic, 'The large number of countries where female smoking is low could well follow the transition observed for men unless important lessons are learnt and applied about smoking disincentives for women.'

More fine-grained data on smoking in different subgroups of the region's population are urgently needed, including data on attitudes towards smoking in these subgroups, as well as sufficient funds to enforce smoking cessation bans.

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8. Social Work with Women Who Use Drugs in Central Asia

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Background

According to the International Federation of Social Workers (IFSW) (2014), social work is a practice-based profession and an academic discipline that "engages people and structures to address life challenges and enhance wellbeing" (IFSW 2014). Women are a group whose well-being is negatively affected in many ways due to unequal treatment on both a personal and a structural level. Even though social work differs tremendously around the world, according to this global definition, social work has a clear mandate to address the many challenges associated with the inequalities faced by women. In addition to the disadvantages experienced by women in general, there are some groups that are particularly disadvantaged, such as women who use drugs. For this particularly disadvantaged group, social work frequently serves as the initial and, in certain cases, sole point of interaction (Natale et al. 2010). In many instances, social workers are the only professionals that offer support to women who use drugs, are in the position to provide services that recognize their specific needs, and have a clear mandate to address the inequalities on a structural level. Central Asia is a region where women who use drugs are disadvantaged in many ways and where social work is still in its infancy. Therefore, this raises the question of how social work in Central Asia (Kazakhstan, Kyrgyzstan, Turkmenistan, Uzbekistan, and Tajikistan) works with women who use drugs.

Women in Central Asia

Since the collapse of the Soviet Union, the countries of Central Asia have simultaneously transitioned to a democratic system of governance as well as a market-based economic system (Omelicheva 2015). According to Joshi and Childress (2017), these changes have led to shifts in cultural norms the emergence of a dynamic civil society, the restructuring of the public health and social sectors, and legal and policy reforms.

After these countries gained independence, women and men in this region faced new pressures, with the economic collapse and the restructuring of the economic, political, and social sectors. Women suffered additional challenges as their social safety net was rapidly crumbling or being actively dismantled. While some women stopped working due to a lack of childcare support and protection for working mothers, others stopped having children. The downsizing of the public sector and the prioritization of hiring men in the newly emerging private sector led to higher unemployment among previously employed women. Women seeking alternative income opportunities found it difficult to finance their entrepreneurial activities as they did not own land, a car, or other assets suitable as collateral for loans. Instead, women became of the largest demographic group working as shuttle traders, a business that requires only small amounts of capital. Moreover, women were more willing than men to take lower-paying service sector jobs (United States Agency 2010). In addition to this development caused by the collapse of the Soviet Union, there are competing socio-political models of 'womanhood', which, according to the United States Agency (2010), contain patriarchal elements. While in the Soviet period, state-supported daycare centers, medical care, and other social services helped employed women maintain their homes and families, today these services are less available and more expensive, and working women must juggle responsibilities at both the workplace and at home (United States Agency 2010). According to the Global Gender Gap Index, which annually benchmarks the current state and evolution of gender parity across the dimensions of Economic Participation and Opportunity, Educational Attainment, Health and Survival, and Political Empowerment, Eurasia and Central Asia ranks fourth out of the eight regions on the overall Gender Gap Index (World Economic Forum 2023). Based on this index, it will take 167 years for the Eurasia and Central Asia region to reach gender parity if they continue at the current rate of progress (World Economic Forum 2023). In a study conducted by Joshi and Childress (2017) in Kazakhstan, Kyrgyzstan, and Tajikistan, women were asked whether they approved of a husband beating his wife if she goes out without telling him, neglects their children, argues, refuses to have sex, or burns food. The prevalence of intimate partner violence acceptance for at least one of the five reasons varied from 12,3% in Kazakhstan to 45,3% in Kyrgyzstan and 74,5% in Tajikistan.

Women Who Use Drugs

Overall, women in Central Asia – even if it should be pointed out that there are, of course, far-reaching differences between the various countries of the region – are thus exposed to gender-specific role attributions and injustices. These inequalities between men and women within the general population become even more apparent within specific groups, such as people who use drugs.

> "*Women who inject drugs experience a 'double jeopardy' because of institutionalized stigmas for being born female and also for using drugs*" (El-Bassel et al. 2013).

Substance use disorders differentially affect women and men worldwide (Fonseca et al. 2021). According to the World Drug Report provided by the United Nations Office on Drugs and Crime (UNODC) (2023), there are more men than women injecting drugs. However, Fonseca et al. (2021) state that there is increasing substance use in females and the gender gap may be narrowing. Even though there are more men injecting drugs, women who inject drugs are 1.2 times more likely than men to be living with HIV (UNODC 2023). This is even though HIV rates among drug users are already high. In 2022, compared with adults in the general population, HIV prevalence was seven times higher among people who inject drugs (The Joint United Nations Programme on HIV/AIDS [UNAIDS] 2023). Furthermore, women who inject drugs are likely to have an intimate male partner who initiated them into drug use (UNODC 2023). Therefore, the reasons for drug initiation and use are different for men and women (Fonseca et al. 2021). Women are more likely to be exposed to a higher risk for sexual transmissions of infections, both through sex work and through their increased vulnerability to abuse from law enforcement officers and intimate partners, as well as through being the victim of physical assault or rape (UNODC 2023). Only one in five people with drug use disorders receives drug treatment. Women are most affected by the barriers to accessing treatment (UNODC 2023). According to the World Drug Report (UNODC 2023), in addition to the family expectations and responsibilities that they face, women experience further barriers to accessing treatment, including an increased fear of legal sanctions, increased social stigma, lack of childcare, and fear of losing custody of their children while in treatment.

Women who use psychoactive substances face stigma and discrimination both in society as a whole and among their close circle (Harm Reduction

Network Association 2022). Furthermore, women who use drugs are often also part of certain other groups, such as sex workers, that face more severe vulnerabilities, including high levels of stigma and discrimination (UNODC 2023). Even though women tend to progress faster to drug use disorders than men, they continue to be underrepresented in drug treatment. When it comes to the use of amphetamine-type stimulants, this gap is particularly high. While almost one in two users of amphetamine-type stimulants is a woman, only one in four people in treatment is female (UNODC 2023). Even though more men than women die of drug overdose, the excess mortality risk in women who use drugs is typically higher than in men (UNODC 2023). Females also suffer from more severe medical problems related to drug use. Psychiatric comorbidity, mainly depression and post-traumatic stress disorder, are more frequent in females than in males (Fonseca et al. 2021).

Women and Drugs in Central Asia: The Special Case of Women Living with HIV

In Central Asia there has been a decrease in injecting drug use (Stöver/Michels 2022). Although the prevalence of HIV has decreased among injecting drug users in Central Asia and China due to implemented harm reduction strategies, such as needle/syringe programs and opioid substitution treatment, since 2010 the numbers of new HIV infections have continued to rise in Eastern Europe and Central Asia (a 49% increase) (UNAIDS 2023). In 2019 the region was far from reaching the 90-90-90 targets: 70% of people living with HIV knew their status, 44% of those who had been diagnosed were receiving antiretroviral therapy (ART), and 41% of those receiving treatment were virally suppressed (UNAIDS 2021). According to the UNAIDS (2023), this deficit situation can be attributed mainly to a lack of prevention services for people from marginalized and key populations, such as women. According to the Eurasian Women's Network on AIDS (2023), gender inequalities are a key driver of the HIV epidemic and influence the vulnerability and marginalization of women and girls around the world. The percentage of women compared to men living with HIV differs greatly from country to country. In Eastern European and Central Asian countries, the percentage of women living with HIV is higher than 35%, with 36% in Kyrgyzstan, 42% in Moldova, 40% in Kazakhstan, 41% in

Tajikistan, 43,9% in Belarus, 45,4% in Uzbekistan, and 45,5% in Ukraine (Eurasian Women's Network on AIDS 2023).

According to the Eurasian Women's Network on AIDS (2023), women in Central Asia experience gender-based violence, and when it comes to the HIV response, they continue to be marginalized, criminalized, and subjected to stigma and discrimination. A study conducted in Eastern Europe and Central Asia found that 52% of women in this region had experienced violence after being diagnosed with HIV (Godunova et al. 2019). 68,5% of the women living with HIV indicated having experienced economic violence. 24,4% were forbidden from seeking medical, social, and other support services, while 29,5% stated that they had been forbidden to work. 28% of the women living with HIV experienced sexual violence, of which 19,2% associated the sexual abuse with their HIV status. 71% of the women who took part in the study who had faced physical violence did not seek assistance, and 60,5% of respondents who suffered sexual violence did not seek assistance. According to this study, 42% of women living with HIV indicated having experience of using drugs, and 19,2% had experience of being in prison (Godunova et al. 2019). 51,2% of the respondents were living in poverty (Godunova et al. 2019). According to Godunova et al. (2019), gender stereotypes and HIV-related self-stigmatization contribute to the fact that women living with HIV can remain in situations where they face violence for many years.

Laws and existing inequalities exacerbate the problems women and young people face in accessing HIV treatment, care, and support, as well as services related to sexual and reproductive health, mental health, and harm reduction (Eurasian Women's Network on AIDS 2023). According to a study carried out among people who inject drugs in Kyrgyzstan, women experience difficulties in obtaining quality medical care, accessing harm reduction programs, and also in obtaining social support (AIDS Foundation East-West in the Kyrgyz Republic 2019).

In addition to these far-reaching disadvantages, women have specific needs compared to men. According to the Eurasian Women's Network on AIDS (2023), for example, there is a need to provide medical and social support for mothers living with HIV who have made the decision to breastfeed, to provide access to breast milk substitutes and enable women living with HIV to continue accessing ART post-delivery.

Social Work with Women Who Use Drugs in Central Asia

There is some belief that social work did not exist in the EECCA (Eastern Europe, Caucasus and Central Asia) prior to 1991. However, according to Zaviršek (2015), considerable research shows that professional social work education was established in some countries in the region after World War I but was disrupted and closed down at the end of World War II. After 1991 social work education was established in nearly all countries of the region, with the exception of Turkmenistan.

Even though, in Central Asia, Kazakhstan offers the largest number of social work undergraduate programs, social work in this country is still in the midst of its development. Tulebayev (2021) calls social work in Kazakhstan "a relatively young profession" (Tulebayev 2021). In April 2019, the Republic of Kazakhstan officially registered a National Alliance of Professional Social Workers (IFSW 2019). The aim of the alliance is to create public awareness of the importance of social work and public respect for the profession. Furthermore, the alliance works to ensure that basic global standards, such as the development and approval of the National Code of Ethics for Social Workers, are integrated in the country. Moreover, the alliance is intended to improve the quality of social work education; to strengthen the capacity of practical services; to ensure that the needs of relevant ministries, universities and local executive bodies are considered; to retrain and advance the training of social workers; to certify social workers; and to accredit other related social service specialists (Stöver/Michels 2022).

In Kyrgyzstan, with the acquisition of independence, work began to reform the social security system and adapt it to a market economy. There was a need to develop professional social work and create a new social policy based on social protection and support for people who find themselves in difficult life situations (Matkarimov 2020). By 2000, the following areas had emerged and began to develop: social work in the healthcare sector, in the education system, in rural areas, and in the management system. In addition, social work with people with disabilities, with children and youth, with women who have been subjected to violence, with low-income families have appeared (Nurova/Aitabaeva 2014). Women who use drugs belong to the category of people who find themselves in a difficult life situation. The specificity of this target group lies in the need for simultaneous medical, social, psychological, and legal support. However, in Kyrgyzstan, the main participants involved in the provision of social services and

the prevention and treatment of drug addiction are medical institutions and non-governmental organizations (NGOs). NGOs are mainly financed by donor organizations; as a rule, these are short-term service projects, which limits long-term planning. To expand approaches to solving social problems, the 'Program of State Social Order in the Field of Health Care of the Kyrgyz Republic' and 'Standards of Services for Key Population Groups within the Framework of State Social Order in the Kyrgyz Republic' were developed, which provide a legal basis for the provision of social services to the population through grants allocated from the state budget. After the introduction of the mechanism of state social ordering, the state had the opportunity to solve social problems in an alternative way, through the provision of grants on a competitive basis to non-profit organizations (Republican AIDS Center 2020).

Although social work does exist in Central Asia – as the examples of Kazakhstan and Kyrgyzstan have shown – social work in the region is still in its infancy (Stöver/Michels 2022). According to a literature review on the development of social work and the social service workforce in the Europe and Central Asia region, there is great variation in terms of the types of social services that have been developed, how social work is defined, and the extent to which it has developed as a profession and an academic discipline (Rogers 2018).

> *"Across the region, a wide specter of different social work practices coexist, varying from very innovative, radical, and liberating ones for persons requiring services and support to oppressive, traditional, and narrow-minded pathology-based responses by professionals and social work institutions"* (Zaviršek 2015).

It is difficult to understand the extent of the workforce deployed in each country because different definitions of social services, and social workers exist. Furthermore, the difference in the language used to describe people who work in social services also contributes to this confusion. In most countries in Central Asia, major challenges exist in terms of workforce planning, which makes it difficult to ensure the deployment of workers with the right competencies into the right positions throughout the country, as well as appropriate payment. Social workers in the region tend to be underpaid and work in challenging environments. Furthermore, nearly all countries in the region have definitions of social work anchored in legislation and offer social work education programs at bachelor's degree level as a minimum. However, in some countries the curricula require

considerable strengthening and updating. Moreover, there are workers in many countries of the region in statutory social work positions that do not have social work education or training, and one key challenge for the governments of the region is to clearly define the training required for statutory social work (Rogers 2018). Stöver and Michels (2022) state that there are outreach workers who sign up on a voluntary basis working in social work positions. In most countries, social services are delivered by both government and non-government service providers. Another problem is that there is no standard model of how social work has developed in the region and no 'best practice' or single standard to which countries should aspire (Rogers 2018).

This description of social work, a profession still in its infancy, is also reflected in the field of addiction. Zábranský and Mravčík (2019) state that there is generally a lack of social workers in the field of addiction. Social workers working with people who use drugs remain scarce because of the lack of investment in the education, training, and professional development of social workers in Central Asia. Therefore, in all Central Asian countries, social work services are struggling to meet the needs of key populations that are affected by the negative consequences of the HIV/AIDS epidemic and injecting drug use (Stöver/Michels 2022).

Although women who use drugs are exposed to specific injustices – especially women who face multiple challenges, like drug use and HIV – and have other needs than men, no literature could be found specifically reporting on social work with women who use drugs in Central Asia. In other countries around the world, there are social work services that specifically target women who use drugs and offer women-centered drug treatment services (Terplan et al. 2015). There are drug consumption rooms that solely target women (Belackova et al. 2019), shelters for women who use drugs (Beaugard et al. 2024), and substance use disorder treatment services for pregnant and postpartum women (Meinhofer et al. 2020). This underrepresentation of the topic in the social work literature in Central Asia may well be due to the fact that social work is less developed in these countries. As described earlier, social work in Central Asia is still in its infancy (Stöver/Michels 2022). Although literature is scarce, there are nevertheless social work services that specifically care for women. An example of such a service is presented below.

Case Example

In Kyrgyzstan, there are two public organizations, Asteria and Girlfriend, focused on providing a comprehensive package of social services to women who use narcotic substances. The organizations' activities are aimed at improving women's access to quality services, providing such services as temporary housing, food, hygiene supplies, and encouragement to get tested for HIV and sexually transmitted infections (STIs). The organizations' specialists advise all clients on the principle of 'equal to equal' and provide clear and reliable information on HIV/AIDS issues, reproductive health, and substitution therapy. If a woman needs medical help, the staff of these centers refer her to friendly gynecologists, narcologists, and other specialists (AIDS Foundation East-West in the Kyrgyz Republic 2019).

Discussion

As described at the beginning of this chapter, social work has the task of supporting women who use drugs on the one hand and on the other hand, is uniquely positioned to reach vulnerable populations. It is clear from the information presented in this chapter that social work in Central Asia has so far only fulfilled this task to a limited extent. Therefore, social work is faced with the following challenges when working with female drug users in Central Asia.

According to the IFSW (2014), structural barriers contribute to the perpetuation of inequalities, discrimination, exploitation, and oppression. Social work strives to liberate the oppressed and promotes both social inclusion and social cohesion. According to Sidorenko and Moroz (2022), laws that criminalize HIV, sex work, and drug use make women, especially young women, more vulnerable to violence and structural inequalities. Social work has a political obligation to address these topics. Social work in Central Asia is therefore called upon to address injustices at a political level and campaign for change.

As mentioned earlier, there are many injustices that can be traced back to gender and sometimes originate due to cultural norms. Therefore Childress et al. (2024) argue that scholars, policymakers, and service providers – in many cases social workers – must collaborate to actively dispel the widely accepted beliefs about gender, marriage, and the status of women in order to break the cycle of abuse and provide help at the individual and

community levels. Social work is therefore called upon to create programs to address and counteract the existing prejudices and stigmas that affect female drug users in particular.

Another important consideration is the offering of social work services that are aimed specifically at women who use drugs. These programs have been proven to be effective (Ashley et al. 2003). At the very least, greater consideration should be given to the specific needs of women within the existing services.

Furthermore, as social work is still developing in these countries, there may be an opportunity to include gender-related content in the curriculum for social workers.

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