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## 'If she is a good woman ...' and 'to be a real man ...': gender, risk and access to HIV services among key populations in Tajikistan

Elizabeth J. King<sup>a</sup>, Kateryna M. Maksymenko<sup>b</sup>, Yadira Almodovar-Diaz<sup>c</sup> and Sarah Johnson<sup>d</sup>

<sup>a</sup>Department of Health Behavior and Health Education, University of Michigan School of Public Health, Ann Arbor, USA; <sup>b</sup>Kyiv, Ukraine; <sup>c</sup>Harvard School of Public Health, Boston, USA; <sup>d</sup>Management Sciences for Health, Boston, USA

### ABSTRACT

The HIV epidemic continues to grow in Tajikistan, especially among people who inject drugs, sex workers, men who have sex with men and incarcerated populations. Despite their susceptibility to HIV, members of these groups do not always have access to HIV prevention, testing and treatment. The purpose of this study was to identify and understand the gender constraints in accessing HIV services for key populations in Tajikistan. Using focus-group discussions and key-informant interviews the assessment team collected information from members of key populations and those who work with them. Several themes emerged from the data, including: low levels of HIV knowledge, gender constraints to condom use and safer drug use, gender constraints limit HIV testing opportunities, gender-based violence, stigma and discrimination, and the lack of female spaces in the HIV response. The results of this study show that there are well-defined gender norms in Tajikistan, and these gender norms influence key populations' access to HIV services. Addressing these gender constraints may offer opportunities for more equitable access to HIV services in Tajikistan.

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### KEYWORDS

HIV; gender; key populations; Tajikistan

## Background

The HIV epidemic continues to grow in Eastern Europe and Central Asia, especially among key populations (DeHovitz, Uuskula, and El-Bassel 2014). Tajikistan, the poorest country of the former Soviet Union, is a low-income country (World Bank 2015). Tajikistan's population is 8.2 million (World Bank 2014), and it is estimated that about 10% of the population migrates for work each year, primarily to the Russian Federation (IOM 2014). The most recent data estimate that there are 14,000 people living with HIV in Tajikistan (UNAIDS 2013). While adult men make up the majority of registered people living with HIV in Tajikistan, the proportion of women among this population has steadily been on the increase over the past decade (UNAIDS Tajikistan 2012) and last year women accounted for 39.5% of people living with HIV

in the country (UNAIDS 2014). The most recent sentinel surveillance data show the following HIV prevalence among key populations: 16.25% among people who inject drugs, 8.5% among incarcerated populations, 4.43% among sex workers and 1.71% among men who have sex with men. Less than half of members of key populations have tested for HIV and received their results (UNAIDS Tajikistan 2012). There also remains room for improving key populations' access to HIV services. The increasing number of women among new HIV cases and the increasing rates of sexual transmission indicate a need for a better understanding of the gender dynamics of the HIV epidemic in Tajikistan.

Beyond surveillance data, there is a dearth of information on the social and contextual factors influencing the epidemic in Central Asia, particularly for Tajikistan. Previous research indicates that gender dynamics may play an important role in the spread of HIV. The main HIV risk factors for women in Central Asia include having a male sexual partner who injects drugs, having a male partner who has been incarcerated or having a male partner who is a migrant worker (Thorne et al. 2010). Male migrant workers from Tajikistan are likely to engage in sexual risk behaviours while abroad, including unprotected sex, reduced condom use after alcohol and sex with multiple partners in the past month (Weine et al. 2013). Women living with HIV are highly stigmatised, in part because of the cultural norms surrounding female sexuality that prohibit sexual activity outside of marriage and the persistent belief that people who have HIV acquired it through immoral behaviour (Smolak 2010).

In order to build on the little that is known about the gender issues influencing access to HIV services, we conducted an assessment to identify gender-based constraints to equitable participation and access by male and female key populations to HIV programmes and services. This assessment was guided by the PEPFAR Gender Strategy framework. The PEPFAR Gender Strategy aims to achieve gender equality and reduce structural and gender inequalities by means of integrating gender into all HIV programmes and focusing on five strategic areas, including: '(1) increasing gender equity in HIV/AIDS programmes and services, including access to reproductive health services, (2) preventing and responding to gender-based violence, (3) engaging men and boys to address norms and behaviours, (4) increasing women's and girl's legal protection and (5) increasing women's and girl's access to income and productive resources, including education' (PEPFAR 2012, 229). This assessment focused on identifying differences in equitable access to HIV services (strategic area 1) and exploring the underlying gendered relations leading to these inequities (strategic areas 2–5).

## Methods

Data collection took place in the capital city of Dushanbe and a city in the southern part of the country, Kurgan-Tube. Data collection consisted of a series of key-informant interviews, roundtables and focus-group discussions. The assessment team conducted two roundtables (with a total number of 10 participants) and five individual interviews with stakeholders, donors, project implementers and government healthcare service representatives. Focus-group discussions were conducted with members of key populations and outreach workers at non-governmental organisations (NGOs) that serve key populations. Focus-group discussions allowed the assessment team to include a wider range of perspectives despite limited time and financial resources. Additionally, focus-group discussions encouraged dialogue about gender norms in the community and participants to either confirm or debate the ideas presented by other participants. The assessment team conducted 12 focus-group

discussions with a total of 79 participants. Members of key populations were recruited for participation in the focus-group discussions by staff at the respective NGOs. Selection criteria was based on self-reported involvement in the activity of a key population, being at least 18 years of age, willingness to participate in a group conversation about HIV risk, utilisation of HIV testing and treatment services, attitudes about gender norms and gender relations. Given the sensitive nature of discussions around gender norms, all focus-group discussions with key populations were conducted in single-sex groups except for the group of recently released prisoners due to logistical issues. Focus-group discussions took place on the NGO premises in a closed room without programme staff and managers present. Verbal informed consent was obtained from all participants. Anonymity of participation and confidentiality of information were ensured. Focus-group participants were offered refreshments and a gift package of toiletries as a token of appreciation for their time and information shared. All research protocol and interview guides were reviewed and approved by the USAID offices in Washington, DC, and Central Asia.

The two-member assessment team conducted the interviews in Russian, and was accompanied by an interpreter for Tajik-Russian translation in Kurgan-Tube. All interviews and focus-group discussions were audio-recorded. The assessment team took detailed notes during each session. The assessment team conducted group data analysis together. Notes were compared and audio files were referred to in order to complement the written notes or clarify any discrepancies. Data were organised based on the following categories: HIV risk behaviour and risk environment, HIV testing and counselling, HIV treatment and care, HIV support and care, gaps and recommendations, and any additional information not captured in these categories (other). Each key population was considered separately and then emerging, cross-cutting themes were identified. Triangulation of data was achieved by presenting information from the focus-group discussions to key stakeholders during the final roundtable and through a debriefing session with USAID/Tajikistan.

## Results

Table 1 shows a description of the participants in the gender assessment.

The following results are organised according to the cross-cutting categories that were identified as salient issues related to access to HIV services for key populations in Tajikistan.

### *Low levels of HIV-related knowledge*

Gaps in HIV knowledge including, routes of transmission, methods of prevention and about HIV treatment were common across focus-group discussions. This was especially true for participants who were not receiving any outreach services. For example, participants often confused how HIV is transmitted, making statements such as 'HIV is transmitted through coughing and breathing' (Dilshod,<sup>1</sup> man who injects drugs, Kurgan-Tube). HIV knowledge among recently released prisoners in the focus groups was low, and participants often confused TB and HIV in their modes of transmission and symptoms. They talked about reducing their risk by not using other people's dishes, toothbrushes or razors, or not spending time with people believed to have HIV. If a person is known to have HIV in prison 'no one will eat with that person'. Some of the recently released prisoners mentioned the importance of condoms and clean needles, though they also reported that washing needles before

**Table 1.** Participants in the gender assessment of access to HIV services for key populations in Tajikistan.

Participant group	Location	Data collection method	Number of participants
UN Organisations	Dushanbe	Roundtable/interview	3
USAID Implementing Partners	Dushanbe	Roundtable	8
Government Organisations	Dushanbe	Interview	4
Female sex workers	Kurgan-Tube	Focus-group discussion	12
Outreach workers with female sex workers	Kurgan-Tube	Focus-group discussion	3
Men who inject drugs	Kurgan-Tube	Focus-group discussion	13
Women who inject drugs	Kurgan-Tube	Focus-group discussion	4
Outreach workers with people who inject drugs	Kurgan-Tube	Focus-group discussion	4
Incarcerated populations (recently released)	Kurgan-Tube	Focus-group discussion	5 (3 men; 2 women)
Outreach workers in prisons	Kurgan-Tube	Focus-group discussion	4
Men living with HIV	Dushanbe	Focus-group discussion	8
Women living with HIV	Dushanbe	Focus-group discussion	9
Outreach workers with people living with HIV	Dushanbe	Focus-group discussion	4
Men who have sex with men	Dushanbe	Focus-group discussion	8
Outreach workers with men who have sex with men	Dushanbe	Focus-group discussion	5

reusing or sharing was a common risk-reduction strategy in prisons. Representatives of other key populations were clear in distinguishing that HIV is different from tuberculosis and that it was something transmitted 'via blood or in the bedroom' (Zara and Lola, female sex workers in Kurgan-Tube), but were not able to explain exactly how HIV is transmitted or the necessary preventive measures to take. The women who inject drugs had low-levels of knowledge about HIV, as well as lacking information about their sexual and reproductive health. In feedback sessions, stakeholders explained that the lack of knowledge about these issues is especially salient for women because there is a tendency to have girls pulled out of school after the eighth grade, to be kept at home and prepared for marriage.

These misconceptions also influenced risk perception, and there was a tendency for participants to not get tested for HIV because they were not aware of their susceptibility. Most of the women living with HIV said that they were surprised when they were diagnosed with HIV because they did not know that they were at risk for infection. As Parvina explained: 'Earlier I thought that only prostitutes get sick with HIV, but then I realised that drug users could also get HIV.' This woman knew her husband used drugs, but was not aware that this could put him at risk for HIV. Rustam explained that he didn't get tested for HIV because 'I had my son tested, and my son was negative' (man who has sex with men, Dushanbe), demonstrating his belief that HIV is passed from father to son. Outreach workers, like Lena and Dima, said that they themselves need more information on other sexually transmitted infections (STIs) and hepatitis because 'people ask about them, but we cannot answer them'.

### ***Gender constraints to condom use and safer drug use***

Gender norms and societal expectations about gender relations influence HIV risk, transmission and serostatus disclosure among key populations. Outreach workers reported that the predominant attitude towards condom use is that 'a person who uses condoms is not a good or moral person.' This was especially true in the attitudes towards women wanting to use a condom. Zafar explained: 'If a woman insists on a condom, everyone will wonder why' (man living with HIV, Dushanbe). Alisher commented that: 'If a woman asks to use condoms, it means that she is sick' (man who injects drugs, Kurgan-Tube). Women risked being subjected

to violence if they asked men to use a condom or attempted to abstain from sex with their male partners. Female sex workers talked about male clients not wanting to use a condom or that it was 'just not customary to use condoms'. When asked about the extent to which they were able to demand condom use with clients, many female sex workers had never attempted to request this. Some participants said that if a sex worker asked a client to use a condom, he would think that she was sick. The outreach workers did say that they have some female sex workers who do insist on condom use and always take lots of condoms from the organisation, but these are the women who are already accessing HIV prevention services.

Across the focus groups with key populations, men reported that it is difficult to discuss condom use with their wives and girlfriends. They said that it is not a subject that should be brought up with women. Women reported that it is either impossible or nearly impossible to negotiate condom use with their husbands, sexual partners and clients. Healthcare providers and outreach workers reiterated that women are often not able to ask their husbands to use condoms.

Men reported not using condoms because using them made them feel less of a man and was also less pleasurable: 'How could I sleep with my wife using a condom? There is no pleasure in that. I would be better off not even touching her!' (Dima, outreach worker with people who inject drugs, Kurgan-Tube). Men said that their wives also did not want to use a condom with them. For example, 'My wife said that she wants to have sex without a condom because she loves me. She says "to hell with HIV as long as we are together. Love conquers everything"' (Farrukh, man living with HIV, Dushanbe). In addition to feeling less of a man, men who have sex with men also reported not using condoms because of fear of loss of pleasure and/or pain. They also commented that if they tried to insist on condom use they would lose a sexual partner and it is very difficult to find sexual partners given the stigma this group faces. Condom negotiation was reported to be especially difficult for 'passive', or receptive, partners and for those being paid in transactional sex among the community of men who have sex with men.

Participants in the focus groups and roundtables reported that women were often introduced to injection drug use by their male sexual partners and that their dependency was often supported by their husbands or boyfriends. If the male partner is incarcerated, gets sick, passes away or leaves, the women are left in very vulnerable situations. In these situations, women might exchange sexual services for drugs, money or shelter. Some of the men who injected drugs expressed the idea that women are more at risk for HIV because 'they want to try everything and they cannot stop. Those women around the hotels seduce men who do not suspect them to be infected and transmit the virus [HIV]' (Alisher, man who injects drugs, Kurgan-Tube). Participants shared very little information about specific drug use activities among women, which may be attributable to the fact that women who inject drugs are a hidden population in Tajikistan. They did however describe the power dynamics involved in drug using practices. Those who have the power, often defined by who has contact with the drug dealers, are the ones who inject first; and those who have the least power in a relationship, inject last. Additionally, key informants noted that it is may be extremely difficult for women to come to an organisation that is labelled as being for people who inject drugs because of the high levels of stigma associated with being a woman who injects drugs.

There is also a risk related to men migrating abroad for work, and the wives to whom these men return. The men are often migrating out of economic necessity. As Nigora, a representative of a donor organization working on HIV-related issues in the country, noted: 'There in

Russia they agree to anything ... they don't speak Russian. The adaptation period is difficult. There they start drinking, visiting prostitutes, smoking, using drugs. And, when they come back they continue these behaviours.' These risk behaviours are especially true for younger men who lack knowledge about HIV and are prone to pressure from more senior men in their social networks while abroad to engage in unsafe behaviours. It was described as common to 'get the first pay check and go visit the "girls" [sex workers]'. Or as one government health system official described, 'These are hot, southern, young, healthy men who cannot stop themselves.' It is these ideas of masculinity that encourage unsafe behaviours and increase HIV risk for young men and their female partners when they return home.

### ***Gender constraints limit HIV testing opportunities***

HIV testing was not often discussed between partners. Asking a partner to test for HIV is difficult, especially for women. 'Neither men nor women can bring their spouse to get tested because of the stigma attached to HIV and STIs. Even discussing HIV testing with a spouse is a taboo topic' (Firuz, man who injects drugs, Dushanbe). It is especially difficult for women living with HIV to bring their male partners in for HIV testing. The AIDS Centre staff said that 'It is easier for men to bring their wives for testing than to convince women to bring their husbands.' The outreach workers reported that if a woman asks her husband to get tested for HIV (e.g. when he gets back from migrant labour), he will accuse her of involvement in sex work. Wives of migrant labour workers reported that they could not ask about their husband's HIV serostatus. Healthcare providers noted that male labour migrants who do test positive for HIV do not always disclose to their wives, that it is often difficult for men to bring their female partners for HIV testing when they return and that it is even more difficult for a wife to bring their returning husbands given power dynamics within the relationship.

Men who have sex with men in this study said that if they go for testing at the AIDS Centre, then they do not mention their sexual orientation nor do they feel comfortable talking about it with the HIV testing counsellors. These men also said that it would be very difficult for them to bring their wives with them to test for HIV. This population also remains untouched by outreach services. The men say that are not able to tell their wives why they need to get tested, do not think their wives are at risk and, in many cases, would need approval from the woman's family members to take their wives for testing.

Testing during pregnancy is one of the most common ways that women in Tajikistan get tested for HIV. In fact, many women living with HIV said that they first received their diagnosis during pregnancy. There is limited counselling available at this time, especially if a woman is diagnosed using a rapid test during labour. Outreach workers reported that women often do not return for their results if tested during antenatal care, and that they often have to call the women and take them to get their results. Blood analysis for confirmatory testing is only done in Dushanbe; therefore, women who undergo rapid testing during labour in other towns have to sometimes wait three or four months to receive these results. AIDS Centre staff said that it is very difficult when a pregnant women receives an HIV diagnosis because she is often blamed by her husband or family. The lack of counselling was also noted in focus-group discussions with other key populations. For example, female recently released prisoners said that they gave blood for analysis in prison, but did not know what for and did not receive counselling. However, men said there was voluntary counselling and testing offered to them in prisons. Outreach workers with female sex workers said that there is a

tendency in their community for a woman not to seek treatment for HIV or STIs because of fear of disclosure and embarrassment, but that a man would more readily seek treatment.

### ***Gender-based violence contributes to HIV risk and serves as a barrier to services***

Intimate partner violence was referred to by numerous participants in the focus-group discussions and interviews as a 'normal occurrence', especially in smaller cities and rural areas. When asked about intimate partner violence, Madina replied: 'Of course my husband has the right to beat me. He is my husband. He feeds me.' Female participants talked about experiencing violence in their homes and fear of violence if they brought up the subject of condom use with their male partners. And, when asked about whether or not it was okay for women to bring up the subject of safe sex, male participants replied with statements such as, 'if she demands sex with a condom, she will get it [hit]' (Oleg, man who injects drugs, Dushanbe) or 'If she is a smart woman, she will not refuse sex' (Dilshod, man who injects drugs, Kurgan-Tube). Outreach workers explained that gender-based violence influences the ability of women who inject drugs to negotiate safe sexual and drug-using practices. Addressing gender-based violence has been difficult within the HIV sector. Testing counsellors said that while they see that intimate partner violence is a problem among women visiting the AIDS Centre, they do not have time to discuss everything during post-test counselling, that the issue of violence sometimes comes up, but that they do not have the time to ask all of their clients about it.

Some members of key populations are at risk for violence outside the home. Police violence is a critical concern for female sex workers in Tajikistan. Outreach worker, Lena, explained that 'police do not view a sex worker as a person.' Outreach workers conduct annual workshops with the police, but said that these are not sufficient to have a significant impact on the situation. Men who have sex with men talked about fearing violence from police or others due to stigma. Transgender individuals are especially difficult to reach through outreach services, they encounter hate-based violence and society does not allow them the right to wear women's clothing or live their lives as women. No services exist specifically for transgender individuals.

### ***Stigma and discrimination are barriers to services***

Levels of stigma and discrimination were high across key populations, and these were major factors inhibiting access to services. Participants in the focus-group discussion with women living with HIV described how the general population in Tajikistan has very low levels of knowledge about HIV, people think that HIV can be transmitted by air and shared dishes and these misconceptions add to society's stigmatisation of people living with HIV. They reported that even those who are most empowered may travel to international forums and talk about their positive serostatus, but they do not speak about it publicly in Tajikistan. Female participants described instances when a man forbids his wife in Tajikistan from taking antiretroviral therapy so that no one learns of the couple's HIV serostatus while he is working abroad. HIV is highly stigmatised and not an issue that is readily discussed among men who have sex with men. There are limited support services for HIV-positive men who have sex with men because they experience HIV-related stigma among the gay community, and it is

nearly impossible for them to disclose their sexual orientation among support groups for people living with HIV.

While stigma is high for all people living with HIV in Tajikistan, it is also strongly gendered. The predominant perceived attitude towards people living with HIV is that 'If she was a good woman, she would not have become infected. It is not a disease of a decent person.' Ideas of femininity and what it means to be a woman influence how women living with HIV react to their diagnosis and the control they feel they have over their lives and seeking services. For example, women are told that it is their fate to stay with their husbands and that a married couple is obliged to stay together because they both have HIV and their children have HIV. Some women in the focus-group discussion said that they are dependent on their husbands financially and for housing. Manizha said her husband is kicking her out of the house because of her HIV-positive serostatus. Outreach workers confirmed that this is a threat for other women living HIV as well.

Stigma and discrimination are also related to being a member of a key population. For example, sex work is highly stigmatised and something 'a good woman would not do'. People who inject drugs are treated poorly by neighbours, police and healthcare providers. Women who inject drugs are at even more risk because they are violating gender norms: 'Women are judged more. They are offended, belittled and shunned' (Tanya, woman who injects drugs, Kurgan-Tube). Men who inject drugs said that the women in their social networks who use drugs are often not viewed as women anymore. Stakeholders reiterated this idea with statements such as: 'Well, once she has already crossed the line to start using drugs, she is not held to the same gender norms.' There are elements of gender relations that constitute significant barriers for women's utilisation of HIV prevention services. Men may prohibit their wives from leaving the home or using harm reduction services, and women may fear disclosing their addiction through visiting harm reduction services or buying needles at a pharmacy.

The men who participated in focus-group discussions, outreach workers and AIDS Centre staff all described how stigma and discrimination against men who have sex with men and homosexuality are very high in Tajikistan. Participants in the focus group talked about how they cannot be open about their sexual identity, that they fear people in their work places finding out, that religious structures alienate them, that they are limited in where they can safely meet male sexual partners and that if they do get any HIV prevention or testing services, then it is done in secrecy. It was explained that many gay men are married to women and there is societal pressure to maintain a social identity of a heterosexual male with a family: 'In order to be a real man, he has to be strong, to be married and have kids' (Asim, outreach worker with men who have sex with men, Dushanbe). The men also reported being highly susceptible to police violence and the threat of police violence if their identity is exposed. Participants in the focus groups also said they are hesitant to visit an NGO site because of the stigma, risk of being seen and lack of trust of other men who have sex with men in disclosing their identity. Outreach workers report going to outdoor gathering places (*pleshki*) or visiting men in their homes, but that they cannot approach new people. Thus, referral most often happens through friends and social networks, and prevention efforts do not reach men who are not connected in these circles.

Participants in the focus-group discussions reported being treated poorly in the health-care setting:

They refused me medical help when I was in labour .... It was written in my documents that I am HIV-positive. We paid \$400, unofficially, for the birth. But they still treated me like a dog. No

one came to check on me ... if no one knew that I was HIV-positive, they would have treated me okay. (Firuza, woman living with HIV, Dushanbe)

Men living with HIV also reported instances where they had been refused medical care. Participants were quick to note that the providers at the AIDS Centre were not like other healthcare providers, and that they did not experience discrimination there.

This gender assessment revealed that patients' rights are often not protected in Tajikistan. Women living with HIV talked about unsterile hospital environments, not having control over the use of the medical supplies, which they are required to bring in themselves, and being at risk for nosocomial infections. Healthcare providers carry a high social status and, given the gender inequalities in society, doctor-patient control is stronger for female than male patients. For example the general attitude among women living with HIV was that no one will criticise a doctor for disclosing their HIV status because 'if you complain, it will only be worse' (Indira, woman living with HIV, Dushanbe). Non-governmental organisation staff also mentioned that it is difficult to get women to mobilise and advocate for their rights. The disempowerment of women and people living with HIV may contribute to the lack of motivation described by the outreach workers.

### ***Lack of women-centred spaces in the HIV response***

A common theme in the data was that there is a lack of women-focused spaces in Tajikistan's response to the HIV epidemic. For example, there is not a space specifically tailored to female sex workers in Kurgan-Tube. The current space used for outreach services is housed in a facility for people who inject drugs. This means that there is limited opportunity for the women to meet separately and visitors identifying as drug users visiting the centre (predominately male) have priority in the use of the space and receiving services. Women in the focus group said that they were concerned about STI symptoms and pregnancy, but unsure as to where to get information.

Outreach workers were able to tell more about men who inject drugs compared to women who inject drugs, and that these women are a 'hidden group' in Tajikistan. Harm reduction services designed specifically to meet women's needs are lacking. There is a lack of female outreach workers in the NGOs dedicated to working with people who inject drugs. This makes it extremely hard to reach women. One approach has been to create separate spaces for women and men in one drop-in centre for people who inject drugs in Dushanbe. However, key informants noted that it may be extremely difficult for women to come to a drop-in centre that is labelled as being for people who inject drugs because of the high levels of stigma associated with being a *woman* who uses drugs. Providers of the pilot programmes for opioid substitution therapy said that only 8 of the 148 clients are women. It is often more difficult for women to get services due, in part, to their role as caretaker of the children and home, lack of financial resources for transportation, needing the husband's permission and the stigma of being a woman who uses drugs.

Capacity building and income generating activities are needed for female key populations. Some of the women living with HIV talked about not taking antiretrovirals because 'there is nothing in my future and I will die anyway' (Indira, woman living with HIV, Dushanbe). NGO staff said that what they need to provide is a way to 'give the women fishing poles and teach them to fish, rather than just give them fish', so that the women will be empowered to make changes in their lives and not need to rely on the NGO for food and medicine. Many

of the women across the focus-group discussions talked about how they are economically dependent on men. There are government grants available for women's groups in Tajikistan, but women living with HIV are not listed as a priority subgroup for receiving these grants. The UNAIDS country representative noted this gap as an important area to address so as to encourage the establishment and sustainability of initiatives for women living with HIV. Stakeholders, donors and government officials expressed that written laws and policies regarding gender equality are good and that the Tajikistan government is open to promoting women's rights. However, it might be the case that there is nothing in the laws and policies that *prohibit* women from accessing services, but that there are not policies in place to *promote* their inclusion in these services and *support* them in overcoming barriers unique to their position as women in society.

## Discussion

Several cross-cutting issues emerged from this assessment. Poverty is a major factor influencing risk behaviours and accessing services. Drug use and poverty are associated factors in many of the men's lives. Every key population is affected by migration, characterised mostly by men migrating for work abroad and wives left at home. Women who are economically dependent on men are even more limited in negotiating safe sexual and drug using behaviours, asking their male partners to get tested for HIV, or accessing services themselves. Intimate partner violence is highly socially acceptable and a major barrier to accessing HIV prevention methods, testing and treatment. Condom use is low, being considered morally unacceptable (for example, a woman who asks to use a condom raises suspicion of engaging in immoral behaviour) and to reduce pleasure for men. Women across all key populations are limited in their ability to negotiate condom use. There are well-defined gender divisions in Tajikistan. There are gender norms about who does what for whom – that is, the men are breadwinners and make decisions about sexual health, and women are responsible for taking care of the home and satisfying their husband's needs. These gender norms also influence what is considered appropriate and what is permitted, which has implications for HIV risk and access to HIV services. Police violence is a significant barrier to getting services and adopting safer sexual and drug using behaviours for sex workers, men who have sex with men and people who inject drugs. The reaction from the police can in part be attributed to perceived deviation from socially acceptable gender norms. For example, a sex worker may challenge the gender norm of women's 'innocence' and not engaging in sexual activity outside of marriage, or a man who has sex with another man may challenge the dominant norms of masculinity.

Findings from this study help to fill a gap in what is known about the HIV epidemic in Tajikistan. HIV testing in among the general female population is low. The results from the 2012 Tajikistan Demographic and Health Survey showed that just 31% of women aged 15–49 are knowledgeable about where they could get tested for HIV, 15% had ever been tested for HIV and very few (5%) of them had been tested in the past year (Measure DHS 2013). The high levels of stigma and discrimination reported by key populations in this gender assessment can be further contextualised by looking at societal attitudes in Tajikistan. General population demographic surveys have demonstrated that stigma and discriminatory attitudes towards people living with HIV are widespread. For example, the Multiple Indicator Cluster Survey found that over 90% of women aged 15–49 agreed with at least one discriminatory

statement toward people living with HIV; and 43% of urban and 39% of rural women in Tajikistan would want to keep it a secret if someone in the family had HIV (State Committee on Statistics of the Republic of Tajikistan 2007). Less than half of women would be willing to care for a family member with HIV in their home (Measure DHS 2013). The findings from this gender assessment also indicate that key populations' access to HIV services is constrained not only from the stigma related to HIV, but also from the stigma related to being identified as members of key populations (such as female sex workers or men who have sex with men). The societal stigma and discrimination towards these key populations is embedded, at least in part, in gender norms and the attitudes that certain gender norms have been violated.

There are several limitations to the conclusions drawn. Conclusions cannot be generalised to all key populations in all cities and towns in Tajikistan. There are other HIV-related activities taking place in Tajikistan that were not included in this study. Also, participants may not be representative of how all members of key populations think or act. This may be especially true for those people who do not receive services from NGOs or are hard-to-reach and hidden from outreach services. In order to help validate the information learned in the focus-group discussions with key populations, the data were triangulated with information from interviews and roundtables with stakeholders, donors and researchers.

The findings from this gender assessment may have several implications for further research, programme and policy implementation to address the HIV epidemic in Tajikistan. While it is important to consider the specifics of each key population in regard to access to HIV services, there are several cross-cutting issues related to gender norms that if addressed may have a positive impact on increasing access to HIV prevention, testing and treatment for key populations. Efforts to promote safer sexual and injection drug use behaviours should include components that address women's limited ability to negotiate risk reduction strategies with their male partners. Prevention programmes should encourage men to understand that they should consider the risk of HIV to their female partners and that safety is not just a question of personal risk. HIV testing programmes should include strategies to promote dialogue between men and women, assess for the safety in disclosing an HIV-positive serostatus to male partners and family members and provide counsellors with the skills and resources to address gender constraints to the uptake of HIV testing and referral for treatment. More dedicated safe spaces for HIV prevention, testing and treatment services are needed for members of key populations, and this is especially true for women. It is crucial that HIV programmes include components to address gender-based violence. While this assessment offered some insight into the difficulties facing women who inject drugs and the female partners of men who inject drugs, further research is needed to better understand the gender dynamics involved in injection drug use in Tajikistan. More systematic data should be collected on the overlap between members of key populations and the migrant population. There is also a need for increased integration of activities specific to migrants in HIV prevention and treatment programmes for other key populations. Labour migrants may need special services given their transitory lifestyle. Policy makers should consider gender issues when developing the HIV national strategy and allocating funding for HIV programming. Strengthening women's education and economic independence from men is important in decreasing women's susceptibility to HIV infection and addressing the vulnerability of women living with HIV.

There is a global gap in research and programming to address how gender norms and inequalities shape HIV risk and access to programming for key populations (Spratt 2010).

Addressing gender inequality within the HIV response in Tajikistan is in line with the global priorities for curbing the spread of HIV. A recent global review of gender gaps in the HIV response showed that regions with concentrated epidemics are doing worse than countries with generalised epidemics on integrating women-focused policies into national strategies and considering gender-based violence and male involvement in their HIV responses (Carael et al. 2009). An analysis of HIV interventions found that including cost-effective gender-responsive interventions in HIV strategies would improve programme efficiency and sustainability (Remme et al. 2014). Gender inequality is a major barrier to successful programmes for the prevention of mother-to-child transmission (Ghanotakis, Peacock, and Wilcher 2012). Harm reduction services have not been widely implemented in the Central Asian Republics (Beyrer 2011); women, especially, have limited access to harm reduction services in Central Asia (Shapoval and Pinkham 2011). While the findings from this assessment may not be unique to Tajikistan, the results shed important light on the need for a gender-sensitive response to HIV in order to have a positive impact on an epidemic concentrated among key populations.

## Note

1. All of the names used in this manuscript are pseudonyms.

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