



Key problems of sexual and reproductive health of women living with HIV in Tajikistan through the prism of human rights (according to the study)

DUSHANBE – 2019

WORDS OF GRATITUDE

Public organization “Tajikistan Network of Women Living with HIV” expresses its deep gratitude to the Dutch non-profit organization Foundation AFEW International, registered in the Chamber of Commerce of the city of Amsterdam, Netherlands, for providing support in the study “Key problems of sexual and reproductive health of women living with HIV in Tajikistan” through the prism of human rights. ”

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PO “Tajikistan Network of Women Living with HIV is very grateful to all respondents who participated in the study and shared their experience, expressed their opinions and assessments. Thanks to their sincerity and interest, one can see the real picture on the access of PLWH to sexual and reproductive health and other social services.

We express our gratitude to all members of the network who provided the collection of empirical information on the regions of the country.

Authors of the report: gender expert, Ph.D. in Philosophy, Bozrikova Tatyana, Khaidarova Tahmina, head of the public organization “Tajikistan Network of Women Living with HIV”.

FOREWORD

Your attention is presented with a report on the results of the study "Key problems of sexual and reproductive health of women living with HIV in Tajikistan through the prism of human rights"

The study is unique in that for the first time in Tajikistan it was organized and conducted by women themselves affected by the HIV epidemic, who are members of the public organization "Tajikistan Network of Women Living with HIV".

The Tajik network of women living with HIV was created in 2010 with the support of the Public Organization "Mental Health and HIV / AIDS Center" and was officially registered with the Ministry of Justice of the Republic of Tajikistan on December 23, 2011. Organization mission: protecting rights and lobbying the interests of people living with HIV (PLHIV) in the Republic of Tajikistan. TNW+, which unites 48 network members in all regions of the country, represents the interests of women and girls living with HIV and their children. In recent years, more than 2,500 PLHIV have been assisted. Currently, 150 women living with HIV and affected by the epidemic are receiving TNW+ support.

The main objective of the study is to identify key problems and needs of PLWHA in the field of sexual and reproductive health through the prism of human rights, as well as to identify priorities for inclusion in national strategies and action plans on measures to address the HIV / AIDS epidemic, taking into account gender aspects and human rights of PLWH .

When conducting the study, we proceeded from the fact that the basis for ensuring the well-being and dignity of women living with HIV is a comprehensive approach to protecting health and respecting human rights. The right to SRH is an integral part of the right to health, as enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights.

Attention to SRH issues for women living with HIV is also due to the fact that from year to year in Tajikistan there is an increase in the proportion of sexual transmission of HIV infection (56.1%) and an increase in the number of women of reproductive age among those registered with a diagnosis installed for the first time. If in 2014 the number of women of reproductive age among those registered with a diagnosis established for the first time was 354, then in 2018 there were already 438 women.

SRHR and HIV are inextricably linked. Acquisition of HIV and disclosure of information can negatively affect the ability of people to protect and exercise their rights in the area of SRH, can lead to stigma and discrimination, as well as to gender-based violence, including within the framework of services.

We hope that the materials presented will be useful to everyone who works in the field of measures to counteract the spread of HIV and provide support to women living with HIV.

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1. Research methodology

The research methodology is based on the methodology and adapted tools of the Salamander Trust organization used globally. Similar studies were conducted in Ukraine, Moldova and other countries.

Research Objectives:

1. To explore the key problems and needs of WLH in the area of sexual and reproductive health through the prism of human rights.
2. Identify priorities for inclusion in national strategies and action plans for action on the HIV / AIDS epidemic, taking into account gender aspects and human rights of WLH.

Tasks:

- ✓ Conduct an analysis of the regulatory framework on this issue.
- ✓ To study the experience of WLH in obtaining services in the field of sexual and reproductive health.
- ✓ To identify the level of awareness of WLH regarding their rights, safe motherhood, etc.
- ✓ Determine the level of accessibility and use of sexual and reproductive health services.
- ✓ Identify key factors affecting the access of WLH to various social services and their capabilities.
- ✓ Identify the basic needs and requirements of WLH in the area of sexual, reproductive health and a healthy life.
- ✓ Develop recommendations on the observance of rights and increasing the access of WLH to sexual, reproductive health and other social services.

Object of study - women living with HIV at the age of 18 years and older, recognizing their status, from different regions of the country.

Target Regions

- ✓ Dushanbe
- ✓ Khatlon region, including Kulyab and Bokhtar regions
- ✓ Republican Subordination Areas (RSA)
- ✓ Sughd region

Research methods

To achieve the objectives used a set of research methods:

1. Desk research (analysis of the regulatory framework, national strategic and program documents, statistical data, etc.)
2. The quantitative method: interviewing WLH using the face-to-face interview method on the basis of a standardized questionnaire.
3. Focus group discussions.

Face-to-face interviewing with WLH.

The survey was conducted on the basis of a standardized questionnaire, including several sections:

1. General information about the respondent.
2. Human rights and experience in obtaining sexual and reproductive health services.
3. Experience and problems in various aspects of everyday life of WLH in the area of SRH and other areas:

- a. Healthy sex life.
- b. Pregnancy and fertility.
- c. Violence and discrimination against WLH.
- d. Mental health and HIV.
- e. The burden of caring for family members.
- f. HIV treatment and side effects.
- g. Economic opportunities and access to social services.

In addition to closed questions, each section of the questionnaire provided open questions on the proposals and recommendations of the target group, as well as on specific cases of receiving certain services.

The sample for the survey of WLH.

The sample was territorial, quota based. The sample size was 400 people. The survey was conducted in all regions except GBAO. In each region, the sample size was equal - 100 people. Quotas were established by place of residence (city, village) and age.

Table 1. Sample for the survey of WLH by region and type of settlement (person)

Region	Total	City	Village
Dushanbe	100	100	
RSA	100	30	70
Khatlon	100	30	70
Sughd	100	70	30
TOTAL	400	230	170

The total number of districts / cities in which respondents were interviewed was 20 units (see Appendix 1). The list of districts / cities and the number of respondents in them were determined taking into account the burden of the epidemic.

The sample of respondents was carried out among the beneficiary visitors of organizations providing services to PLHIV.

The age quotas for the WLH survey were calculated in proportion to the ratio in the total population of those registered with a diagnosis established for the first time in the period 2014-2018.

Table 2. Sample for interviewing WLH by age (person)

Age groups	General population ¹		Selection q-ty
	Q-ty	%	
18-29	698	34,3	137
30-39	793	39,0	156
40- 49	380	18,6	74
50 years and older	164	8,1	32
Total	2035	100	400

Focus group discussions.

¹ Statistics Agency under the President of the Republic of Tajikistan. Health care in the RT. Dushanbe. 2019, p. 32

A total of 4 focus group discussions were held. Two focus groups were held with participants from the target group in Dushanbe and regions of republican subordination. Each focus group had 10 participants. The focus groups included WLH with age from 24 to 36 years. The discussion centered around topics such as “The family status of WLH and their relationships with family members”, “The access of WLH to sexual and reproductive health services”, and “Violence and discrimination against WLH”.

As part of the coordination meetings, the discussions also gathered case studies and proposals by WLH on improving the quality of access to services and preventing violence against WLH, which are presented in this report.

2. Brief information on HIV prevalence in Tajikistan with a focus on gender aspects.

The Government of the Republic of Tajikistan in order to counter the spread of HIV infection has adopted a number of strategic and programmatic acts:

- ✓ National program to combat the HIV epidemic in the Republic of Tajikistan for 2017–2020.
- ✓ State program for the prevention of mother-to-child transmission of HIV for 2017–2020.
- ✓ National action plan for the protection of sexual and reproductive health of mothers, newborns, children and adolescents for 2016–2020, etc.

The strategic directions of the National Program in the context of gender include a number of issues on HIV prevention, HIV testing, treatment and care for HIV infection, as well as legal aspects aimed at combating stigma and discrimination against people affected by the HIV epidemic. In 2016 - 2017, the clinical protocols for antenatal care of pregnant women were revised and amended. HIV testing in the country is carried out free of charge among representatives of key populations, as well as among vulnerable groups such as pregnant women and children, as part of an ongoing program to prevent mother-to-child transmission of HIV.²

From 1991 to September 30, 2019, a total of 11762 cases of HIV were detected in Tajikistan, including adults and children. Of these, 26.8% died. As of September 30, 2019, the number of PLHIV is 8613 people.

The HIV epidemic in Tajikistan has been characterized in recent years by the following trends:

- ✓ Increased number of new HIV cases detected.
- ✓ Changes in the structure of the transmission pathways due to an increase in the genital tract and a decrease in the proportion of injection routes of HIV transmission.
- ✓ An increase in the proportion of women among new HIV cases, especially due to women of reproductive age.
- ✓ Reducing the proportion of the vertical transmission of HIV in the structure of transmission of infection.
- ✓ Reduced HIV incidence among people who inject drugs.

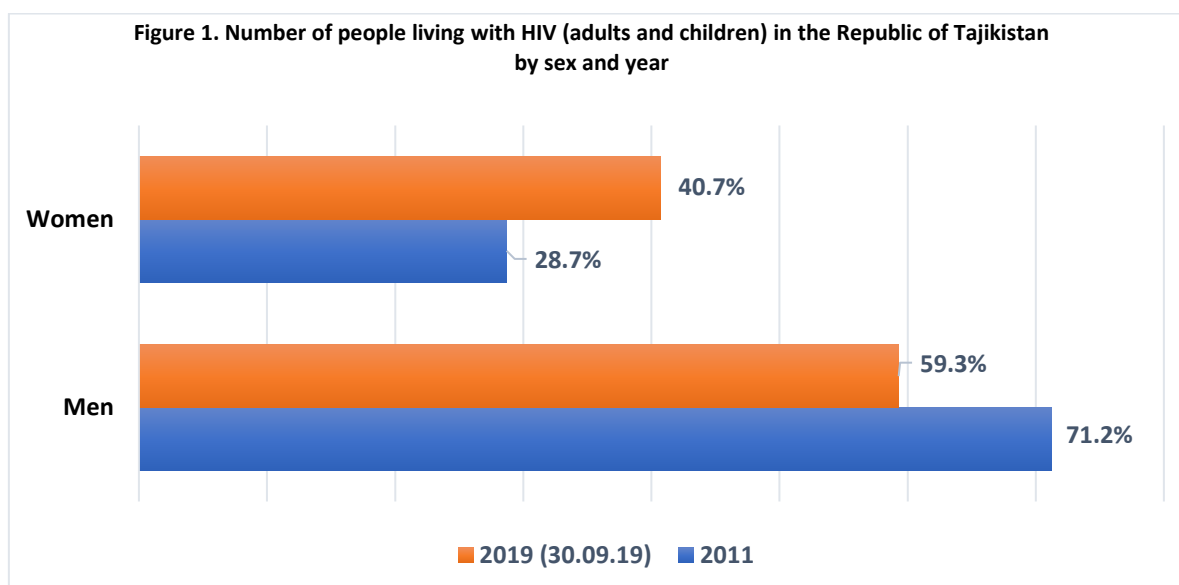
² See: National Review of the Republic of Tajikistan on the Implementation of the Beijing Declaration and Platform for Action (1995) within the framework of the implemented agenda for sustainable development until 2030 and the outcome documents of the twenty-third special session of the General Assembly in the context of the twenty-fifth anniversary of the Fourth World Conference on the status of women and the adoption of the Beijing Declaration and Platform for Action in 2020. 2019, p. 44.

- ✓ Growth among new cases of HIV among migrant workers.

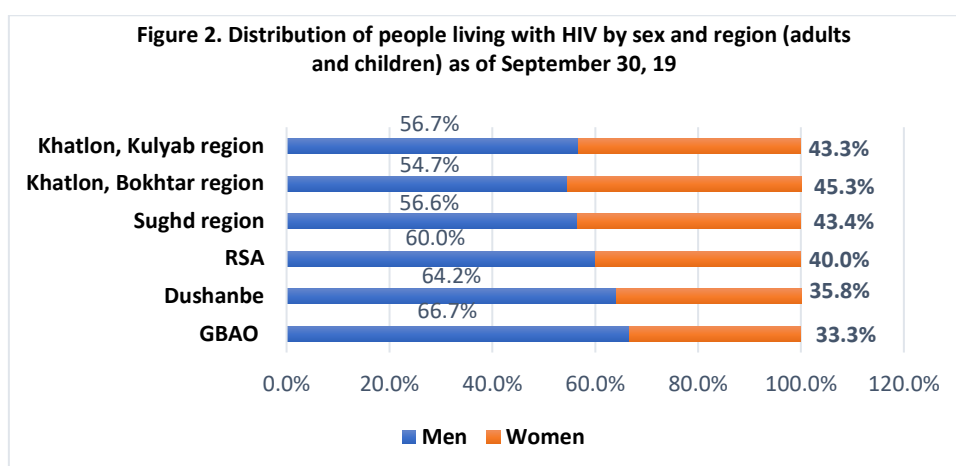
Table 3. The spread of HIV in the Republic of Tajikistan from 1991 to September 30, 2019.

Indicators	From 1991 to 09/30/2019	In %
Identified HIV cases (adults and children)	11 762	100
Men	7576	64,4
Women	4186	35,6
Transmission ways		
Sexual	6601	56,1
Injection	3763	32,0
Vertical	467	4,0
Unidentified	931	7,9
Died	3149	26,8
Number of PLHIV	8613	73,2

As of September 30, 2019, 5105 of the total number of people living with HIV in the country are men and 3508 are women. However, the growth rate of HIV incidence among women is much higher than among men. If from 2011 to 2019 (as of September 30.) The number of men increased 3 times, then among women it increased by more than five times.



By region, the ratio of men to women among PLHIV varies. The largest share of women is in Khatlon and Sughd regions. Women are the least represented among PLHIV in GBAO and Dushanbe (see Appendix 2).



The measures taken to optimize the diagnostic, treatment processes and monitoring of treatment in the republic contribute to the improvement of indicators in several areas. Since 2014, the number of pregnant women with HIV infection in the republic from 99 cases decreased to 77 cases as of September 30, 2019.

Table 4. The number of pregnant women with HIV infection ³

	2014	2015	2016	2017	2018
GBAO	1	2	1	4	2
Khatlon region	25	31	12	21	30
Sughd region	29	26	19	10	18
Dushanbe	27	8	18	3	7
RSA	17	22	25	22	20
RT	99	89	75	60	77

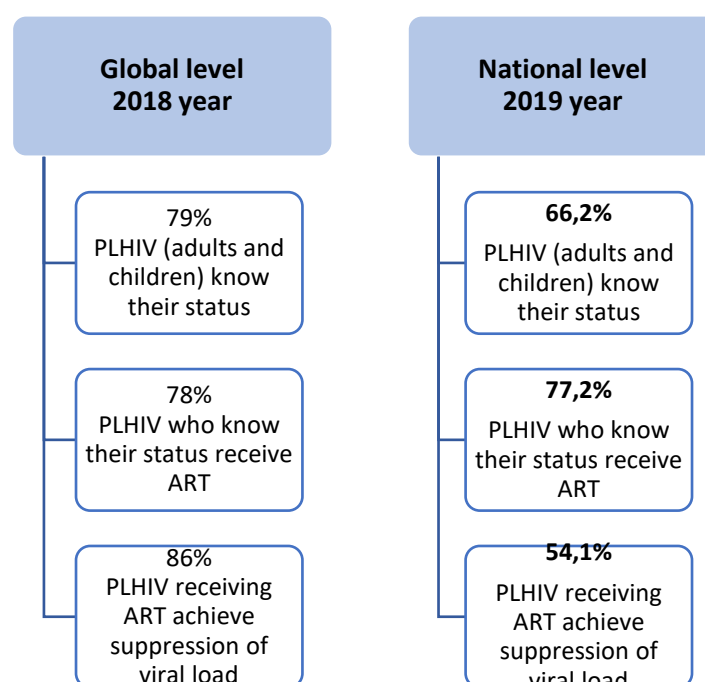
Tajikistan is gradually moving towards achieving the goals of the UNAIDS Strategy 2016–2021. The goal of UNAIDS Strategy 1 by 2021 is 90-90-90: 90% of PLHIV (adults and children) are aware of their status; 90% of PLHIV who are aware of their status receive antiretroviral therapy (ART) and 90% of PLHIV who receive ART achieve suppression of viral load (suppression of HIV).

According to global statistics, in 2018, 79% [67-92%] of people living with HIV knew their status. Among people who knew their status, 78% [69-82%] had access to treatment. And among people receiving treatment, 86% [72-92%] achieve suppression of viral load.

Figure 3. Achievements of Tajikistan by the UNAIDS Strategy Targets for 2016–2021. (goal 1 of the Strategy - 90-90-90) ⁴

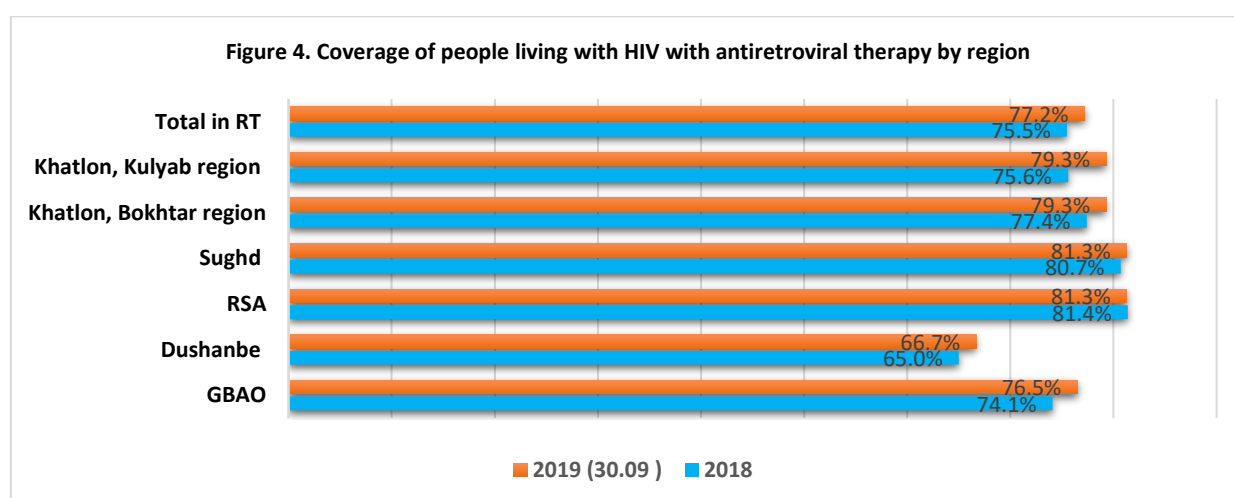
³ Statistics Agency under the President of the Republic of Tajikistan. Health care in the RT. Dushanbe. 2019, p. 33

⁴ See: Used global data from: <https://www.unaids.org/en/resources/fact-sheet> "Global HIV / AIDS Statistics-2019 Newsletter" and RT data from the presentation "Epidemic Status and HIV Response" among women and youth as part of the national sustainable development goals agenda. " Nurlaminova Z.A., Head of the Dispensary Department of the State Institution "RC AIDS". Dushanbe, Forum, December 4, 2019



In order to reach as many people living with HIV as possible with life-saving treatment (ART), Tajikistan has switched to WHO recommendations for prescribing treatment (adults, adolescents, children) for treatment as soon as possible after they are diagnosed with HIV. As part of the optimization of the treatment process, in Tajikistan, almost 100% of pregnant women living with HIV receive ART. A new National Clinical Guide for HIV Treatment, Care, and Support for Adults, Adolescents, and Children has been prepared and approved by the Ministry of Health and Social Protection of the Republic of Tajikistan. 5

According to official data for 2019, in the whole country, 77.2% of PLHIV who know about their status receive ART. However, analysis of data by region reveals a different level of ART coverage. The highest rates of coverage for people living with HIV with antiretroviral therapy are in the Sughd region and RRS (81.3%). In the opposite group are PLHIV in Dushanbe (66.7%). (see Figure 4 and Appendix 3).

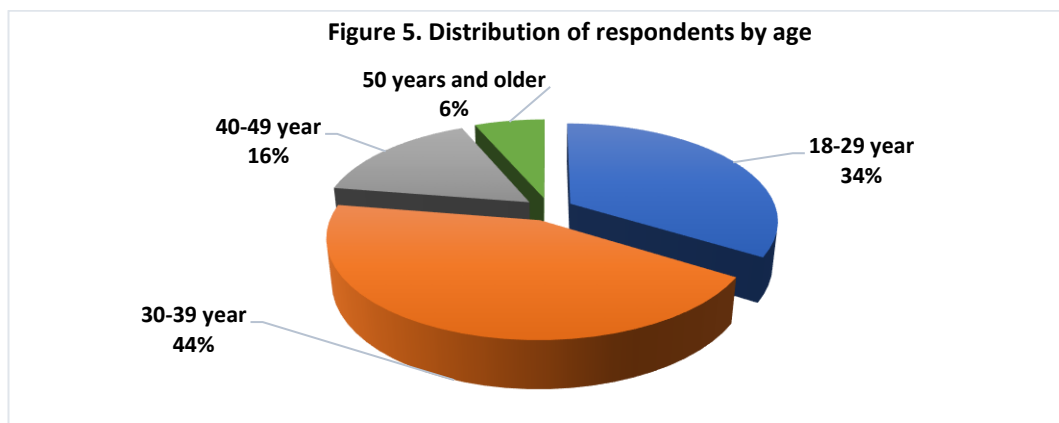


5 From the presentation “The status of the epidemic and HIV responses among women and youth as part of the the national sustainable development goals agenda”. Nurlaminova Z.A., Head of the Dispensary Department of the State Institution "RC AIDS". Dushanbe, Forum, December 4, 2019

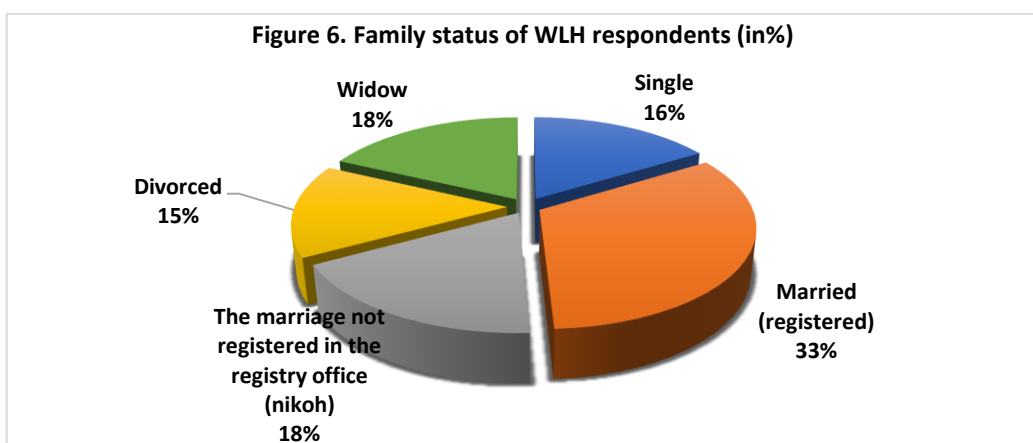
3. Socio-demographic characteristics of WLH respondents

About 57% of WLH respondents live in urban areas, 43% - from rural areas. The average age of respondents is about 35 years (within the 95% confidence interval). The youngest respondents are now 18 years old, the oldest - 64 years old. By region, this indicator varies slightly. In Dushanbe, the average age is 34 years old, in Sughd region - 38 years old, in Khatlon region - 31 years old, in RSA - 36 years old.

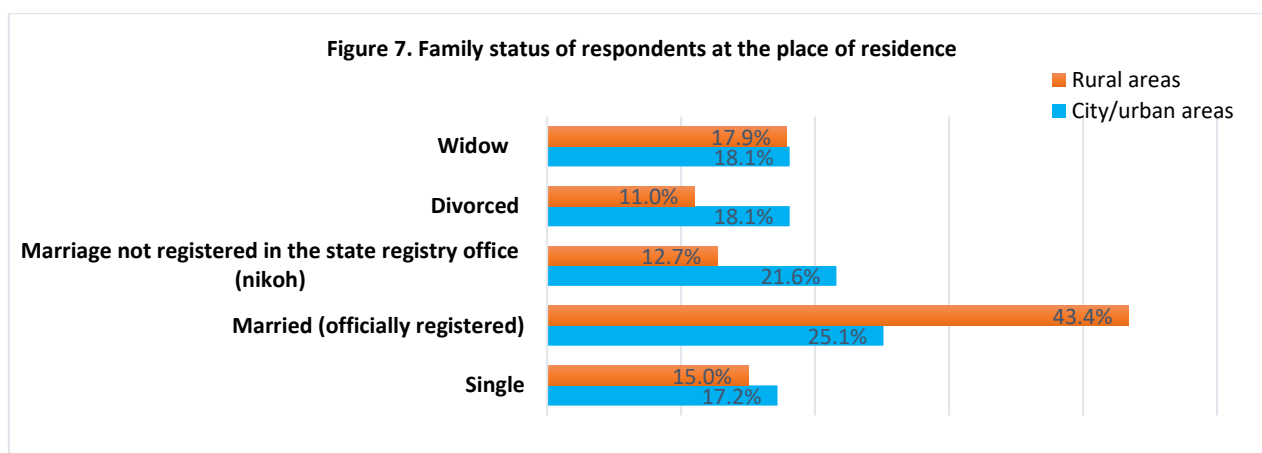
The vast majority of respondents (93.5%) are from the reproductive age group. The correlation of age groups is as follows: 18-29 years old - 135 people, 30-39 years old - 175 people, 40-49 years old - 64 people and 50 years old and older - 26 people.



Some differences are recorded by age groups in the context of the city and village. Among urban respondents, the share of the age group 18-39 years old (75%) is lower and the share of the group of 50 years and older (9%) is higher than in the rural group (80% and 3%, respectively).

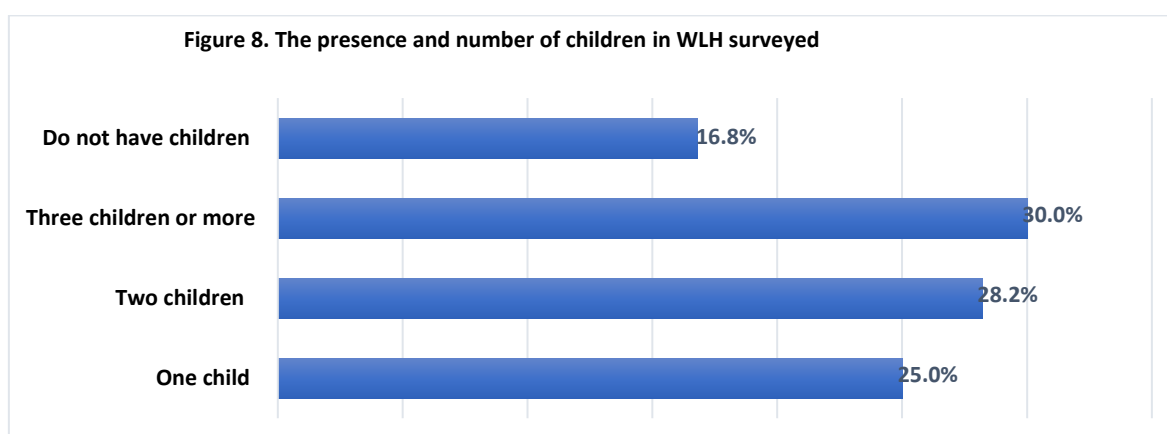


According to the family status, approximately every second woman is married, or married according to the Muslim rite (nikoh). Of the second half, 16% of women are single, 18% are widows and 15% are divorced.



As the data in Figure 6 show, among urban respondents, compared with rural respondents, the proportion of WLH who are unregistered in the Civil Registry Office, divorced and single is higher.

The vast majority of WLH have children (83.2%). Of these: 30% have one child, 34% have two children and 36% have three or more. It should be noted that five women living with HIV have six children, nine have 5 children. There are no significant differences in the presence and number of children by city and village.



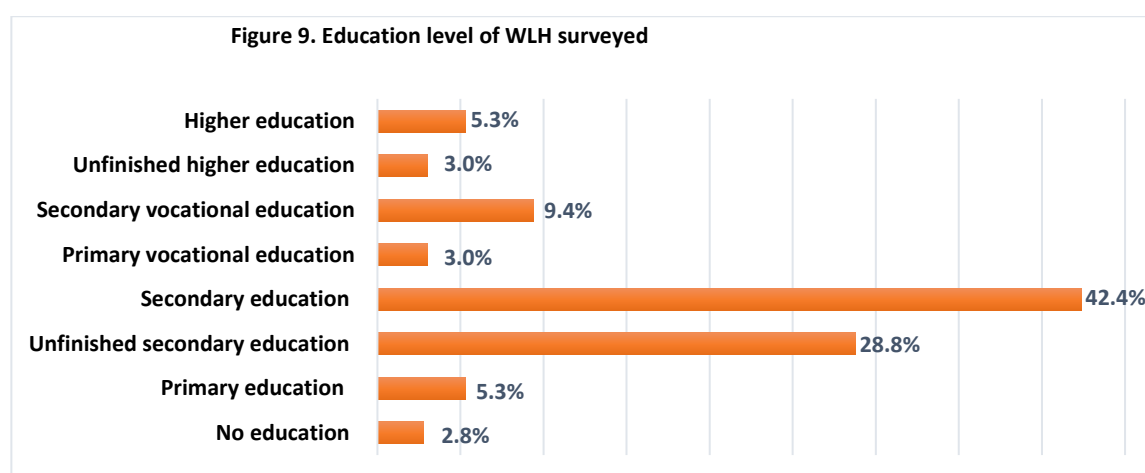
In Dushanbe, 86% of respondents have children, in Sughd - 73%, Khatlon - 94%, and RSA - 80%. Compared to WLH from Sughd region, among women in Dushanbe, Khatlon region and RSA, the proportion of mothers with many children (three or more) is significantly higher.

Table 5. The presence of children among respondents by region (in%).

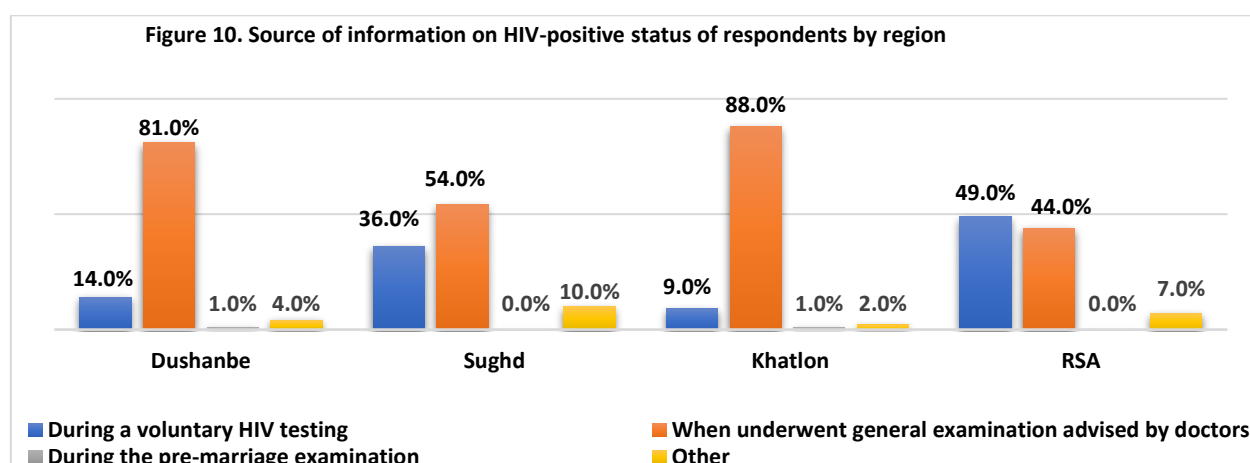
Region	Of the total number of children			No children
	One	Two	Three and more	
Dushanbe	20,9	37,2	41,9	14,0
Sughd	45,2	31,5	23,3	17,0
Khatlon	23,4	37,1	39,3	6,0
RSA	33,7	28,8	37,5	20,0

The vast majority of WLH (71.2%) have incomplete secondary and complete secondary education. About 21% of respondents have vocational education who are proficient in some type of specialty. At the same time, only 8.3% of respondents have higher and incomplete higher education. About

3% of WLH have no education at all. Just over 5% completed only primary school. There are no significant differences between respondents from rural and urban areas.



According to our respondents, two-thirds of our respondents (66.8%) found out about an HIV-positive result during a general examination by doctors or institutions. During voluntary HIV testing, 27% found out. Less than one percent learned during pre-marital examinations. Under other circumstances, 10% of respondents found out about their status.



In the context of regions, except for RSA, the majority of respondents found out about their positive status during a general examination referred by doctors. In the city of Dushanbe and the Khatlon region, this figure is over 80%. In the regions, during the voluntary HIV testing, the largest number of respondents learned from RSA and Sughd.

4. HUMAN RIGHTS AND EXPERIENCE IN OBTAINING REPRODUCTIVE HEALTH SERVICES

At the heart of ensuring the well-being and dignity of women living with HIV is an integrated approach to health and human rights. The right to SRH is an integral part of the right to health, as enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights.

In 2016, the United Nations Committee on Economic, Social and Cultural Rights (CESCR) determined that the right to SRH is “an integral part of the right to health”. To ensure sexual and reproductive health and protect the rights of women and girls living with HIV, the following essential conditions must be met:

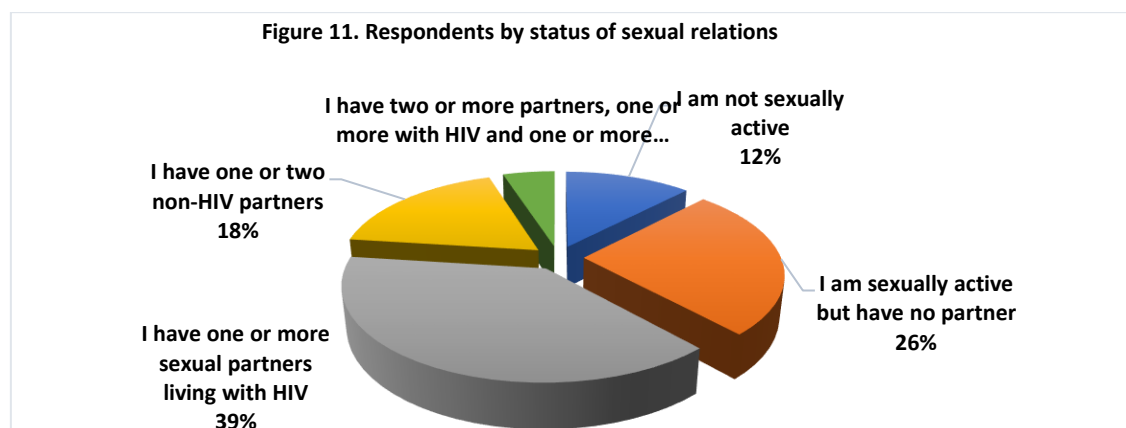
- ✓ An integrated approach to building health system programs, in particular in the area of sexuality and sexual health, should be based on respect for human rights and gender equality.
- ✓ Health systems must take into account existing inequalities in access to health care and the quality of services provided, which adversely affects the situation of women living with HIV.
- ✓ Women living with HIV should be given the necessary rights and opportunities and involved in the development of policies and programs that affect them.
- ✓ In order to ensure high quality data and provide remedies for violations of the rights of women living with HIV, monitoring, evaluation and reporting procedures need to be strengthened.

One of the principles of good practice in the field of sexual and reproductive health and rights (SRHR) for women living with HIV developed by WHO is the principle of “Healthy sexuality throughout life.” According to this principle, the choice of women living with HIV should be supported. all their diversity, who want to be in a safe and full sexual relationship and receive satisfaction from sexual activity at any age. On the other hand, one should be sympathetic to the decision of those women living with HIV who prefer to abandon active sex life.⁶

Status of WLH by Sexual Relations.

The vast majority of our respondents (88%) identify themselves as sexually active. At the same time, 26% indicated that they are sexually active, but have no partner, **that is, they have a physiological and emotional need for sexual intercourse.** Due to the fact that they have a need for sexual relations, they lead a sexual life if they find a partner.

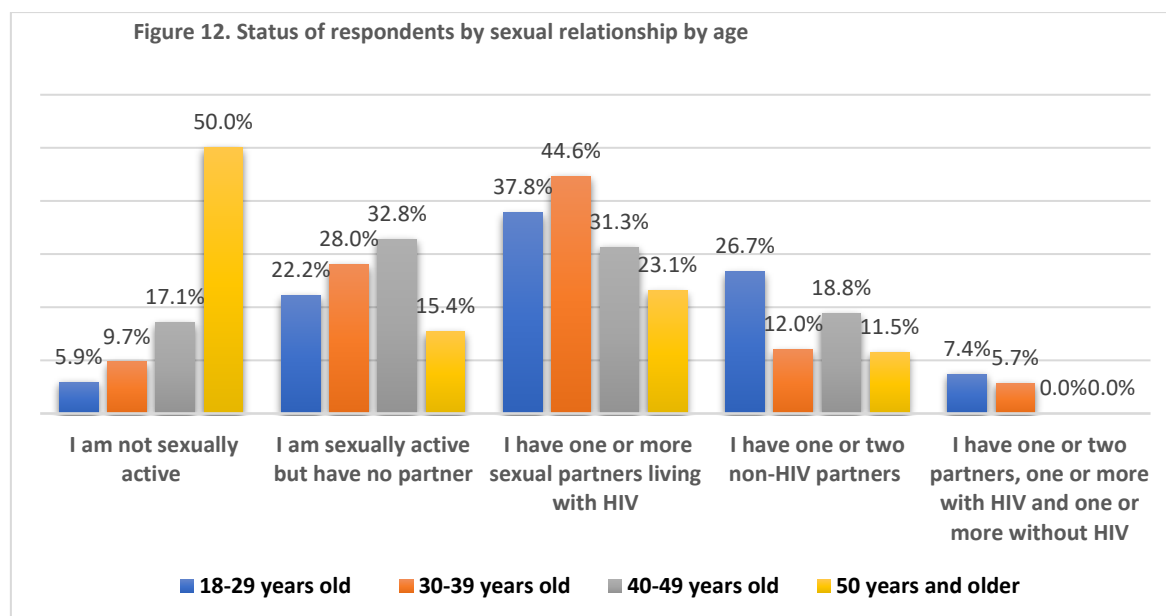
Of the remaining groups, 39% have one or more sexual partners living with HIV. Have two or more partners, among which one or more with HIV and one or more without HIV - 5%. The group of WLH with one or two partners who do not have HIV is 18%.



⁶ See: WHO. Consolidated Guidelines on Sexual and Reproductive Health and the Protection of the Rights of Women Living with HIV. 2018.s. 10. https://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/

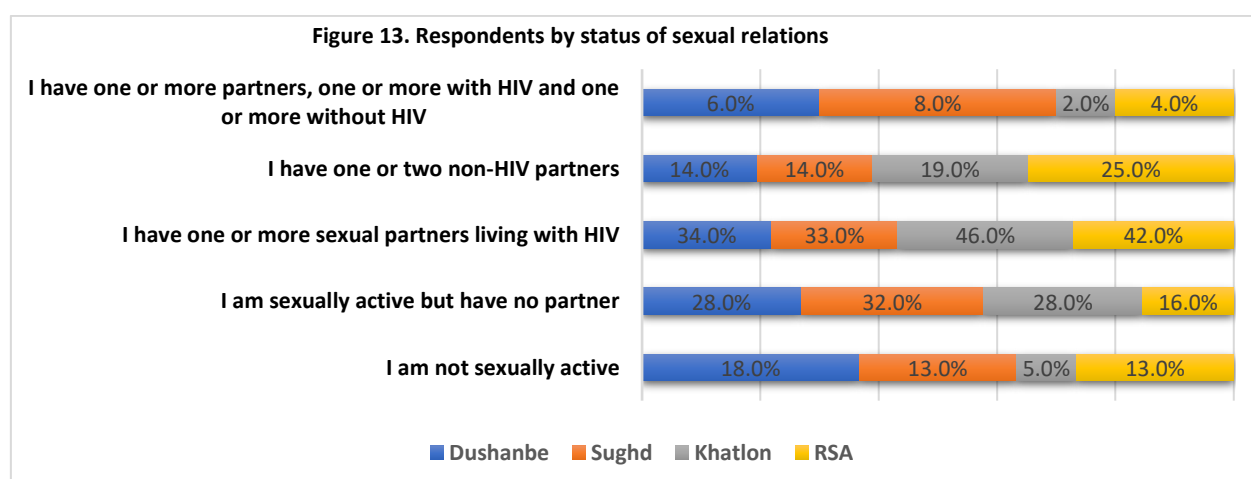
The differentiating factor influencing the status in sexual relations is the age of the respondents. As can be seen from the data in Figure 12, the younger the WLH, the higher the activity. Among respondents who have HIV-infected sexual partners, the largest share is in the age groups from 18 to 39 years.

In the group of respondents for whom sexual partners do not have HIV, the highest percentage are WLH between the ages of 18-29 and 40-49.



A comparative analysis of the status of women by region reveals that in all regions, the majority of Women living with HIV have one or more partners living with HIV.

Among women who are not sexually active, the largest proportion (18%) is in Dushanbe, and the smallest is in Khatlon.



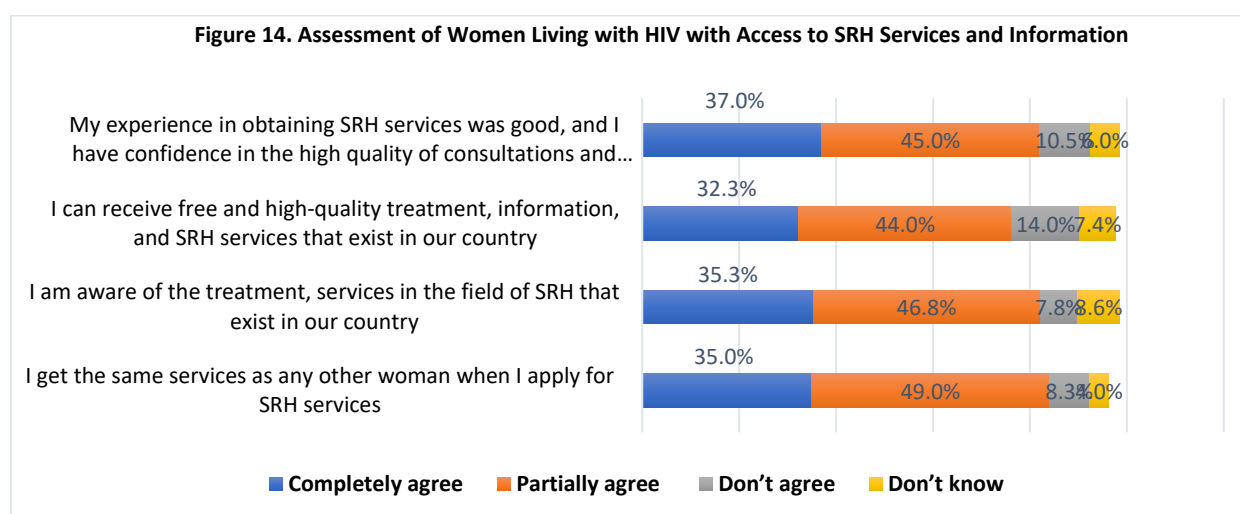
Given that the vast majority of women living with HIV are of reproductive age, it is very important to ensure full access to available, affordable and quality reproductive and sexual health services. A survey found that most women living with HIV have limited access to quality SRH services. First of all, this applies to the system of primary health care. It is here that women living with HIV

are most often faced with discrimination in obtaining medical services. Therefore, most HIV-positive women are afraid to open their status and do not seek services in primary health care facilities in the community.

The results of the survey show that, on average, one in three respondents of Women living with HIV clearly believes that she:

- ✓ receives the same services as any other woman when she applies for SRH services;
- ✓ can receive free and high-quality treatment, information, services in the field of SRH when she needs them;
- ✓ is aware of the treatment, services in the field of SRH that exist in our country.

Moreover, 37% of respondents unequivocally assess their experience in receiving sexual and reproductive health services as good, and they have confidence in the high quality of counseling and treatment.



At the same time, about half of the survey participants only partially agree with these statements, and from 7.8% to 14% do not agree with these statements. At the same time, from 4% to 8.6% of respondents generally found it difficult to assess access to SRH services.

As the focus group discussions with representatives of the key group showed, these estimates are largely due to the fact that the overwhelming majority of people living with HIV are seeking services from the AIDS Centers or a personal doctor. According to their estimates, the attitude of health workers is friendly, and the quality of services is usually good. The calls of women living with HIV for services in primary health care facilities (PHC) are rare. The main arguments for refusing to use PHC services were two main ones: The fear that they learn about their status, as well as the manifestation of discrimination and stigma in these medical institutions.

According to the participants of the focus groups, *“if you seek medical help at a regular clinic, antenatal clinic or even a private medical institution, it all depends on whether you open your status or not. In the case of non-disclosure of the status, the attitude and quality of the services of a doctor, nursing staff is usual, as with all clients. But once you open your status, the situation changes dramatically. Both the doctor and the nursing staff immediately begin to mistreat, find a million reasons not to provide assistance, etc. In a word, sheer stigma and discrimination.”*

The stories of Women living with HIV about receiving sexual and reproductive health services given during the main survey confirm the statements of the focus group participants.

After I was diagnosed in 2017 during pregnancy, I turned to a gynecologist at my place of residence in the city of Vahdat for help. But they didn't accept me there at all, because I had HIV

and redirected me to the RC AIDS. The doctors from this center helped me, put me on a temporary registration, and I was under their supervision until the birth of my baby. I gave birth to a healthy baby, and I am very grateful to the doctors from the AIDS center, especially the gynecologist.
WLH, 42 years old, Dushanbe. The widow has 3 children.

Because of my HIV status, I only go to the AIDS Center. I do not go to other doctors because I am afraid to go to other medical institutions. The gynecologist at the AIDS Center treats me well; counseling is always provided for other sexually transmitted infections. I am very pleased with the services of a gynecologist at RC AIDS. She understands and supports me.

WLH, 31 years old, Khujand, divorced, has 1 healthy child.

I do go to a gynecologist, but only to the one at the AIDS Center. I am afraid to go to other gynecologists for my reproductive health. The fear of my status and the uncertainty about whether I could stand up for myself led me to the conclusion that I would not go to other doctors. Therefore, I do not go to the gynecologists at my place of residence.

WLH, 36 years old, Bokhtar, divorced, has 2 children.

When I was pregnant, I went to the polyclinic at my place of residence to visit the gynecologist. I wanted to register myself in order to control my pregnancy. But I was very upset, because when they found out that I was HIV-infected, they immediately began to disdain and discriminate against me.

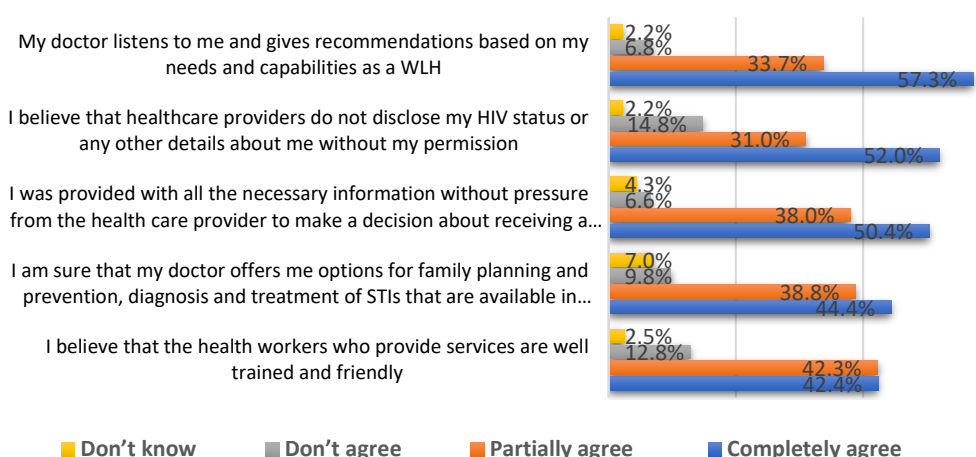
WLH, 22 years old, the city of Kanibadam, married.

In Tajikistan, in 2018, in accordance with WHO recommendations, piloting began to integrate the provision of HIV services in PHC facilities. Given the considerable number of cases of discrimination and dissemination of information about the status of women who applied to PHC facilities by health workers for others, many women expressed concern about the possible restriction of their access to SRH services in connection with their transfer to PHC facilities. Therefore, it is very important at the initial stage, and subsequently, to integrate the provision of HIV services in PHC facilities, to conduct extensive training for PHC staff regarding the features of working with a key group and to pay special attention to strengthening the responsibility of health workers for disclosing the status of WLH.

According to the data presented in Figure 14, over 57% of WLH believe that at the time of admission, the doctor makes recommendations based on their needs and capabilities as Women living with HIV. Every second WLH is confident that health workers do not disclose her HIV status or any other details without her permission, and provide all the necessary information to make a decision about receiving a service or treatment.

Unlike this group of respondents, another group of respondents only partially agree with this assessment (from 31% to 38%).

Figure 15. Evaluation of the quality of services and attitudes of health workers to WLH in the field of SRH

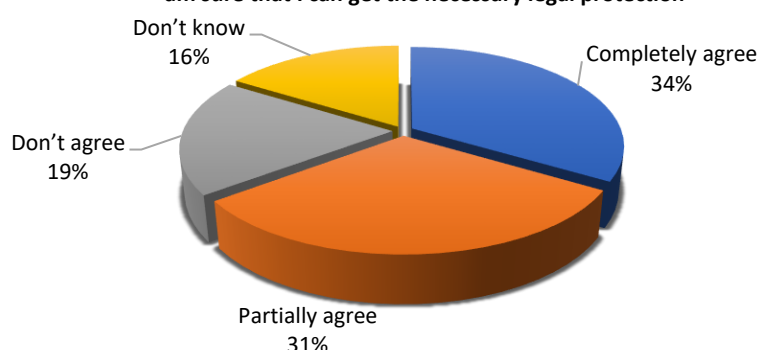


When assessing the level of training and friendliness of health workers, already less than half of WLH fully agree with the statement that health workers have good training. Only 44% fully agree with the statement that the doctor offers them family planning and prophylaxis, diagnosis and treatment of STIs that are available in our country. Approximately the same group in number joined this opinion only partially.

An analysis of the responses of WLH does not record a high level of awareness of the target group regarding their rights. Only every third woman completely agrees with the opinion that she knows her rights, and if they are violated in medical facilities, she knows where to file a complaint. Approximately the same number of WLH confirmed partial agreement with this opinion. In turn, over 32% either disagree with this opinion or find it difficult to assess their level of awareness.

According to our respondents, only 34% are unequivocally confident that in case of violation of their rights, as WLH, they will be able to receive the necessary legal protection. While 19% are of the opposite opinion, and 16% found it difficult to answer this question.

Figure 16. WLH Assessment: "If my rights as a woman living with HIV are violated, I am sure that I can get the necessary legal protection"



Conducted focus groups also record a different level of awareness of participants about their rights. Of the total number of WLH, only one third know their rights relatively well. Other participants do not have full knowledge to protect their rights, or do not know anything at all (usually from among those who recently learned about their status).

I had a sad experience with my rights. I went to the clinic. But after I talked about my positive HIV status, I was immediately denied medical services. I began to say that this was a violation of my Constitutional rights. In response, they told me that I'm sick, and that they can no longer help me. What hurt the most is that it was the doctors who would tell me this. I didn't go anywhere to complain.

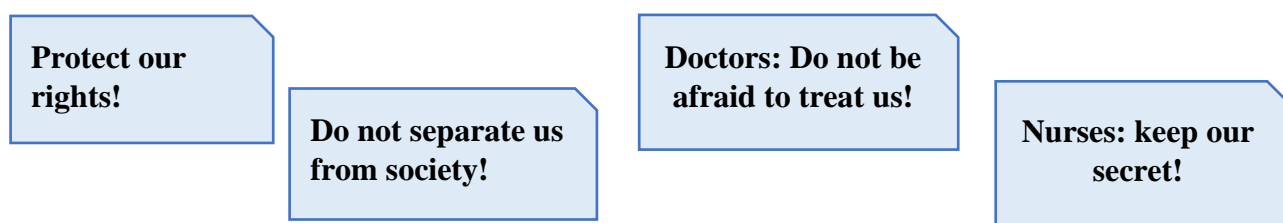
WLH, 36 years old, Vose district.

The survey results and focus groups record the impact of respondent education on their level of awareness. The lower the level of education, the lower the awareness of their rights.

The weak motivation WLH to increase their level of knowledge on protecting their rights is determined, judging by the discussions in the groups, that they can still receive full-fledged services only at AIDS centers or on a paid basis in private health facilities. In state medical institutions, they “shy away from them, like from lepers,” “and they will even tell the whole world about my status.”

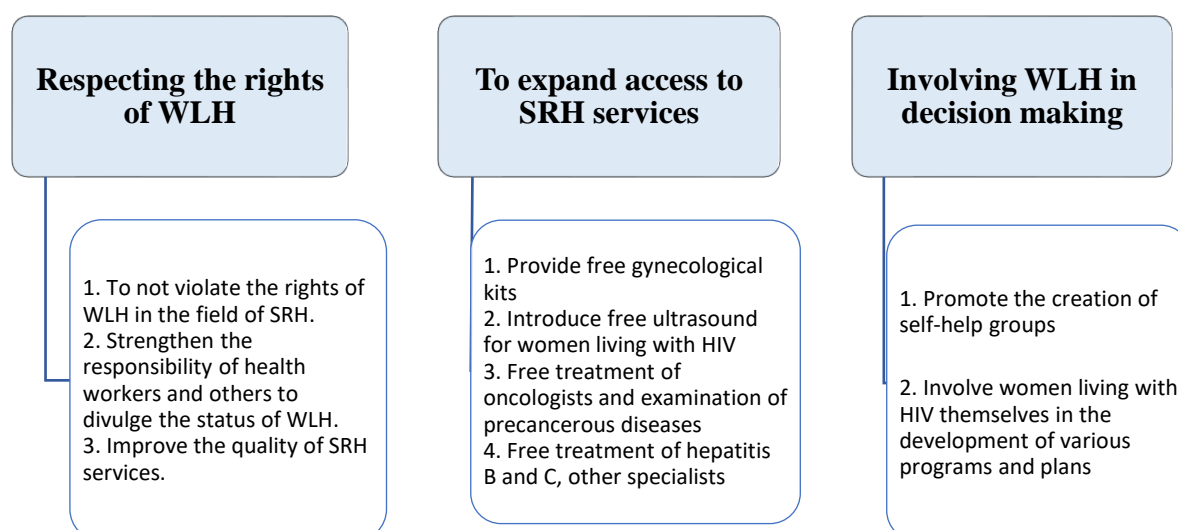
Everyone unanimously calls the AIDS Centers and relevant public organizations as potential structures that will help them protect their rights. To the question of what other state structures can help them, answers were received: “no one”, “we trust no one else”, “all the same, in other places there are no specialists who know about us (PLHIV) or simply under any pretext, when they find out about your status, refuse legal support ”and etc.

The study participants received a whole range of proposals and appeals to ministers, deputies, doctors to expand and improve the quality of services in the field of SRH.



The respondents' suggestions on expanding and improving the quality of SRH services can be grouped in three areas: respecting the rights of WLH, expanding access to SRH services, and involving them in decision-making processes.

Figure 17. Proposals of interviewed WLH to increase access and quality of SRH services



5. EXPERIENCE AND CHALLENGES ON DIFFERENT ASPECTS OF DAILY LIFE FOR WLH IN THE FIELD OF SEXUAL AND REPRODUCTIVE HEALTH AND OTHER SPHERES

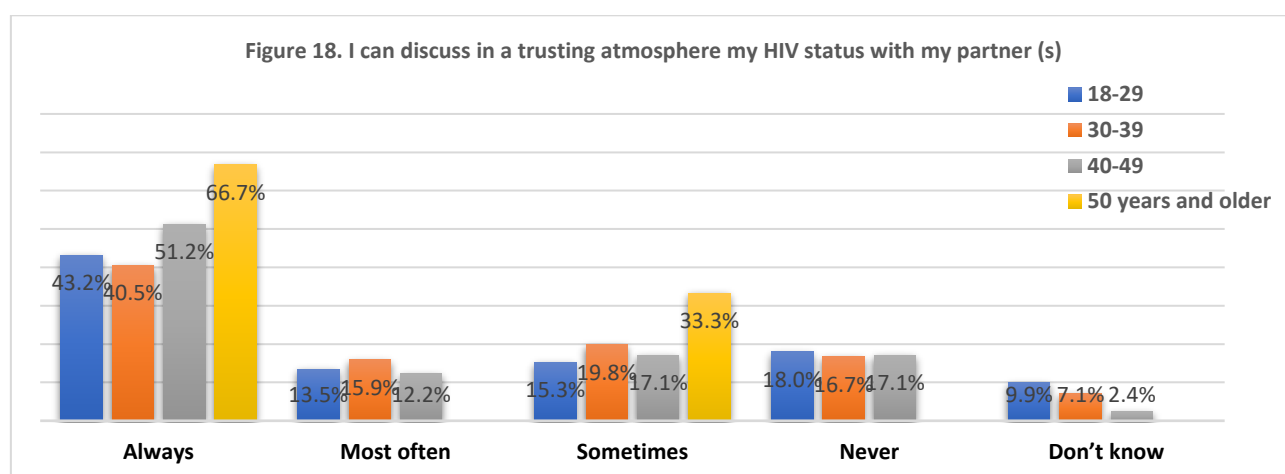
5.1. Healthy sex life

Women with HIV have the same right and opportunity as all women to enjoy a healthy, safe and satisfying sex life, free from coercion, discrimination and violence. However, as a survey of women living with HIV showed, many respondents are embarrassed to talk about this and are not always ready to discuss these issues with their partners, doctors. In our opinion, this is due to the fact that the sexual sphere as a whole in the republic is subject to traditional gender stereotypes. First of all, the topic of sexual relations is not customary to discuss in Tajik families.

One of the most common stereotypes in this area is as follows: "a man and a woman must have different models of sexual behavior." Under the influence of established opinions is the topic of what sex is for women and men. For men - this is primarily a means to satisfy a desire, and only in second place, a means to procreate. For women, sex is primarily a means for giving birth to children, one of the main marital duties under Sharia law. At the same time, women, as a rule, also cannot talk about sex and take initiative in sexual relations - this is regarded as profligacy.

The presence of HIV is not a sign of sexual ill-health, but is a feature of the partner, which should be adapted to achieve sexual harmony, i.e., adapt your sexual behavior to the behavior of the partner. For people living with HIV, it is important that certain conditions and rules of sexual behavior are associated with preventing infection.

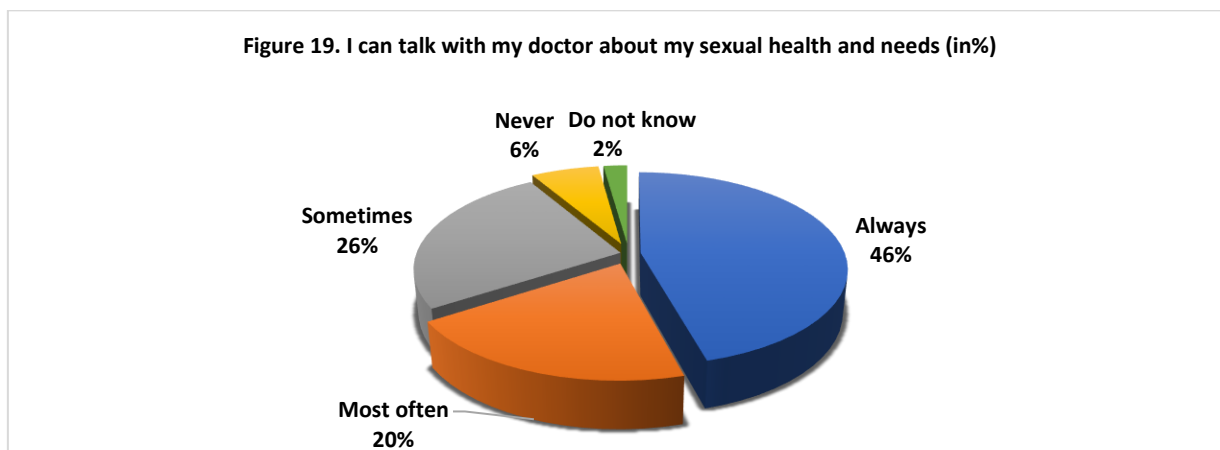
One of these conditions is the disclosure of HIV status to a sexual partner. Given that most of our respondents became infected from their husbands or partners, in this situation the question of discussing the characteristics of sexual relations in a confidential atmosphere comes to the fore. According to women living with HIV, only 58% can always or most often discuss their HIV status in a trusting atmosphere with their partner / partners. For 18% of respondents this is permissible only occasionally. 18% can never do this, and 7% found it difficult to assess.



The age and place of residence of the respondents have a certain impact on the discussion in a confidential atmosphere of HIV status with their partner / partners. In contrast to the age group of 50 years and older, among respondents of reproductive age (18-49 years old) there are fewer women living with HIV who discuss this issue "always" and a large proportion are the group that "never" discusses (see figure 17). In terms of place of residence, urban women, compared to rural women, often discuss this issue with their partner / partners. The most vulnerable group in this

matter are women living with HIV from among current / former MS. Of these, 54% said that they can never discuss their status with their partner.

According to the survey, two-thirds of respondents can “always” or “most often” talk with their doctor about their sexual health and needs. Every fourth woman only “sometimes” can discuss these issues with her doctor. There are no significant differences in this matter between rural and urban women. Among respondents of reproductive age, groups of 18-29 years old and 40-49 years old are more likely to discuss these issues with their doctor.



One of the conditions of sexual behavior that promotes a healthy sex life is equal relations between partners, lack of coercion and violence.

As can be seen from the data in table 6, a little more than 40% of the respondents want to have sex often. Every second woman has such a desire sometimes. Just over 5% of respondents never feel this desire. At the same time, 57% of women living with HIV find sex “pleasant” for themselves and for their partner (s) “always” or “most often”.

Table 6. Sexual experience of respondents (in%).⁷

	Always	Most often	Sometimes	Never	Do not know
I want to have sex often / have a strong sexual desire	18,3	24,2	50,2	5,2	2,1
I find sex pleasant for myself and for my partner (s)	26,1	30,8	34,0	3,1	6,0
I have sex to satisfy my partner	25,1	29,8	36,6	4,4	4,1
I myself suggest sex to my partner (s) and suggest how to have sex	14,0	16,4	42,3	24,2	3,1
I have sex when I want	13,9	28,6	43,5	10,9	3,1
I have sex when my partner (s) wants	23,5	33,3	37,1	2,0	4,1
It's easy for me to experience an orgasm during sex	20,9	26,0	37,5	4,1	11,5

Measures to protect and promote SRH are important for preventing HIV infection and ensuring the health and longevity of people living with HIV. Among these measures, it is advisable to highlight the ability of women living with HIV to make decisions about when, how and with whom

to have sex, get married and how many children, etc. At the same time, sexual violence by an intimate partner increases the risk of acquiring HIV.

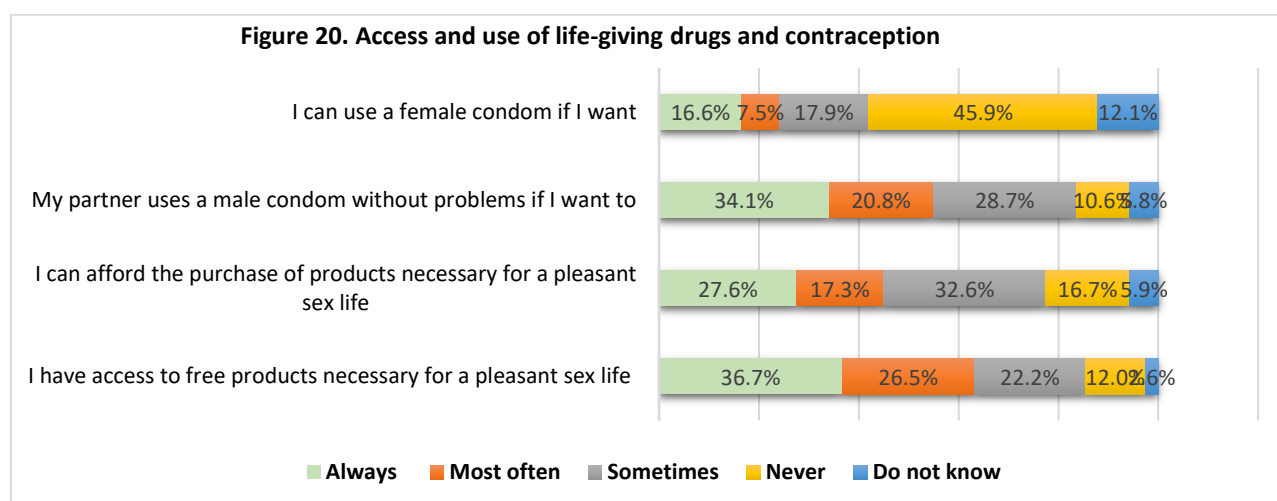
According to respondents, about 57% have sex when their partner (s) want and 55% have sex to satisfy their partner. Among the respondents, less than half (42.5%) have sex as they wish. Just over 30% often themselves take the initiative to have sex.

Pay attention to the answers on the safety of sexual relations. Only 58% of WLH indicated that “always and most often” could have sex without fear of transmitting HIV to their partner (s). At the same time, they feel safe with their partner (s) “always and most often” 61%. One in four women, judging by the answers, only sometimes can have sex without fear of HIV transmission to their partner (s) and feel safe with their partner (s). At the same time, a considerable proportion of respondents either “never” feel safe with their partner (s) or cannot assess the situation. Even higher is the percentage of women who fear the transmission of HIV to their partner.

Table 7. Estimates of sex safety respondents with their (s) partners (in%).

	Always	Most often	Sometimes	Never	Do not know
I can have sex without fear of HIV transmission to my partner (s)	39,9	17,7	25,8	8,8	7,8
I feel safe with my partner (s)	41,6	19,8	25,8	7,1	5,7

Two other conditions are very important for the sexual behavior of WLH: the correct and constant use of condoms and regular testing for sexually transmitted infections. According to the answers, 55% of the respondents have a partner who uses a male condom without problems if they ask for it. Only occasionally do partners fulfill this condition in 28.7% of WLH. About 11% of partners never use a condom at the request of respondents. About 6% found it difficult to give an answer.



It is alarming that only less than half of the respondents (42%) can use a female condom if they wish. Of these: 16.6% can always use it, most often - 7.5%, sometimes –17.9%. At the same time, about 46% never use a female condom. Slightly more than 12% found it difficult to answer, which may be due to the fact that they don’t even know what a “female condom” is.

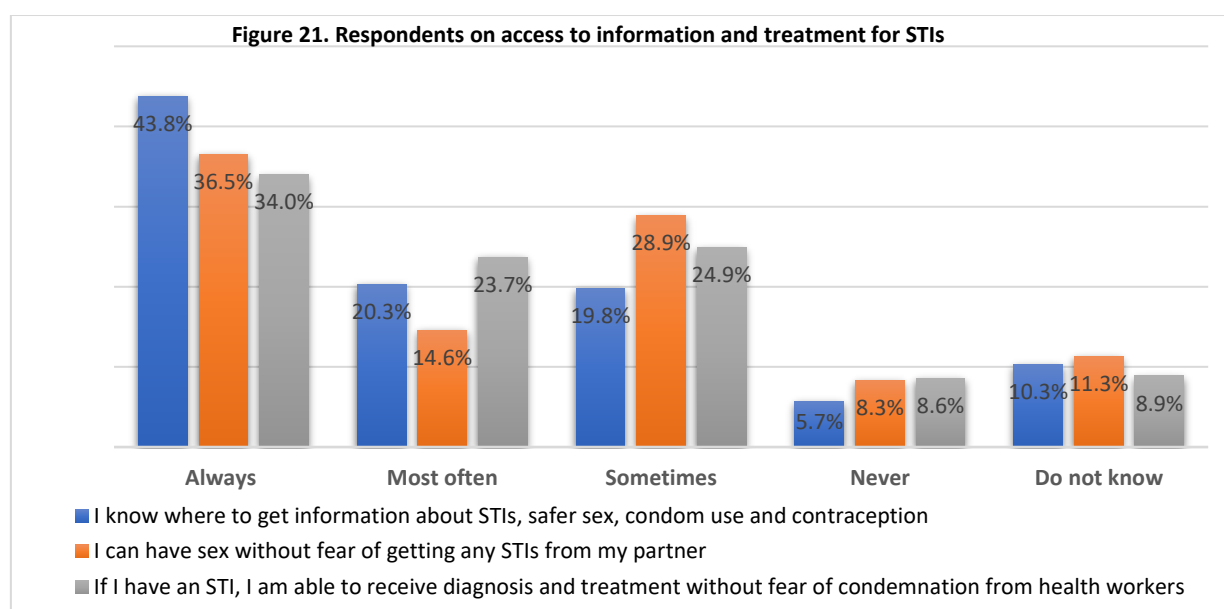
Judging by the responses of WLH, one of the reasons for not using it may be limited access to contraception. Only 63.2% of respondents have access to contraception always or most often. Every third woman either never has access to free products necessary for a pleasant sex life, including

Moreover, the access of young WLH aged 18-29 years, in comparison with older women, is more limited to free contraception. If among the age group of 18-29 years only 52% have access to these funds, then among the group of 40-49 years old 74%.

About 28% can always afford to buy products necessary for a pleasant sex life, most often just over 17%, sometimes about one out of every three WLH.

The spread of pseudo-religious stereotypes about the prohibition of contraceptive use may also affect the use of condoms. In this regard, in the work on HIV prevention among the population on the basis of cooperation with religious organizations, it is advisable to pay attention to the list of reasons adopted by religious legislators for which contraception is and is not allowed (see Appendix 4)⁷

For our respondents, the issues of regular screening for sexually transmitted infections (STIs) are very relevant, since only about 37% can constantly have sex without fear of getting any STIs from their partner. Most often this possibility is recorded in 14.6%. About 29% are confident in the safety of receiving STIs only occasionally. Just over 8% are never sure that they will not undergo STIs. Over 11% found it difficult to assess this situation.



At the same time, only about one in three women is fully confident that in the case of an STI, she will be able to receive diagnosis and treatment without fear of condemnation from health workers. Most often, about 24% of women can receive adequate diagnosis and treatment of STIs. Every fifth respondent has such an opportunity only occasionally. At the same time, approximately 9% of women living with HIV believe that they will never be able to get the necessary STI services without the conviction of health workers.

With access to information about sexually transmitted infections, safer sex, the use of condoms and contraceptives, the picture is fixed a little better. Almost 44% know exactly where to get the information they need about STIs. Just over 20% most often know these sources. But at the same time, a rather large group of women living with HIV who only sometimes know these sources, either never know at all, or find it difficult to assess their capabilities (19.8%, 5.7%, and 10.3%, respectively).

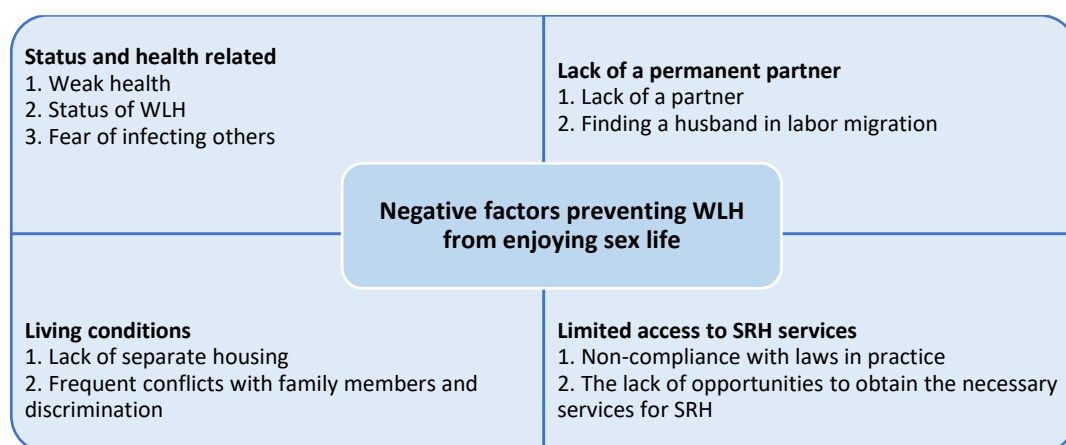
⁷ Abdel Rahim Omran. Family planning in the interpretation of Islam. Translation from English. Dushanbe, 2001, p. 53-54.

It should be noted that age, place of residence, as a rule, does not have a significant impact on certain issues regarding safe sex and obtaining services. The only thing that should be noted is a higher level of awareness among younger women living with HIV about sources of information about STIs.

Among the factors that most affect the awareness and availability of various services in the field of safe sex is the level of education of respondents. The higher the level of education, the wider the opportunities. For example, while among women living with HIV with higher education, 75% know where to get the information they need about sexually transmitted infections, among respondents without education or with primary education, only 37%.

All the negative factors that prevent WLH from enjoying a sex life can be grouped into four groups: those related to status and health, lack of a partner, living conditions and limited access to SRH services. A considerable part of respondents (20%) found it difficult to identify the most significant factors.

Figure 22. Negative factors preventing WLH from enjoying a sex life.



According to the vast majority of focus group participants, one of the most pressing problems of women living with HIV is the problem of housing. As a rule, even married women live in the house of the husband's parents, who is registered as their new parents or husband's brothers and other relatives. Because of this, family conflicts and scandals very often arise. Often, after relatives find out about the status, a woman with children is simply expelled from the house.

Among the positive factors that help or which can help a woman have a pleasant sex life, most often indicated by hierarchy, and were called such as:

- ✓ Husband / partner support
- ✓ Good health of the woman herself and the partner
- ✓ get married
- ✓ Be equal with your husband
- ✓ Separate housing from the parents of the husband / my parents
- ✓ Lack of fear to infect a partner, etc.

According to a survey on sexual health and safety, WLH are most in need of psychological assistance. Moreover, they are very interested in creating or expanding mutual assistance groups, receiving support from public and other organizations to help build mutual understanding with

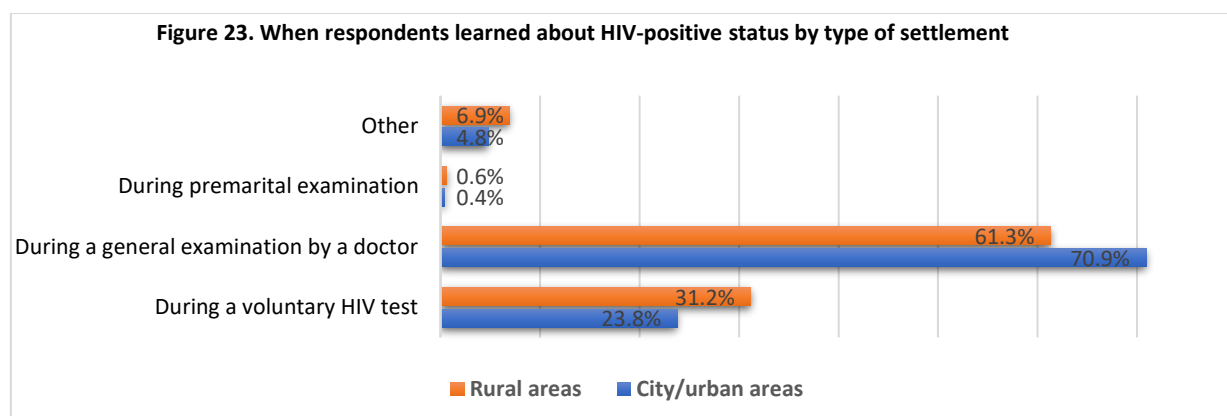
family members and relatives. Legal assistance in solving various family and other problems is no less popular.

5.2. Pregnancy and the ability to become pregnant (fertility)

The responsible attitude of women to pregnancy issues, whether it is from the general population or women living with HIV, is a key condition for the birth of a healthy baby. Moreover, responsibility should be manifested not only at the cognitive level, but also at the emotional and behavioral levels.

The importance of observing this condition is further highlighted against the background of information received regarding testing during pregnancy and the presence of unplanned pregnancies. According to respondents' answers, only every second woman was tested voluntarily for HIV during pregnancy. Moreover, almost every second woman had one or more unplanned pregnancies.

The vast majority of respondents found out about their HIV-positive status during the general examination (66.8%). During a voluntary HIV test, only 27 % found out about their status. According to the data obtained, among rural women there are a higher proportion of respondents who found out about their HIV-positive status during voluntary HIV testing.



Significant differences are recorded on this issue by regions. If in Dushanbe during voluntary testing, 14% found out, in Khatlon region - 9%, then in Sughd region - 36%, in RSA - 49%. Moreover, during pregnancy, a greater number of women living with HIV learned about their HIV-positive status in Khatlon region (39%) and RSA (31%), compared with Dushanbe (24%) and Sughd region (21%).

By definition of the World Health Organization (WHO), reproductive health is a state of complete physical, mental and social well-being, and not just the absence of diseases in all areas related to the reproductive system, its functions and processes. Reproductive health, as described in the Program of Action of the International Conference on Population and Development, is associated with the ability to have children and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health goods, services, institutions and information, allowing individuals to make informed, free and responsible decisions regarding their reproductive behavior.⁸

⁸ See Program of Action of the International Conference on Population and Development, chapter 7.

Women with HIV have the same right as all women to make a choice: whether they want to have children and if they want, then when. And to make this choice in a safe and supportive environment, knowing that they can be healthy mothers of healthy children. Or, on the contrary, to have support in their choice not to have children if they do not want it.

According to the majority of women surveyed living with HIV (76.3%), they can make a choice and decide **to have a child** (first, second, etc.) without fear of what people will say. At the same time, the number of women in deciding **not to have a child** without looking at others is slightly less (68.6%).

It should be noted that the decision to refuse to have a child does not have a significant place of residence (city and village), but some differences are recorded by age. The young age cohort of 18-29 years, in comparison with the group of 30-49 years, is more difficult to decide on this step.

It is very important that the majority of respondents received support in deciding whether or not to have children, both from the partner (80.8%), the family (73.5%), and the medical worker (71.1%). It should be noted that urban health workers and family members, compared with rural, more often supported women in this decision.

However, a significant part of WLH interviewed was subjected to pressure from relatives and medical workers when deciding to have a child.

During pregnancy, I turned to our clinic. The gynecologist in every possible way persuaded me to have an abortion and said that why give birth to a sick child, live for yourself. I did not listen to her, I gave birth to a healthy child. When I was in the maternity hospital for preservation, the nurse, when she found out about my diagnosis, forbade me to go to the public toilet because I have HIV.

WLH, 39 years old, Dushanbe, has 4 children.

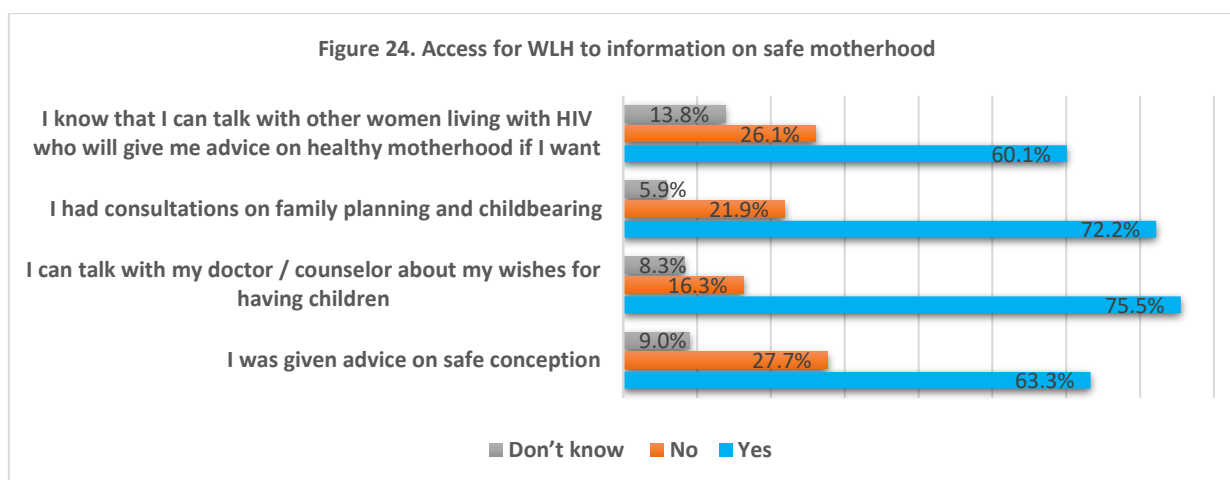
I wanted a baby, and I consulted with my husband. We both have HIV positive status. He was positively inclined and so were his parents. But my parents did their best to oppose our decision, explaining that we don't need a sick child. They thought that if I give birth to a child he will be a pathologically sick child. They brought doctors for consultation, who confirmed the words of my parents that I would have a sick child because of my positive HIV status. But despite their concerns, my child was born healthy, and he is without HIV status.

WLH, 34 years old, Rudaki district, has 3 children,

I became pregnant after infection. At first, AIDS Center employees discouraged me from giving birth. They told me why would I need this, a child can be born sick or die. My husband supported me, he really wanted a child. And the employees of a public organization who invited me to a mutual assistance group explained to me that if I take medicine and give birth by caesarean section, the child will be healthy. But, unfortunately, the baby died immediately after birth.

WLH, Khujand, has 1 child

The right to reproductive health includes both the right of men and women to receive information and access to safe and effective birth control methods of their choice, as well as the right to access appropriate health services that can ensure women have a safe pregnancy and childbirth, and also create for couples the best opportunities in order to have a healthy baby.



It is noteworthy that the majority of women living with HIV were able to exercise their right to receive information on safe and effective methods of birth control in accordance with their choice, thanks to the efforts of doctors and health workers.

Over 72% of respondents indicated that they had consulted on family planning and childbearing issues. Consultations on safe conception received 63.3%. About 76% can talk with their doctor / counselor about desires for having children. A little over 60% can talk with other women living with HIV if they wish, who will give them advice on healthy motherhood.

As the results of the survey showed, indicators on access to treatment, compared with services according to information, are already significantly lower. According to the data presented in Table 6, only 54.1% received assistance with safe conception (that is, without exposing a woman or her partner to the risk of transmitting HIV or other STIs). Only every second woman was able to choose a medical institution where to give birth to a child. About 56% received support in making decisions on how to feed a baby without fear of what people would say.

Table 8. Respondents' assessment of access to services related to pregnancy and childbirth (in%).

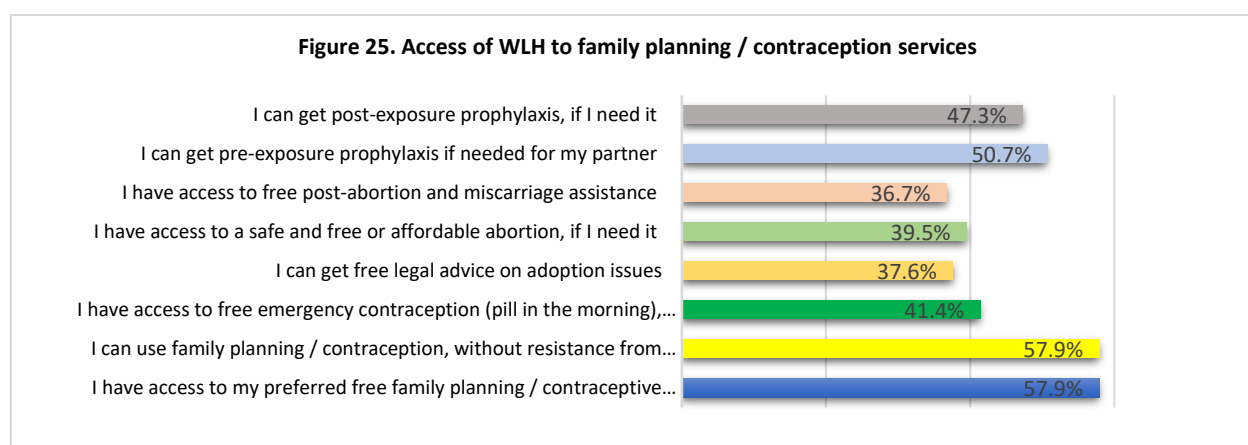
	Yes	No	Do not know
I was helped with a safe conception (i.e. without putting me or my partner at risk of transmitting HIV or other STIs)	54,3	36,0	9,7
I got / can get free infertility treatment, assisted reproductive technology, if I need it	23,1	50,2	26,7
I could choose where to give birth to my baby	51,8	41,3	6,9
I was supported in deciding how to feed my baby without fear of what people would say	55,6	30,7	13,7
I regularly undergo routine examinations / smears for cytology for early diagnosis of cervical cancer	31,9	62,4	5,7
I regularly have gynecologist examinations	25,9	68,9	5,2

The most critical situation is the access of WLH to free infertility treatment services and assisted reproductive technologies. Only 23.1% of respondents received or will be able to receive, if

desired, this type of service. Every second woman claims that she does not have access to this type of treatment, and about 27% find it difficult to answer.

The situation with respondents' access to diagnostic services for the most common oncological diseases of cervical cancer (31.9%) and breast cancer (25.9%) is not better.

The realization of the right to choose women “not to have a child” is closely connected with a whole range of services in the field of SRH. The data presented in Figure 25 demonstrate that among women living with HIV, they have access to preferred free family planning / contraception services and can use family planning / contraception, without resistance from partner (s) only about 58%. For other types of family planning services, respondents have even fewer opportunities (from 36.7% to 50.7%).



It should be noted that according to the respondents, on average, only every second woman living with HIV can receive pre-exposure and post-exposure prophylaxis if she or her partner needs it.

From the UNAIDS Terminology Guide. 2015, p.24.41.

Pre-exposure prophylaxis refers to antiretroviral drugs prescribed before contact or possible contact with an HIV source. A series of studies have shown that a daily oral dose of suitable antiretroviral drugs can reduce the risk of HIV infection through sexual or injecting routes for both men and women.

Post-exposure prophylaxis refers to antiretroviral drugs taken after exposure or possible exposure to an HIV source. Contact with the source can occur as a result of professional activity, as in the case of injury as a result of careless handling of needles, or for reasons not related to professional activity, as in unprotected sex with a partner who has HIV infection.

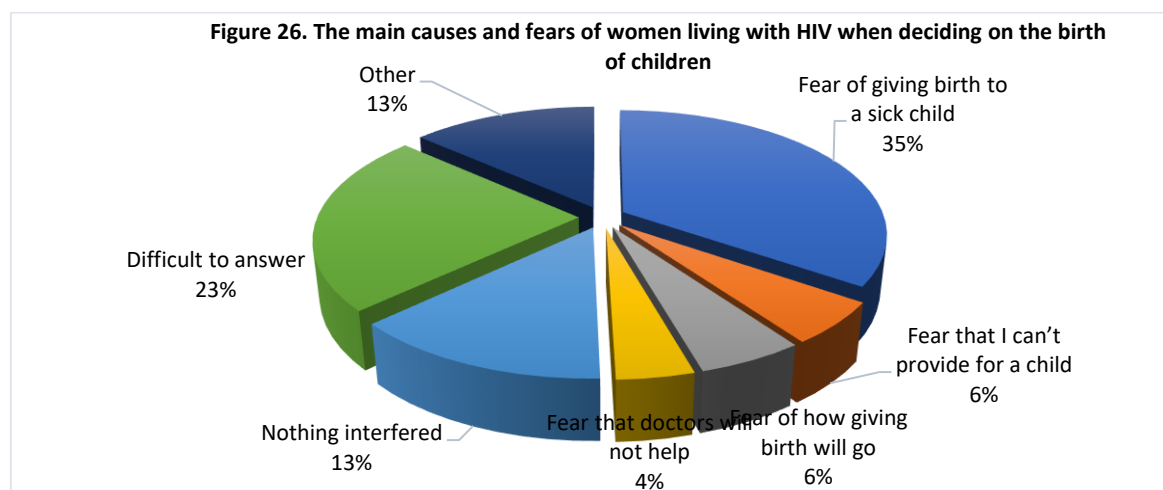
HIV can pass from mother to child during gestation, during childbirth, or with breast milk. According to various estimates, if the mother is HIV-positive, then without special preventive measures, the risk of transmitting the infection to the baby during pregnancy and childbirth is 20 - 45%. Existing prophylaxis with antiretroviral therapy, adequate viral load delivery and refusal of breastfeeding can reduce the risk of HIV transmission by 1-2%.

Among the expected results of the National Program to Combat the HIV Epidemic in the Republic of Tajikistan for 2017-2020, one of the key results is directly related to mother-to-child transmission of HIV: 1.2. Reducing the level of transmission of human immunodeficiency virus from mother to child to 2% or less by the end of 2020.

According to the results of the survey, one in three women surveyed did not take ARVs throughout their pregnancy. At the time of conception, according to the respondents, 44.1% received ARV therapy. Just over 45% started taking ARVs as a preventive measure during pregnancy. The use of prophylaxis only in childbirth is typical for 18.3% of women living with HIV. When interpreting these data, it must be taken into account that the survey involved respondents who were pregnant in various years, including before 2014.

Respondents' replies to the prevention of children of women living with HIV also record non-comforting results. About 60% of infants took syrup in the early days of life. Less than half of children (47%) are provided with artificial mixtures from children's clinics / AIDS centers. PCR analysis was done for children under 2 months of age in 60% of women living with HIV.⁹

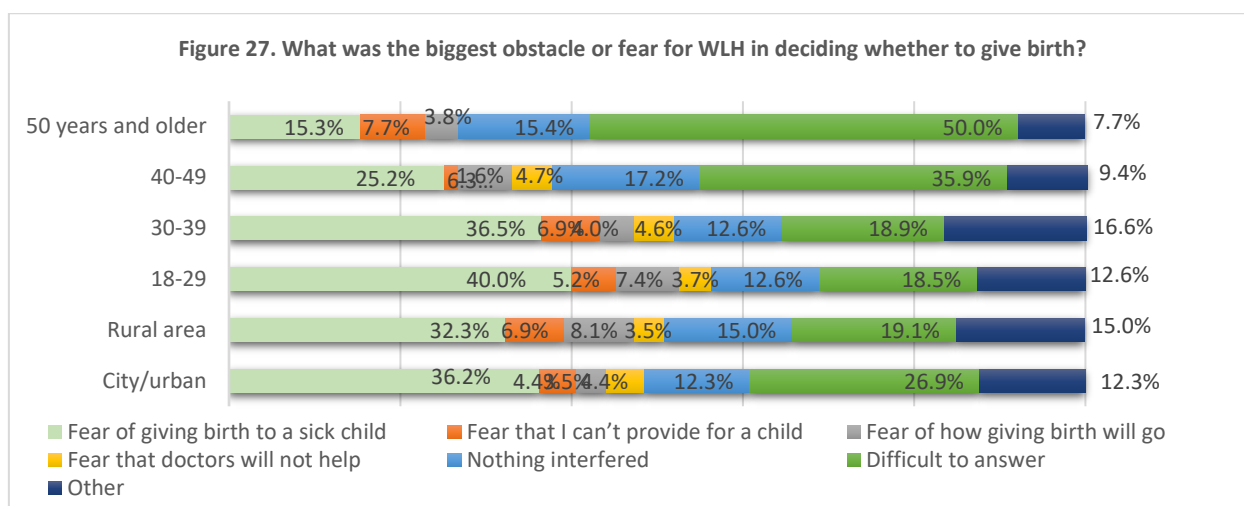
The results of the survey show that the rights of women living with HIV in SRH are often violated, women's access to SRH services is limited for many reasons, sexual relations are complicated due to problems negotiating safe sex with a partner, etc. For a woman to decide the child is often pressured by the partner, relatives, unskilled health workers and others. As a result, most women experience fears and doubts. The decision to have or not have a child is dominated by the fear of having a sick child. In addition to it, women worry: “what if the doctors will not help”, “it is not known how the delivery will take place”, “can I provide for the baby”, etc.



Only not a large part of the respondents indicated that they did not interfere with the decision to have or not have a child (about 14%). The place of residence of the respondents (city or village) did not significantly affect the responses of the respondents. Both among urban (36.2%) and rural women (32.3%), the list of various reasons contains the largest number of respondents, over whom there was a fear that they would give birth to a sick child.

However, the age factor differentiated women's experiences. If in the age group of 18-29 years the key reason was the fear of giving birth to a sick child - in 40%, 30-39 years old - in 36.5%, then among 40-49 years old - 25.2% and in the group of 50 years and older - 15.3%. A significant number of respondents from groups older than 40 found it difficult to identify the causes and fears of their experiences.

⁹ **Polymerase chain reaction** - a blood test that allows you to determine the presence of infection by an infection in the body with a small percentage of errors. The practical essence of this test method in the analysis of molecules of deoxyribonucleic and ribonucleic acids.



Therefore, it is not by chance that the respondents, irrespective of their place of residence, age, education, or other factors, especially indicated the need for psychological support.

5.3. Violence and discrimination against women

Violence and discrimination against women living with HIV is a widespread practice. Gender-based violence against women living with HIV is a consequence of the impact of the existing gender relations system in Tajikistan. On the other hand, women living with HIV are subjected to violence not only on the basis of gender of women, but also on belonging to a group with HIV-positive status.

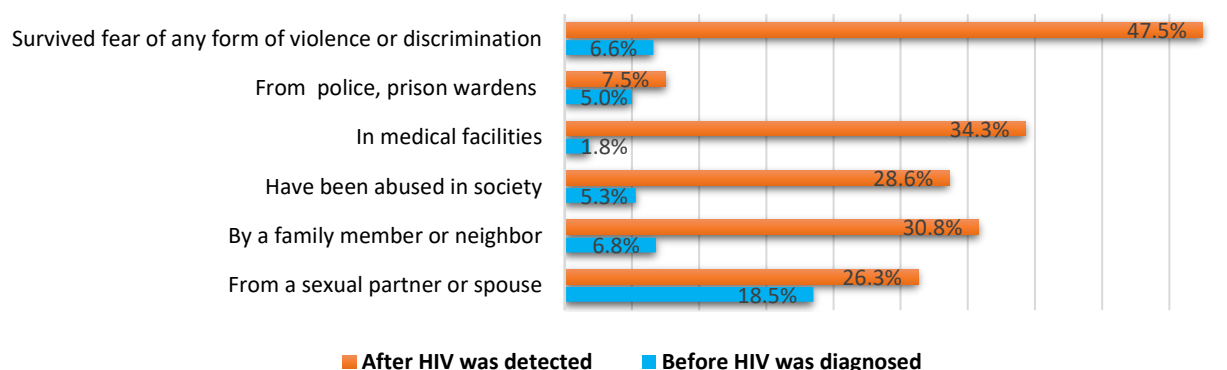
Economic Commission for Europe. Beijing + 25 Regional Implementation Review Meeting. Geneva, October 29 and 30, 2019. Ending violence against women and girls: lessons and decisions from the ECE region (includes Central Asian countries).

2. Violence against women and girls is a persistent and growing phenomenon that causes significant harm to women, children and society as a whole. Globally, one in three women continues to suffer from intimate partner violence. Patriarchal norms, discriminatory gender functions, gender discrimination and societal tolerance of violence against women and girls are still widespread in the region, hindering women's access to justice and reducing the effectiveness of government responses.

The UN Committee on Economic, Social and Cultural Rights, in its general comment No. 22 (2016) on the right to sexual and reproductive health, emphasizes that *“Individuals may be disproportionately subject to cross-discrimination in the context of sexual and reproductive health such groups as, in particular, poor women, people with disabilities, migrants, and people living with HIV / AIDS are most often subjected to multiple discrimination. ”*

According to the survey, cases of violence and discrimination against interviewed women living with HIV by various people and organizations after the detection of HIV-positive status increased significantly. WLH are subject to discrimination and violence both in the family and society, and on the part of an intimate partner, and on the part of other family members, and on the part of health workers, and by police officers, etc.

Figure 28. The manifestation of violence and discrimination against women interviewed living with HIV by various people and organizations before and after detection of HIV-positive status



If before the detection of HIV, violence by family members or a neighbor was experienced by 6.8% of respondents, then after establishing HIV-positive status, 4.5 times more - 30.8%. The number of WLH who have experienced violence in society has increased more than five times (5.3% and 28.6%, respectively). Particularly noteworthy is the huge increase in the manifestation of discrimination against women when accessing medical institutions from 2% to 34%. Under the influence of all this, almost every second woman living with HIV has experienced fear of any form of violence or discrimination. While before the detection of HIV, only about 7% of respondents experienced this fear.

According to the survey, the focus of the group discussions of WLH are exposed to various forms of violence:

- ✓ Psychological violence in the form of insults, humiliations, isolation and more.
- ✓ To a different kind of prohibitions on pregnancy and childbirth, on taking ARV therapy, observation by doctors, etc.
- ✓ Physical violence in the form of beatings and beatings, as a result of which harm to health, even serious ones, is caused.
- ✓ Economic violence - they don't give money, restrict food, drive relatives of the husband out of the house, and do not accept the parents and relatives of women living with HIV and others in the house.

Despite the fact that her husband is often the source of HIV infection for a woman, she is subjected to violence and discrimination by her husband, parents and relatives of her husband. Violence is committed not only on the part of the husband, the husband's brothers, but also on the part of the mother-in-law, sister-in-law, and wives of the husband's brothers.

I was constantly abused by my ex-husband. He beat me half to death. Once he threw an iron on me, and it hit me right in the head. I fainted, but no one helped me at this time. My husband beat me constantly and called me infectious. My mother-in-law did not let me to the dastarkhan (dinner table), did not allow me to sit and eat with them. She said do not sit down with us, you can infect us., The most annoying thing is that my husband was HIV infected, but never supported me, but on the contrary always humiliated me.
WLH, 42 years old, Nurek, divorced.

The husband scoffed and beat me. I did not know where to turn to, he himself infected me, but did not consider himself guilty. There were cases when I closed the door and left home, I was

left without food, hungry and helpless. Once he tied me to a pole with a rope and after that he left, and I was hungry for two days. After such an attitude and bullying of my husband I was left helplessness, so I decided to return to my parents' house. But the situation did not improve; my brothers discriminated against me. They told me, don't sit down with us, don't eat with us, you can infect us. My mom was also against me and would say it would be better if I was not born in our family.

WLH, 21 years old, Kulyab

During the study, many cases were revealed when a woman was simply kicked out of the house, the children were taken away and they were not allowed to see their children.

I don't know how and from where I got infected with HIV. After I was diagnosed, my husband's family found out about my status. My husband did not support me; he kicked me out of the house. They disgraced me in front of all the neighbors and still whoever they see from my friends tell them that I live with HIV. They took my children from me, turned them against me and do not let me see them. They made sure that the children did not see me, telling about me everything that is bad in the world, which is probably why my children avoid me.

WLH, Shakhrinau, 35 years old.

Four women living with HIV participating in the focus group spoke of terrible cases of physical and psychological abuse by their husbands- drug users. However, neither the mother-in-law, nor the husband's brothers, nor other relatives protected them.

The spread of violence against WLH in the family is facilitated by the impact of a whole range of factors: socio-economic, socio-cultural and socio-psychological. The long-term effects of a number of negative factors on men and other family members, such as job loss, or its complete absence, gender stereotypes, as well as the use of alcohol, drugs and others negatively affect the situation of the family and contribute to cruelty towards women living with HIV. Violence by men against women is a direct consequence of the existing inequality in relations between them, which gives rise to the conviction of men in the need to ensure and maintain their power and control in family relations.

Many WLH did not find support and help from their parents or relatives.

After my relatives found out that I was HIV-infected, everyone refused me. And my brother drove me out of the house by force. When I went to my relatives, they didn't accept me there either, everyone said that I was sick and had a lot of other insulting words.

At work, as soon as it became known that I was HIV positive, I was immediately fired. I did not know what to do, I was left without work. Somehow I wanted to go to work to get my things, but the security did not let me in. Moreover, the guard first pushed me hard and I fell, and after I got up he hit me and said "if you come here again, he will treat me even worse."

WLH, 34 years old, Rudaki district, now lives in dormitory in Dushanbe, has 3 children

Violence and discrimination WLH also experience from police officers. The study participants said that when they turned to them for help, they, on the contrary, scared and humiliated them. In addition, in violation of basic rights, acquaintances of WLH were phoned and talked to about their status and demanded that acquaintances be tested for HIV as well.

When I encountered a case of violence and discrimination based on HIV status, I turned to the police. But there, I could not find help. The police department did not accept my statement and said that no one was to blame for me being sick and only when I was beaten or killed then I could come and turn to them.

WLH, 40 years old, Dushanbe.

The police officers, taking my data from the AIDS Center, without my knowledge, made details of my calls. They called all my friends and relatives. They called everyone who was in the contacts of my phone to the police station, sent them for an HIV test, revealed my status to everyone, took explanatory letters from them - who they were and who they were talking to about me. Then they called me to the department. They asked whom and why I called, accused me of infecting other people, threatened me, and said that they would put me in jail. I went to the AIDS Center. They supported me, reassured me, gave me a good characteristics letter, and the police officers apologized and let me go.
WLH, Kulyab, 24 years old.

The attending doctors were given mostly positive reviews. Some respondents said and were very grateful to the doctors from the general system of medical facilities.

Not long ago I applied to the center for reproductive health and I was struck by how the medical staff behaved. Despite the fact that they are all qualified doctors, they were afraid to come to me and turned to me as a leper because of my positive HIV status. They stigmatized me and in the end redirected me to an epidemiologist, referring to the fact that I must go to him first. At the same time, I had all the documents, and I also provided them with a certificate of an undetectable viral load. But, despite this, they did not accept me. Most of all I was hurt by their lack of professionalism and the fact that it was the doctors who stigmatized me. WLH, 28 years old.

When I was in the hospital, I told about my status to the midwife who attended me. She, in turn, told my situation to my neighbor, and she in turn, told the whole house. My neighbors began to terrorize me, saying that I was sick and will infect others. My friend, knowing about my status, brought me her children to watch over them. But my neighbors and the district police all the time would tell me that I should not look after other people's children. I began to invite tenants at my house for extra income; the apartment complex manager told the tenants that I was infected. They wouldn't let me earn for living. If I took children home to watch as a nanny, they would tell the parents of these children that I was sick and that I should not communicate with the children. If I let tenants in, the neighbors reported my illness to the tenants. None of the relatives communicate with me after they found out about my status, neither relatives nor neighbors invite me to any events. They completely separated me from society. I constantly cried, resentment, shame in front of neighbors and relatives, sometimes there is a desire to commit suicide. I can't work anywhere. I am constantly afraid that they will find out and drive me out again. WLH, 30 years old, Gissar, 1 child.

I went to the optometrist of the regional hospital. He examined me and prescribed treatment. Before leaving, I told him about my HIV status. The doctor told me to come on Monday. When I arrived on Monday, the doctor told me that I was healthy and everything was in order. I turned to the Regional Healthcare supervisor for AIDS. She called the head doctor of the regional hospital to receive and treat me. The head doctor directed me to another doctor, that doctor sent me to the third. And the third doctor said to come again on Monday. After that, I did not go to the hospital anymore. I was afraid that after my complaint they would make my situation worse.

WLH, 45 years old, Khujand

5.4.Mental Health and HIV

Mental health problems are closely linked to HIV. Only in isolated cases can HIV-infected people be psychologically prepared for the situation.

If before the detection of HIV infection, not a large part of women living with HIV showed some kind of mental health disorder, then after detecting HIV, these disorders are practically characteristic of the majority. As can be seen from the data in table 9, the vast majority of respondents experience a state of depression, shame, confusion, a feeling of helplessness, the inability to independently understand the situation and decide on their future plans.

Judging by the responses of the respondents, the majority experienced an initial shock from receiving a positive HIV test and over 63% did not want to accept their diagnosis.

Table 9. Conditions experienced by WLH for a long period (more than 1 month), including due to an HIV diagnosis.

	Before I was diagnosed with HIV	From the time I was diagnosed with HIV	Due to HIV diagnoses	Never	Difficult to answer
Depression	26,3%	46,8%	17,3%	8,0%	1,8%
Shame	12,3%	43,5%	25,0%	15,8%	3,5%
Self-incrimination	6,3%	31,5%	21,3%	35,3%	5,8%
Problems of Low Self-Esteem	6,0%	33,5%	23,5%	31,0%	6,0%
Denial, unwillingness to accept your diagnosis	3,8%	51,0%	16,3%	21,8%	7,3%
Strong sense of isolation	6,5%	37,8%	23,8%	27,0%	5,0%
Anxiety / fear / panic attacks	9,3%	48,3%	26,3%	14,3%	2,0%
Insomnia / Sleep Problems	10,0%	41,8%	21,0%	23,5%	3,8%
Anorexia / Food Difficulties	12,3%	31,8%	17,8%	34,3%	4,0%
Difficulty with going out and staying in society	4,0%	29,8%	23,5%	37,5%	5,3%
Loneliness	5,5%	36,3%	20,8%	35,0%	2,5%
Suicidal thoughts	2,8%	24,0%	15,3%	54,5%	3,5%
Post-traumatic stress disorder	3,8%	31,8%	14,5%	43,8%	6,3%
Drug and / or alcohol abuse	2,3%	9,3%	3,8%	72,5%	12,3%

Emerging psychological difficulties and stigma, discrimination have no less impact on women than the disease itself. All this causes a lot of stress and difficulties in interpersonal communication with other people, a fear of infecting your partner, fear that everyone will learn about her status. Any psychological problems affect a person's quality of life.

Over 64% of respondents noted that they experience depression for a long period, about 75% - anxiety, fear, about 62% depresses a strong sense of isolation, 57% have a state of loneliness and low self-esteem. About 40% experienced suicidal thoughts and desires.

After it turned out that I was HIV-infected, my husband left me. It turned out that he was healthy and was not infected with HIV. At first, I took the fact that he left me as a betrayal, but

then I began to stigmatize myself and was depressed for more than 2 months, at night I could not sleep, constantly thinking about suicide. But during that time I met good specialists who explained to me that HIV is not a death sentence and that many people live with HIV status.

WLH, Khujand, 26 years old.

I often have depression due to illness, when I feel bad, I think that I will probably die soon, because of this it becomes really bad. Here, in the city, only the AIDS Center knows about my status, my gynecologist and employees of a public organization. In my village no one knows my status, neither relatives nor neighbors. I'm constantly afraid that they will find out and they will turn away from me, drive me out of the house. Sometimes my health condition worsens and I don't know whether it is due to infection, or because of constant bad thoughts, depression, fear, shame and resentment.

WLH, Bokhtar, 23 years.

As already noted in the previous sections, women living with HIV have an acute need for psychological support, are interested in expanding self-help groups, in creating a 24-hour helpline, and more.

5.5.HIV treatment and side effects.

As part of the implementation of the UNAIDS Strategy for 2016–2021 “Accelerating Measures to End the AIDS Epidemic” and the National Program to Combat the Human Immunodeficiency Virus Epidemic in Tajikistan for 2017–2020, the coverage of PLHIV with antiretroviral therapy is expanding from year to year.

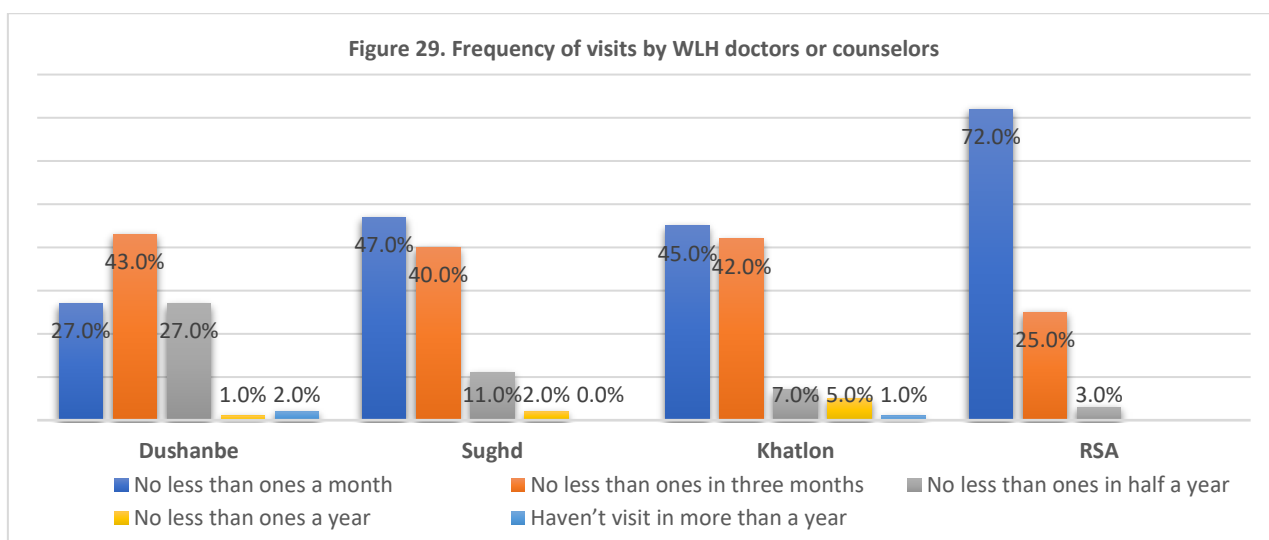
In order to reach as much as possible people living with HIV with life-saving treatment (ART), the country has switched to WHO recommendations for prescribing treatment (adults, adolescents, children) for treatment as soon as possible after they are diagnosed with HIV infection.

Antiretroviral therapy improves the health status of patients and can significantly increase the life expectancy of people living with HIV. Along with this, in recent years, convincing evidence has been accumulated in the world that receiving ARVs by patients prevents the sexual transmission of HIV to their partners, and also that the use of HIV ARVs by negative people in serodiscordant couples can protect them from infection.¹⁰

The vast majority of interviewed WLH try to more or less regularly visit doctors or HIV counselors. About 48% visit doctors at least once a month, about 38% - at least once every three months, 12% - at least once every six months. At the same time, 2% of respondents are at least once a year and less than 1% - more than a year.

As shown by a survey of WLH from rural areas, compared with urban women, they often pay visits to doctors. If among urban residents 40.5% are at least once a month, then among rural residents this figure is 57.2%. Also among rural respondents, the percentage of those who visit doctors with a longer interval is significantly less - more than three months (7.5%), compared with urban respondents (20.3%).

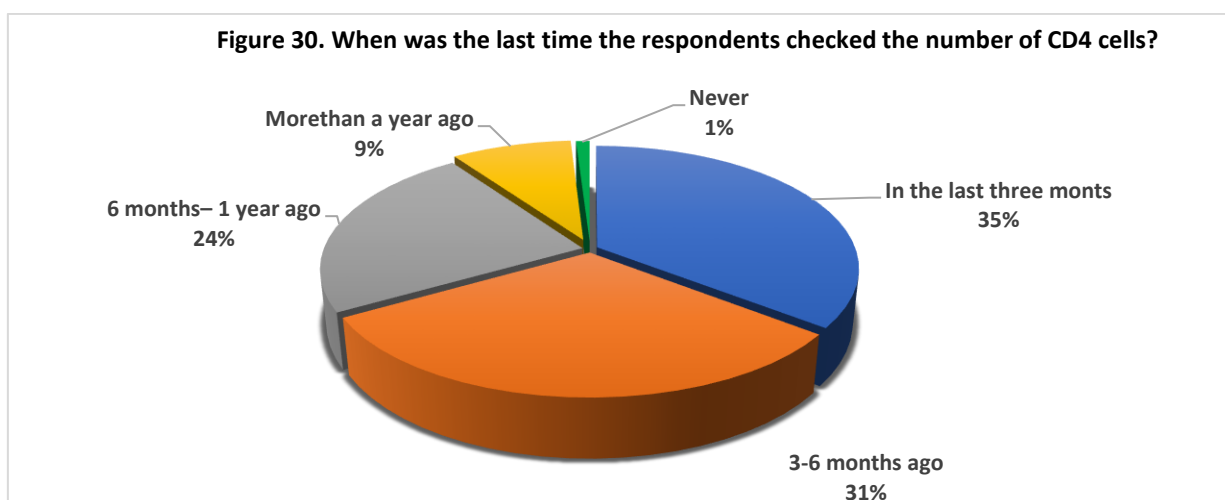
¹⁰See WHO. Consolidated guidelines for the use of antiretroviral drugs for the treatment and prevention of HIV infection. 2013. https://www.who.int/hiv/pub/guidelines/arv2013/short_summary/ru/



In the regional context, significant differences are noted. According to the respondents in the group of the most frequently visited doctors, the majority are people from RSA. The opposite group includes women living with HIV from Dushanbe.

The vast majority of respondents (98.5%) take ARVs. Of the 400 people, 6 people do not take ARV treatment. Of these: 3 people from Dushanbe, 2 from the RSA and 1 woman from the Sughd region. She named “I do not consider it necessary” as the reason for refusing ARV therapy.

To monitor and evaluate how HIV affects health, two types of tests are used: on the number of CD4 cells (shows how strong the immune system is) and on the viral load test (displays the amount of HIV virus in the blood). In this regard, it is very important for women living with HIV to undergo a regular check for the number of CD4 cells and viral load.

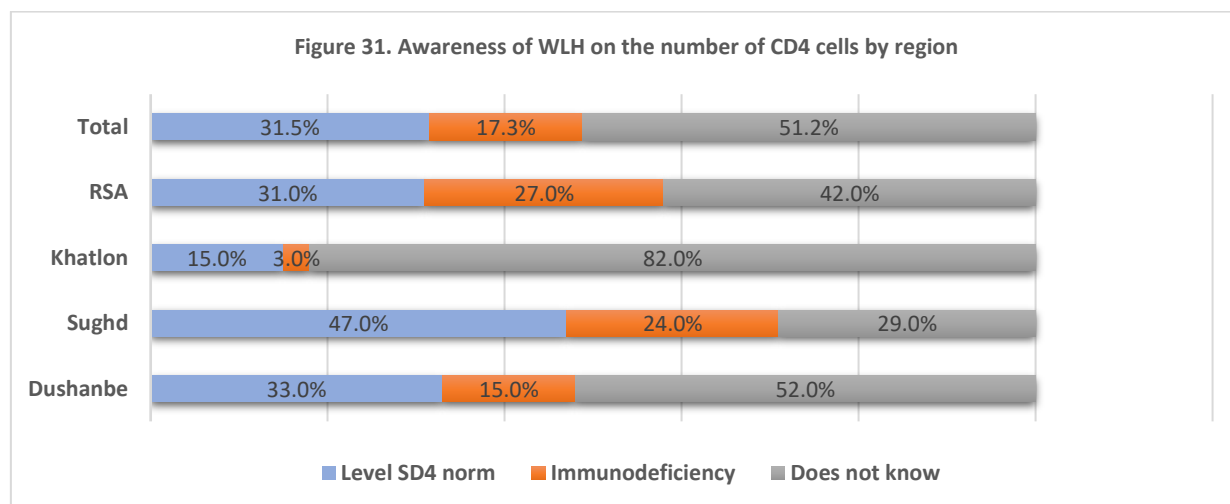


According to the data presented in Figure 30, just over one third of WLH (35.5%) last time checked the number of CD4 cells in the last three months, 31.3% - in the period from the last 3 to 6 months, about 24% - from 6 months to a year. Of concern is the group of respondents who tested more than a year ago (8.8%) and 1% (4 people), who have never checked the number of CD4 cells.

Among urban respondents, compared to rural respondents, the percentage of people who underwent the last test of the number of CD4 cells more than a year ago or never even passed the control is twice as large (respectively, the city: 11.0% and 1.3%, the village - 5.8% and 0.6%).

By regions, the largest number of respondents from the Sughd region, Dushanbe, are in the critical zone. According to WLH from Dushanbe, 10% last time they monitored the number of CD4 cells more than a year ago, and 3% never passed this test at all. Among the respondents in the Sughd region, these indicators are even worse: 17% - more than a year ago and 1% - never passed.

It is noteworthy that only about half of women know their level of CD4. Judging by the answers of the respondents, among informed women living with HIV, normal levels are only 31.5%, and 17.3% show immunodeficiency.

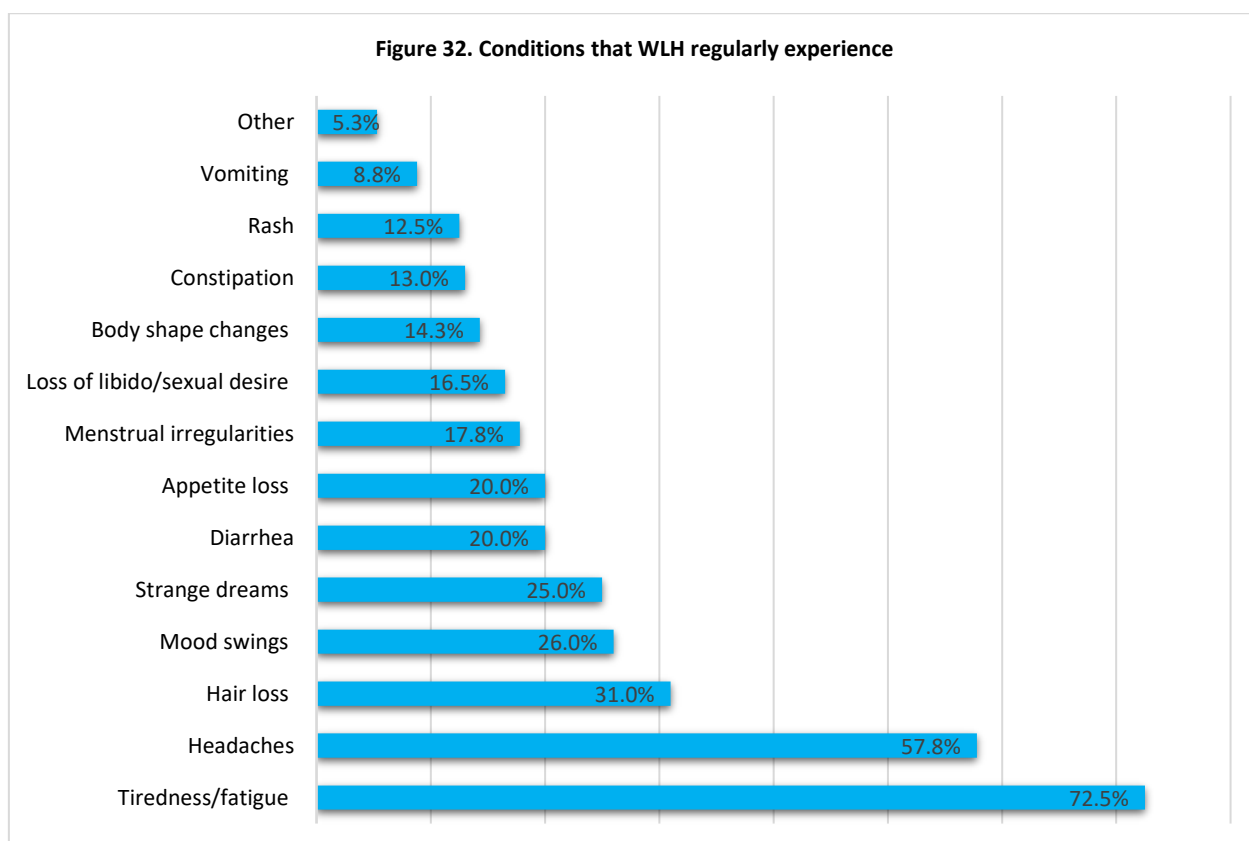


The type of settlement (city and village) did not have a particular impact on the level of awareness of respondents in this matter. However, by region, significant differences are recorded. As can be seen from the data presented in Figure 31, an extremely low level of awareness of their level of CD4 cells is observed among the respondents of the Khatlon region (18%). In the capital, Dushanbe, less than half (48%) of women living with HIV know the number of CD4 cells. In turn, respondents from the Sughd region showed a high level of awareness about the state of their immune system (71%).

According to the results of the survey, one in four women found it difficult to name the drugs they were taking. According to respondents who know the names of ARV drugs, more than half take TDF \ FTS \ EFY-30. The remaining answers were distributed as follows:

- ✓ TDF \ ZTS \ DTA-14 - 11.5%
- ✓ AZT \ ZTS \ EFY-4 - 6.0%
- ✓ AZT \ ZTS \ NYP-2 - 2.7%
- ✓ AZT / ZTS / LPY \ R-1 - 2.1%

As the survey showed, about 9% of respondents do not experience any side effects. However, the vast majority regularly experiences certain unpleasant conditions of the body. About 73% of women living with HIV complain of fatigue / fatigue. About 58% suffer from headaches. Also, the most common side effects, as Figure 32 clearly demonstrates, include hair loss, mood swings, strange dreams, etc.



According to the results of the survey, indicators for checking the viral load do not particularly differ from indicators for checking the number of CD4 cells. Altogether, over 94% were tested for viral load less than a year ago. Of these: 71.6% last tested less than six months ago, 23% - from 6 months to a year ago.

But there are also groups of WLH who took the test more than a year ago (4.3%) and generally never did (1.3%). As in the case of the first test, among them the largest number are respondents from Dushanbe - 8% passed the last time more than a year and 2% did not pass the test at all. But now women living with HIV from the Khatlon region have been added to them, among which 8% have also been tested for viral load last time more than a year.

As it turned out, about 37% of respondents do not know their viral load. At the same time, there is no difference between urban and rural respondents in this matter. While the region of residence acts as differentiating factors. Against the general background, respondents from Khatlon region stand out, among which 61% do not know their latest viral load. Then follow respondents from Dushanbe, among whom 36% do not know their latest viral load. Interviewees from RSA and Sughd regions showed a higher level of awareness. Among women living with HIV from Sughd, 22% do not know the viral load, and RSA - 37%.

One of the key factors affecting the level of knowledge and awareness of WLH is education. If among respondents without education and with primary education 69% do not know the number of CD4 cells, then among respondents with incomplete and higher education - 42%. The same picture is with knowledge of the level of viral load. While among respondents with incomplete and higher education 27.3% do not know their viral load, among respondents without education and with primary education this indicator reaches 45.5%.

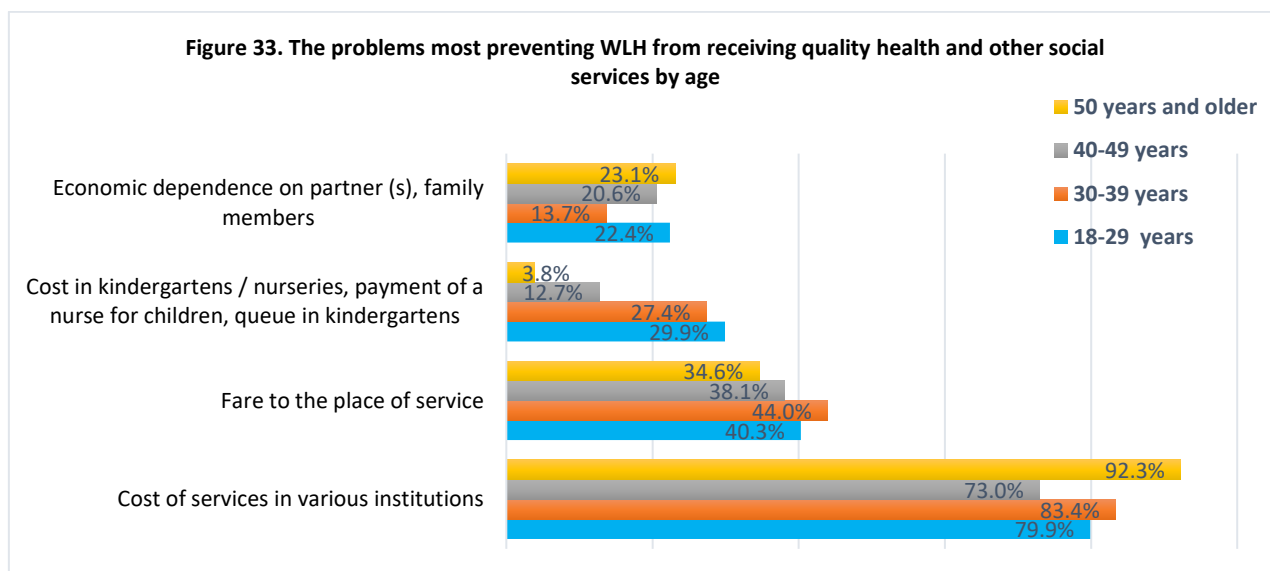
6. Social determinants of access for WLH to health and other social services

According to the WHO definition, the social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances (including health systems) are formed as a result of the distribution of money, power and resources at the global, national and local levels, which, in turn, are influenced by the current policy.¹¹

The social determinants of health are the main cause of inequalities, unfair and preventable differences in health observed within and between countries. In the public health system, the term “social determinants of health” is usually used to refer to a general concept that includes not only social factors affecting health, but also economic and cultural factors, the state of the environment, including those regulated by law and policy or social norms.¹²

The state of the SRHR of women living with HIV is strongly influenced by a number of social, cultural, political and economic factors. The following may interfere with the implementation of the SRHR, in particular: social norms that promote inequality between men and women; intimate partner violence and gender-based violence (NIP and GBV); stigma and discrimination; lack of rights and opportunities for women and girls; human rights violations; and the existence of restrictive and often repressive laws and policies that exacerbate the vulnerability of women living with HIV and limit their ability to achieve health and well-being and to exercise their rights. The same factors create significant barriers to obtaining and using high quality SRH and HIV services.¹³

According to the estimates of the interviewed WLH, access to high-quality medical and other social services is primarily affected by financial and economic factors. As can be seen from the data in Figure 33, regardless of age, among the problems, the LJW were ranked 1st and 2nd among the cost of services in various institutions and the cost of travel to the place of service. Next are issues related to payment for preschool institutions, nurses for children and economic dependence on partners, family members.



¹¹ https://www.who.int/social_determinants/ru/

¹² See: UNAIDS Terminology Guide. 2015, p.50

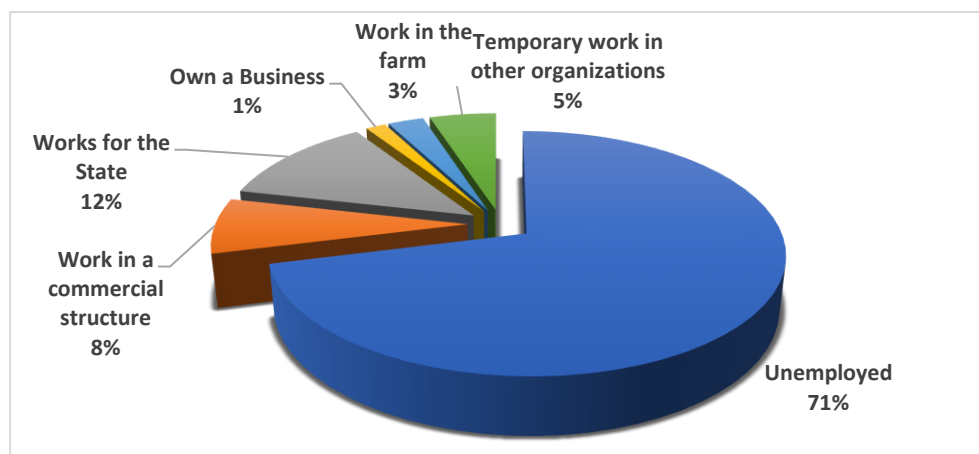
¹³ WHO. Consolidated Guidelines on Sexual and Reproductive Health and the Protection of the Rights of Women Living with HIV. 2018, p. 23. https://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/

Along with these problems, a significant proportion are problems associated with stigma and the violation of rights in the workplace due to HIV; by divorce, widowhood; with care of other family members, lack of support from the family, etc. (see Appendix 5).

Economic opportunities for WLH.

Only every fourth woman works in various institutions or studies. The remaining women do not work for various reasons. Moreover, approximately every second woman is a housewife. About 10% of respondents are unemployed or do not work due to health reasons

Figure 34. Employment status of respondents.



Of the total number of employees, only 59.3% work officially. In the city, the percentage of officially employed people is higher - 63.8%, in rural areas lower - 52.3%

Table 10. Employment status of respondents by type of settlement (in%).

	Total	City	Rural
Studying (student)	1,3	1,3	1,2
I work in a commercial structure	7,5	7,5	7,5
I work for the State	11,3	12,3	9,8
Engaged in business activities	1,5	1,8	1,2
I work in the farm	2,8	2,2	3,5
Unemployed (looking for work)	10,8	11,0	10,4
I do not work, due to health reasons	9,8	11,5	7,5
Housewife	49,0	44,5	54,9
Pensioner	1,0	1,3	0,6
Temporary, one-time work	5,0	6,6	3,4
Total	100,0	100,0	100,0

It is no coincidence that among the problems that impede receiving high-quality medical and other social services, women identified the problem of economic dependence on partners and family members. Every second respondent is a housewife. Along with this, some women are unemployed or do not work due to health reasons.

The decisive role in expanding the opportunities and competitiveness of women in the labor market is played by the availability of professional education and specialty. As already noted in the

description of the socio-demographic characteristics of our respondents, only about 21% of respondents have a vocational education, that is, they have some specialty. At the same time, only 8.3% of respondents have higher and incomplete higher education.

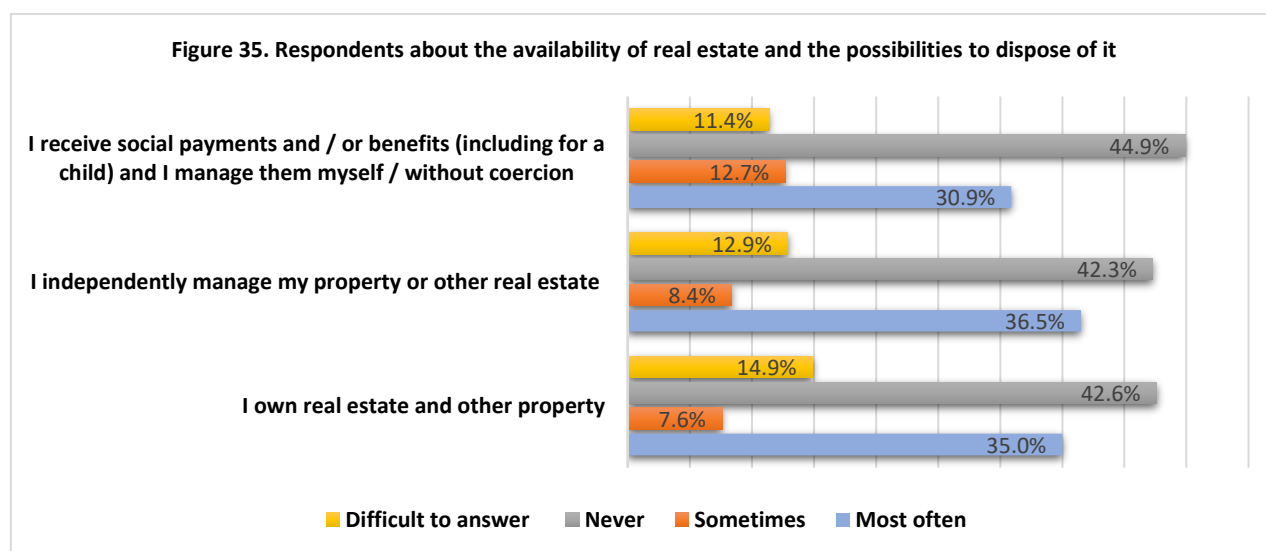
The limited economic opportunities of WLH are caused by the problems of gender inequality as a whole in the republic. While the proportion of men among the employed population of the republic increased from 53.4 percent in 2004 to 59.5 percent in 2016, the proportion of women significantly decreased from 46.6 percent in 2004 to 40.5 percent in 2016.¹⁴

According to the census, in 2010, the proportion of women among the employed population of the republic with vocational education is almost two times lower than men. Rural women have even fewer opportunities for professional education, not only in comparison with men, but also in comparison with urban women. According to the 2010 census, 39.1% of employed urban women have vocational education (higher, incomplete higher, secondary vocational), while among rural women only 8.7%.¹⁵

According to estimates of over 55% of respondents, they are constantly dependent on a partner. Every fourth woman noted that she is sometimes dependent on her partner.

Moreover, according to over 38% of respondents, the birth of a child affected her career at work and income. However, a little over 16% found it difficult to assess the impact of having a baby on their career and income.

According to the respondents, 35% own real estate and other property. About 8% can sometimes own real estate and other property. Moreover, only about 37% of them can independently dispose of this property. Less than half often receive social payments or benefits and can independently dispose of them. (see figure 35).



In a large proportion of WLH, the only source of income is the care for a sick child with HIV. Moreover, as a rule, respondents live in multi-generational families. The average household size

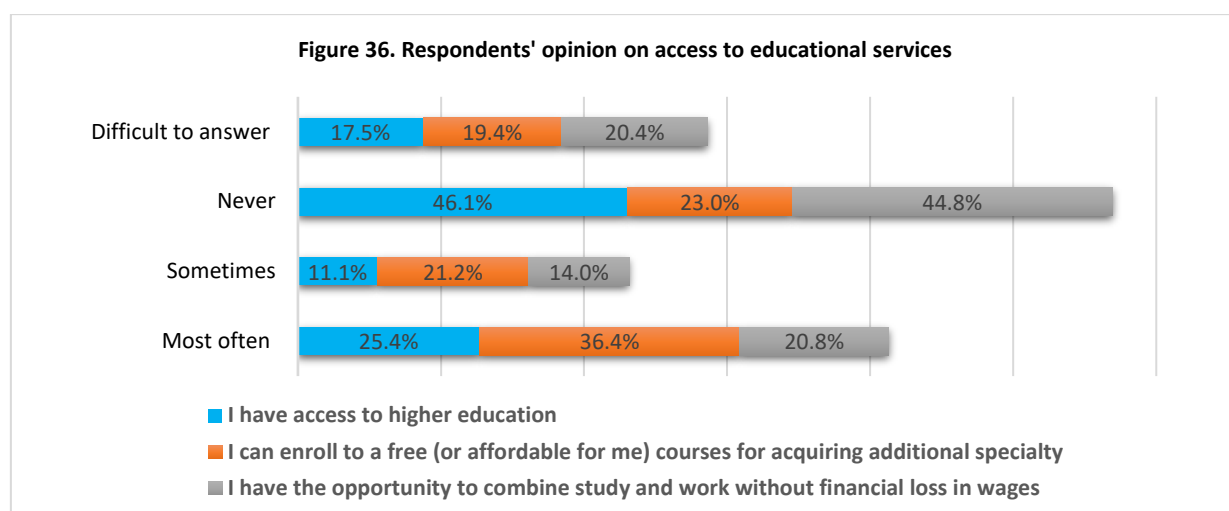
¹⁴ See: Agency for Statistics under the President of the Republic of Tajikistan. The situation on the labor market in the Republic of Tajikistan. (Report prepared on the basis of a labor force survey conducted from July 20 to August 20, 2016). Dushanbe. 2017. p.17

¹⁵ See: Agency for Statistics under the President of the Republic of Tajikistan. 2010 Population and Housing Census. The educational level of the population of the Republic of Tajikistan. Volume IV Dushanbe. 2012, p. 47

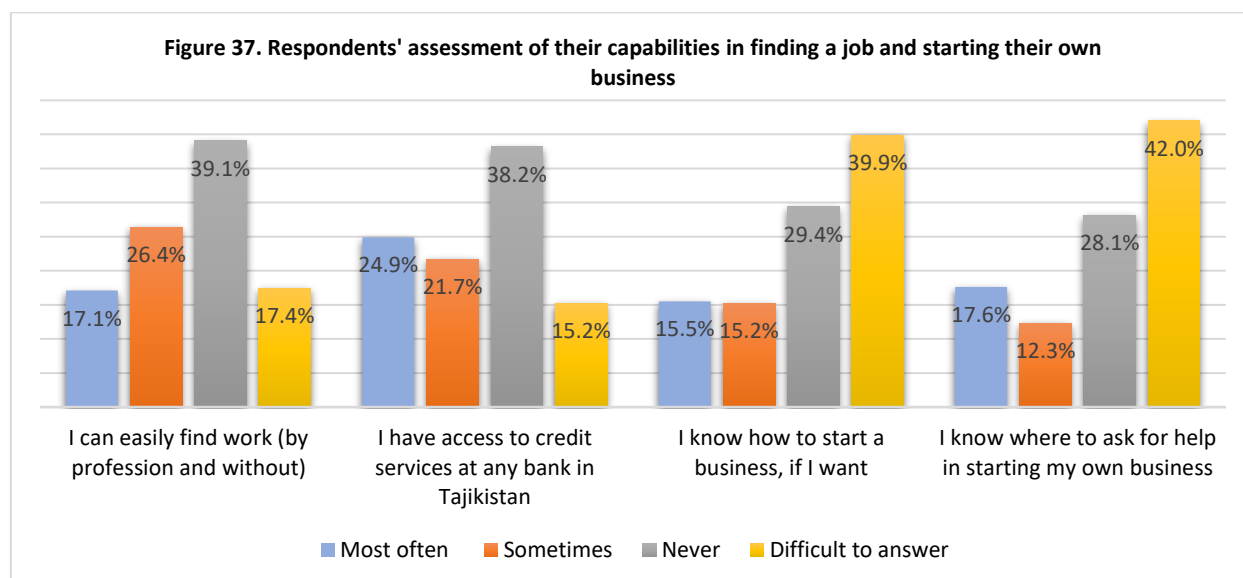
of urban respondents is 6.2 people, rural - 8.4 people. In households where women living with HIV live, the average income per family member per month is 296 somoni, which is approximately one dollar per day.

The results of the survey record the limited possibilities of respondents to obtain higher education or training in vocational education courses. Only one in four women is confident that she most often has access to higher education. While 46.1% said they could never have access to higher education. Difficult to answer this question 17.5%.

According to WLH, training in courses for an additional specialty / new skills is more accessible. Over 36% consider that they will be able to study at such courses. However, almost every fourth respondent is confident that she will never be able to take this opportunity. In addition, 19.4% found it difficult to assess their capabilities in this matter.



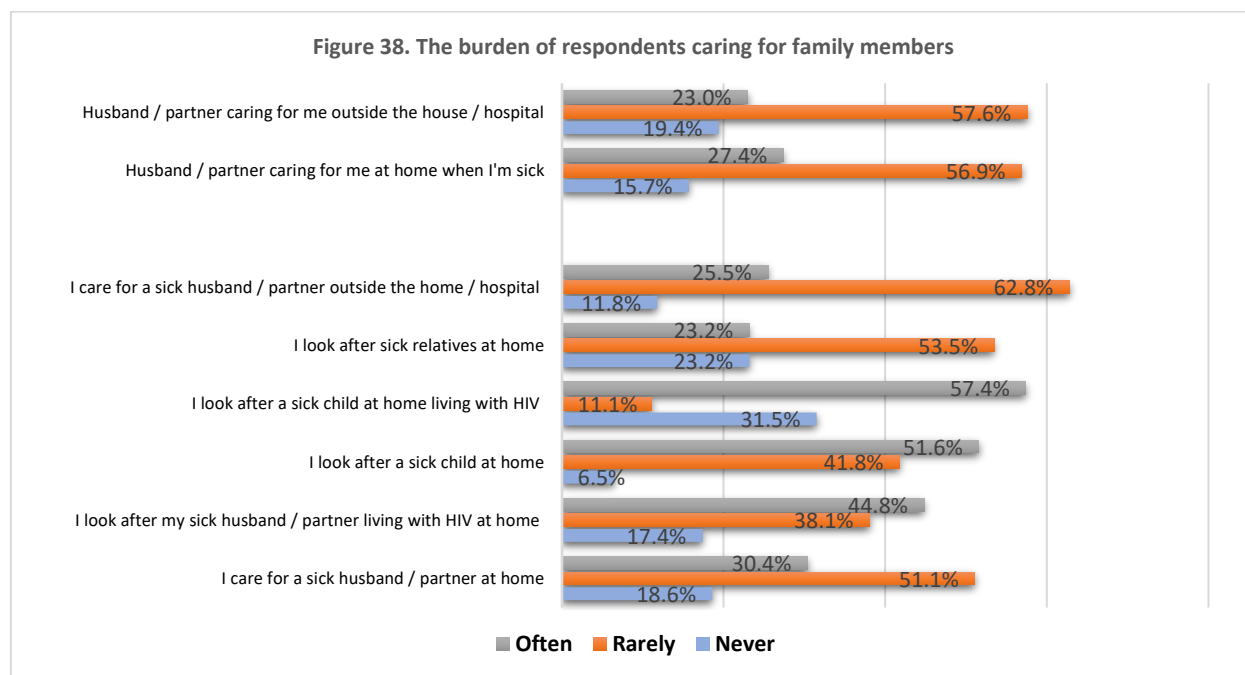
Judging by the answers of the respondents, shown in Figure 37, they are more likely to receive a loan from a bank than to find a job. One in four respondents believes that she has access to credit services at any bank in the country.



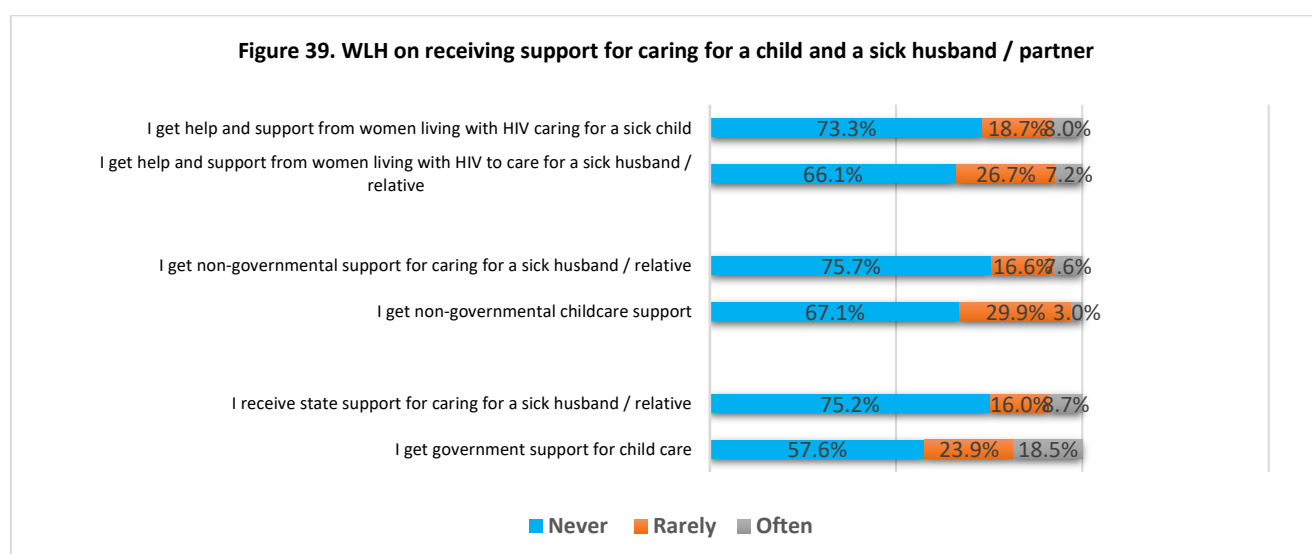
Only about 31% of WLH know how to start a business and about 30% know where to ask for help in starting a business.

Burden of care

As already noted above, according to respondents, among the reasons that impede their access to quality medical and other social services, there is an overload of women to care for family members. Over 93% of WLH often look after a sick child at home, and over 68% are caring for a child living with HIV. About 83% of respondents are caring for at home and about 89% away from home, in the hospital, for a sick husband / partner living with HIV. In addition, women living with HIV have to care for sick relatives at home.



At the same time, 84.3% of respondents noted that their husband / partner takes care of them at home when they are ill. About 81% of WLH receive care from their husband / partner outside the home, in the hospital.



The results of the study record the need for WLH to receive state and non-state support for caring for a child and a sick husband / partner. The data in Figure 39 clearly shows that only a small part

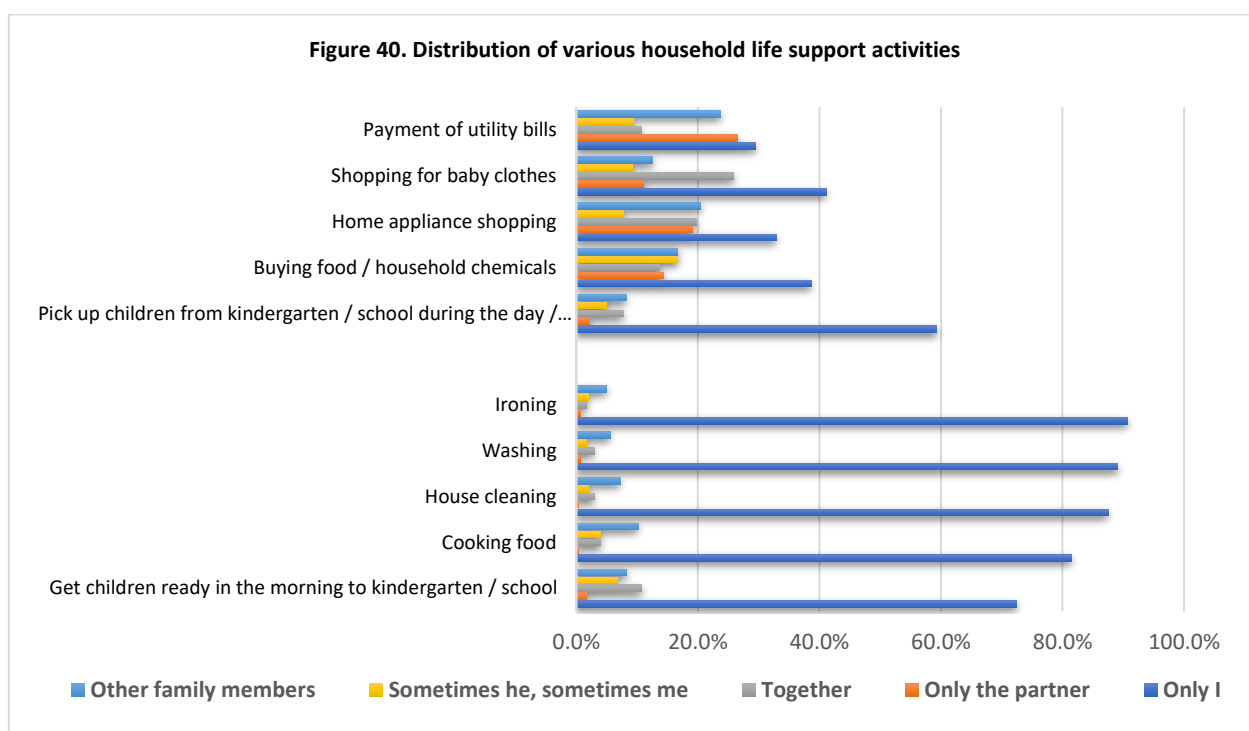
of the respondents often receive the necessary support. The overwhelming majority of women lack support, both from state structures and non-state ones.

In order to implement Art. 15 of the Law of the Republic of Tajikistan “On Counteracting the Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome”, a Decree of the Government of the Republic of Tajikistan “On approving the procedure for assigning and paying state benefits to children under the age of 16 who are infected with HIV or AIDS” was adopted (May 3, 2010 No. 232).

According to this Decree, from January 1, 2011, the payment of a monthly allowance is provided in the amount of seven times for calculation. Thus, in 2011, a monthly allowance in the amount of 245 somoni was paid to parents of children under 16 with HIV status. In 2019, the amount of the benefit is 350 somoni.

To receive the benefit, trustees (parents, or those responsible for child custody) must submit an application for benefits to the employment authorities with a certificate confirming the status of the child, a copy of the guardian’s passport, a copy of the child’s birth certificate for whom the benefit will be issued, and a certificate from the place of residence. According to experts, the registration procedure itself is simple. The main problem is maintaining confidentiality throughout the process, from submitting documents to paying benefits.

The prevailing gender stereotypes and the distribution of gender roles in Tajik families dictate the distribution of homework and other household livelihood activities (see Appendix 6).



The vast majority of homework, that is, what needs to be done inside the home, falls on the shoulders of women living with HIV. In turn, what is associated with activities outside the home and the payment of certain goods and services is performed to a greater extent by the husband / partner and other family members. For example, cooking, cleaning, washing, ironing is the prerogative of the respondent (from 81.5% to 90.7%). Paying the utilities, buying various goods is not engaged in a large part of women, or already with her husband and other family members.

The general problems of gender inequality in the republic are directly reflected in ensuring de facto equality and respect for the rights of WLH in SRH and other areas. Moreover, WLH are subject to multiple discrimination, primarily indirect discrimination. The key group is subjected to both gender discrimination and HIV-positive belonging to the group, apart from discrimination on other grounds (belonging to MS, PWID, etc.)

Despite the measures taken by the Government of the Republic of Tajikistan to expand the rights of women and ensure equal rights for women and men in recent years, discrimination has been recorded in many areas (usually indirect), a decrease in a number of indicators of women, compared with men, in the implementation of the legislative rights granted.

The implementation of national strategies to promote gender equality and the Sustainable Development Goals until 2030 has a number of systemic factors that impede the effective implementation of policies to empower women and ensure the de facto equality of women and men in the republic.

The list of systemic factors that impede the implementation of both the policy as a whole to ensure actual gender equality in the country and for various groups of women, including WLH, in terms of access to various types of social services should include:

- ✓ Lack of a full intersectoral approach in the development of policies to empower women and ensure gender equality in various fields. Most often, it is not taken into account that the solution of a particular problem of inequality of women in specific areas depends on a whole range of factors and on the activities of various institutional structures to protect women's rights, not only in this area, but also in other areas.
- ✓ Weak accounting for the development of planned activities in one direction or another of the structural causes of the inequality of women and men (women's limited access to various types of resources, decision-making processes, violence against women).
- ✓ Weak orientation of the developed programs and measures to assess the real opportunities of women and the result, as compared with men.
- ✓ The rare use of a differentiated approach in assessing the opportunities and needs of various groups of women (rural and urban, young and old, with and without disabilities, etc.) in planning activities. Women are generally evaluated and perceived as a homogeneous group.
- ✓ Weak accounting for new challenges and their impact on women (unregulated migration, strengthening patriarchal norms in society, early marriages, etc.).

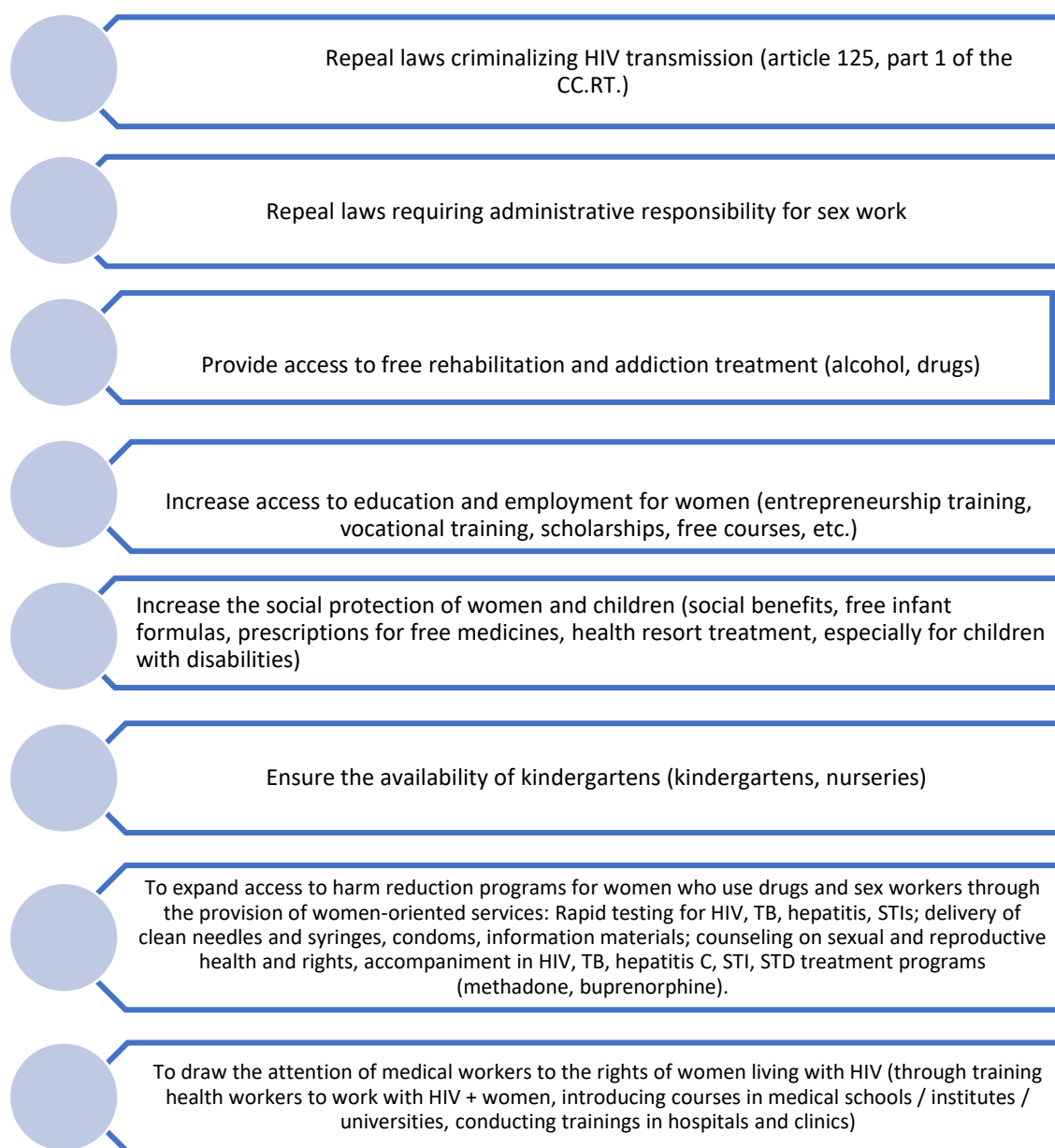
The factors listed above directly affect the effectiveness of implemented measures. It is necessary to take active steps to eliminate systemic factors. Tajikistan, has long passed the first stage in shaping gender policy and ensuring the rights of women, creating a common legislative framework for state guarantees for protecting the rights of women, adopted national and sectoral strategies, programs, plans to promote gender equality until 2030, to protect the rights of WLH and other vulnerable groups.

Currently, Tajikistan is at a more crucial stage - the stage of implementation of adopted strategies, laws and action plans, which requires the selection of the most effective mechanisms for their implementation, taking into account the Beijing Platform for Action, the Convention on the Elimination of All Forms of Discrimination against Women and the new approaches and principles of the SDGs, new challenges. When developing action plans, it is necessary to use a differentiated

approach, taking into account the characteristics and capabilities of certain target groups of women.¹⁶

Interviewed WLH expressed a whole range of proposals to protect their rights and expand access to SRH and other social services. The proposals are aimed both at improving the regulatory framework, and at developing and implementing programs to support them.

Figure 41. Suggestions of WLH to prevent various types of discrimination.



¹⁶ See: Alternative report of the coalition of public associations of the Republic of Tajikistan “From Legal Equality to Actual Equality” on the implementation of the Beijing Platform for Action +25. 2019.

CONCLUSIONS AND RECOMMENDATIONS

The issues of sexual and reproductive health of WLH are very relevant due to the fact that the vast majority of our respondents (88%) identify themselves as sexually active. However, most of them have sexual partners, both HIV-positive and non-HIV partners.

Survey results record limited access of WLH to SRH services. On average, one in every three women surveyed living with HIV clearly believes that she receives the same services as any other woman when she applies for SRH services; can receive free and high-quality treatment, information, services in the field of SRH when it needs them; is aware of the treatment and SRH services that exist in our country. Just over one third of respondents unequivocally assess their experience in receiving sexual and reproductive health services as good, and they have confidence in the high quality of counseling and treatment received.

The vast majority of WLH turn to AIDS Centers or to a personal doctor for services. According to their estimates, the attitude of health workers is friendly, and the quality of services is usually good. Every second WLH is confident that health workers do not disclose her HIV status or any other details without her permission, and also provide all the necessary information to make a decision about receiving a service or treatment.

Claims by WLH for services in primary health care facilities (PHC) are rare. It is here that WLH are most often faced with discrimination in obtaining medical services. Therefore, most HIV-positive women are afraid to open their status and do not seek services in primary health care facilities in the community.

Given the considerable number of cases of discrimination and the dissemination of information about the status of women who applied to PHC facilities by health workers for others, many women expressed concern about the possible restriction of their access to SRH services due to their transfer to PHC facilities. Therefore, it is very important for the integration of the provision of HIV-related services in PHC facilities to conduct extensive training for PHC staff regarding the features of working with a key group and to pay special attention to strengthening the responsibility of health workers for disclosing the status of WLH.

Analysis of the responses of WLH reveals a low level of awareness of the key group in the area of their rights. Only every third woman completely agrees with the opinion that she knows her rights, and if they are violated in medical institutions, she knows where to file a complaint. One third of respondents are also confident that in case of violation of their rights, as WLH, they will be able to obtain the necessary legal protection.

As the potential structures that will help them protect their rights, the majority call AIDS Centers and relevant public organizations. Two-thirds of respondents can “always” or “most often” talk with their doctor about their sexual health and needs.

The respondents' suggestions on expanding and improving the quality of SRH services can be grouped in three areas: respecting the rights of WLH, expanding access to SRH services, and involving them in decision-making processes.

The issues of trusting relationships of WLH with their partner in discussing their HIV status are relevant, since about 40% experience certain difficulties with this. An unequal sexual relationship with an intimate partner / s is recorded due to the fact that more than half of the respondents have sex when their partner (s) want and they do it, first of all, to satisfy their partner. Less than half WLH have sex as they wish.

Fixed problems with the safety of sexual relations. Only 58% of WLH indicated that “always or most often” could have sex without fear of transmitting HIV to their partner (s). At the same time, they feel safe with their partner (s) “always and most often” 61%.

The use of condoms is alarming. Just over half of the partners of WLH use a male condom without problems if they ask for it. Other partners only occasionally fulfill this condition, and 11% of partners never use a condom at all. The situation with the use of female condoms is even worse. Almost every second woman never uses a female condom. However, only every second woman was tested voluntarily for HIV during pregnancy. Moreover, almost every second woman had one or more unplanned pregnancies

There is a lack of full access for WLH to all types of sexually transmitted infections services. Approximately only one in three women is fully confident that in the event of an STI, she will be able to receive diagnosis and treatment without fear of condemnation from health workers. Only about 37% can constantly have sex without fear of receiving any STIs from their partner.

Only every second woman living with HIV can receive pre-exposure and post-exposure prophylaxis if she or her partner needs it.

With access to information about sexually transmitted infections, safer sex, the use of condoms and contraceptives, the picture is slightly better. Almost half of women always know where to get the information they need about STIs. But at the same time, a rather large group of WLH who only sometimes know these sources, or never know at all.

Among the factors that most affect the awareness and availability of various services in the field of safe sex is the level of education of respondents. The higher the level of education, the wider the opportunities.

All the negative factors that prevent WLH from enjoying a sexual life can be grouped into four groups: those related to status and health, lack of a partner, living conditions and limited access to SRH services.

WLH have the greatest need for psychological assistance. Moreover, they are very interested in creating or expanding mutual assistance groups, receiving support from public and other organizations to help build mutual understanding with family members and relatives. Legal assistance in solving various family and other problems is no less popular.

The vast majority of WLH (up to 76%) can take the right to choose to have a child or not have it without fear of others. The place of residence (city and village) does not significantly affect the decision to refuse to have a child, but some differences are recorded by age. The young age cohort of 18-29 years, in comparison with the group of 30-49 years, is more difficult to decide on this step.

It is very important that the majority of respondents received support in deciding whether or not to have children, both from the partner, the family, and the health worker. At the same time, urban health workers and family members, compared to rural ones, more often supported women in this decision. However, not a small part of the interviewed WLH are subjected to pressure from relatives and medical workers when deciding to have a child.

Most WLH were able to exercise their right to receive information on safe and effective methods of birth control in accordance with their choice, thanks to the efforts of doctors and health workers. They had consultations on family planning and childbearing. A little over 60% can talk with other women living with HIV if they wish, who will give them advice on healthy motherhood. The rates of access to treatment, compared with the services of information, are significantly lower. About half the women received help with safe conception. Only every second woman was able to

choose a medical institution where to give birth to a child. Approximately 56% received support in deciding how to feed the baby.

The most critical situation is the access of WLH to free infertility treatment services and assisted reproductive technologies. Every second woman claims that she does not have access to this type of treatment, and about 27% find it difficult to answer. The situation with the respondents' access to diagnostic services for the most common oncological diseases of cervical and breast cancer in the republic is not better (25.9%).

The rights of women living with HIV in SRH are often violated; women's access to SRH services is limited for many reasons. The decision by a woman to have a child is often pressured by a partner, relatives, unskilled health workers and others. As a result, most women experience fears and doubts. The decision to have or not have a child is dominated by fear of giving birth to a sick child and fears associated with the possibility of refusal of health workers to help them.

Violence and discrimination against women living with HIV is a widespread practice. Gender-based violence against WLH is a consequence of the impact of the existing gender relations system in Tajikistan. On the other hand, WLH are subjected to violence not only on the basis of gender of women, but also on belonging to a group with HIV-positive status.

Cases of violence and discrimination against interviewed WLH by various people and organizations after detecting HIV-positive status have increased significantly. Women living with HIV are subject to discrimination and violence both in the family and society, and on the part of an intimate partner, and on the part of other family members, and on the part of health workers, and by police officers, etc.

After the detection of HIV, the incidence of violence by family members or a neighbor has increased many times. The number of WLH who have experienced violence in society has increased more than five times. Particularly noteworthy is the huge increase in the manifestation of discrimination against women when applying to medical institutions. Under the influence of all this, almost every second WLH has experienced fear of any form of violence or discrimination. While before the detection of HIV, only about 7% of respondents experienced this fear.

Despite the fact that her husband is often the source of HIV infection for a woman, she is subjected to violence and discrimination by her husband, parents and relatives of her husband. Violence is committed not only on the part of the husband, the husband's brothers, but also on the part of the mother-in-law, sister-in-law, wives of the husband's brothers.

WLH are subjected to various forms of violence: psychological violence in the form of insults, humiliation, isolation and others, various kinds of prohibitions on pregnancy and childbirth, on receiving ARV therapy, medical supervision, etc., physical violence in the form of beatings and beatings as a result of which harm is inflicted to health up to serious ones; economic violence.

If before the detection of HIV infection, not a large part of WLH showed some kind of mental health disorder, then after detecting HIV, these disorders are practically characteristic of the majority. The vast majority of respondents experience a state of depression, shame, confusion, a feeling of helplessness, the inability to independently understand the situation and decide on their future plans.

The spread of violence against WLH in the family is facilitated by the impact of a whole range of factors: socio-economic, socio-cultural and socio-psychological. The long-term effects of a number of negative factors on men and other family members, such as job loss, or its complete

absence, gender stereotypes, as well as the use of alcohol, drugs and others negatively affect the situation of the family and contribute to cruelty towards women living with HIV.

Only every fourth woman works in various institutions or studies. The remaining women do not work for various reasons. Moreover, approximately every second woman is a housewife. In households with WLH, the average income per family member per month is 296 somoni, which is approximately one dollar per day.

The vulnerability of WLH is also compounded by the fact that they have limited access to economic opportunities and limited autonomy, as well as the many responsibilities that they must fulfill in the household and society.

RECOMMENDATIONS

All state socio-economic programs and strategies of the Republic of Tajikistan must take into account the interests and rights of women living with HIV and from among other key groups.

Include in the State Program for the Prevention of Domestic Violence for 2014-2023. Take measures to protect WLH and women from HIV-infected groups from discrimination and to raise public awareness about HIV and ways of transmitting HIV;

Introduce amendments to the Law of the Republic of Tajikistan “On Prevention of Domestic Violence” with special attention to the need for specialized services in health matters and free legal assistance for WLH and other vulnerable groups of women.

Delete Art. 125 “Infection with HIV infection” from the Criminal Code of the Republic of Tajikistan, as the prosecution of people for non-disclosure of HIV status and HIV transmission, when there is no evidence of intentional transmission is excessive and leads to opposite results for public health. Intentional HIV infection should be included in the general norm on causing grievous bodily harm;

To amend the Code of Administrative Responsibility of the Republic of Tajikistan in order to bring to administrative responsibility medical workers, public servants to administrative responsibility for disclosing confidentiality of persons related to HIV;

To develop a mechanism for realizing the rights of people whose HIV infection has occurred as a result of medical procedures.

For violation of the rules before - and after - test counseling, provide for administrative liability for doctors.

To increase the capacity of judges, prosecutors, police, and the prison system on non-discrimination and HIV / human rights against WLH, women sex workers, women who inject drugs, women former prisoners in terms of international human rights and HIV standards gender sensitive.

Provide AIDS centers with psychologists and lawyers. To solve the issues of providing these personnel and their financing.

To increase the capacity of gynecologists and other medical workers in the primary health care system in matters of non-discrimination of WLH and women from affected groups;

In order to increase the access of WLH to SRH services:

- ✓ Provide free gynecological kits
- ✓ Introduce free ultrasound for WLH
- ✓ Free treatment of oncologists and examination of precancerous diseases
- ✓ Free treatment of hepatitis B and C, other specialist

Develop a monitoring and evaluation system for piloting the integration of HIV services in PHC facilities. In the monitoring process, involve representatives of the community of WLH and, based on the results of monitoring and evaluation, hold public hearings to discuss the effectiveness of the mechanisms used.

Contribute to the creation of new and strengthening the capacity of existing self-help groups for WLH.

Include hepatitis B and C in the list of diseases eligible for disability and free treatment. Establish a transparent procedure for providing free medical and socio-psychological assistance for all PLHIV, especially WLH, women who inject drugs, former prisoners and MS.

To actively involve WLH themselves in the development of various programs and action plans.

To develop a mechanism for exercising the right of parents or legal representatives of children born from HIV-infected mothers to substitute breast milk from the moment a child is born until the time of the final diagnosis;

Consider obtaining benefits for pregnant WLH to purchase essential drugs and improve their nutrition.

Given the concentrated nature of the HIV epidemic in Tajikistan, replace mandatory HIV testing for married people with voluntary and confidential HIV testing, with pre- and post-test counseling as recommended by WHO and UNAIDS.

To develop measures for social support for women raising underage children whose husbands died of AIDS and single mothers with HIV.

Within the framework of national educational policies, develop and implement standards for such forms of education as family and distance education for primary and secondary schools, including the interests of PLHIV.

To increase the potential of teachers of educational institutions at all levels, from preschool to higher and postgraduate education in HIV prevention and non-discrimination of PLHIV

Harmonize the norms of the Labor Code in accordance with the benefits of PLHIV established in the Health Code. Ensure compliance with the requirements of labor laws when employing PLHIV and adopt guidance for employers taking into account international standards on the rights of PLHIV to labor and labor protection. Accept tax incentives for employers hiring WLH.

Introduce into the Code of Administrative Offenses an additional corpus delicti (*Article*), for which employers must bear administrative responsibility for refusing to accept employment on discriminatory grounds and for the additional requirement of documents for employment that are not provided for by the legislation of the Republic of Tajikistan. In case of repeated violation, there

should be criminal liability. Provide the same composition for educational institutions if they require an HIV certificate and exclude students or otherwise discriminate in connection with HIV.

ANNEX 1. Number of WLH interviewed by district

No.	Districts / Cities	Number of respondents
1	Dushanbe	100
	RSA	100
2	Vahdat	25
3	Tursunzade	15
4	Gissar	20
5	Shahrinav district	10
6	Rudaki district	30
	Khatlon region	100
7	Bokhtar	10
8	Qabadiyan district	10
9	J. Balkhi district	10
10	Kushaniyan district	10
11	Kulyab	20
12	Farkhor district	10
13	Vose district	10
14	Hamadoni district	10
15	Danzhara district	10
	Sughd region	100
16	Kujand	35
17	Buston	15
18	Guliston	15
19	Kanibadam	20
20	Spitamen district	15

ANNEX 2. Number of people living with HIV (adults and children) in the Republic of Tajikistan by gender and year

	GBAO	Dushanbe	RSA	Sughd	Khatlon Bokhtar region	Khatlon Kulyab region	RT
2011, total	105	1074	317	343	219	230	2288
2018, total	367	1927	1704	1662	1146	1006	7812
Men	252	1265	1025	946	634	567	4689
Women	115	662	678	716	512	439	3123
2019¹⁷, total	375	1975	1914	1921	1295	1133	8613
Men	250	1268	1149	1087	709	642	5105
Women	125	707	765	834	586	491	3508

¹⁷ As of 30.09.2019

ANNEX 3. Number of people living with HIV (adults and children) receiving ARV treatment in the Republic of Tajikistan¹⁸

Region	Number of PLHIV		The number of PLHIV receiving ARV therapy		% Of PLHIV receiving ARV therapy	
	2018	2019 as of 30.09	2018	2019 as of 30.09	2018	2019 as of 30.09
GBAO	367	375	272	287	74,1%	76,5%
Dushanbe	1927	1975	1252	1317	65,0%	66,7%
RSA	1704	1914	1388	1557	81,4%	81,3%
Sughd region	1662	1921	1341	1563	80,7%	81,3%
Khatlon Bokhtar region	1146	1295	887	1027	77,4%	79,3%
Khatlon Kulyab region	1006	1133	761	899	75,6%	79,3%
Total in RT	7812	8613	5901	6650	75,5%	77,2%

ANNEX 4. Reasons adopted by religious lawmakers for the use of contraception (compiled from various facts)¹⁹

Contraception can be used to:

- ✓ Avoid the risk to the health of the newborn as a result of a change in the composition of his mother's breast milk due to a new pregnancy.
- ✓ Avoid risks to women's health as a result of repeated pregnancy, short intervals between childbirth and young women..
- ✓ Avoid pregnancy if a woman is sick.
- ✓ Avoid transmission of disease to offspring from affected parents.
- ✓ To maintain female attractiveness and normal physical condition.
- ✓ To avoid economic difficulties, the need that can occur at the birth of a large number of children and which can cause parents to resort to fundraising illegally or to hard excessive work in order to feed and raise children.
- ✓ Give appropriate upbringing, education, and religious knowledge to children, which is easier to do in families with few children.
- ✓ To avoid danger for children from converting to another faith from Islam in enemy territory.
- ✓ Avoid giving birth to children during religious decline.
- ✓ Provide a separate corner and separate sleeping accessories for each child, which is easier to do in small families.

Reasons not adopted by lawmakers

- ✓ Avoiding the birth of female offspring.
- ✓ Avoiding pregnancy due to unwillingness to be a mother.

¹⁸ <http://www.nc-aids.tj/statistika.html>

¹⁹ Abdel Rahim Omran. Family planning in the interpretation of Islam. Translation from English. Dushanbe, 2001, p. 53-54.

APPENDIX 5. The list of problems that most impedes WLH from receiving high-quality medical and other social services by age of the respondents.

	18-29 years	30-39 years	40-49 years	50 year and older
Cost of services in various institutions	79,9%	83,4%	73,0%	92,3%
Fare to the place of service	40,3%	44,0%	38,1%	34,6%
Cost in kindergartens / nurseries, payment of a nurse for children, queue in kindergartens	29,9%	27,4%	12,7%	3,8%
Economic dependence on partner (s), family members	22,4%	13,7%	20,6%	23,1%
HIV-related stigma and abuse in workplaces	17,9%	14,9%	19,0%	23,1%
Divorce, widowhood, departure	15,7%	13,7%	20,6%	15,4%
Cost and burden of caring for other family members	14,9%	17,1%	31,7%	3,8%
Lack of family support	14,2%	17,7%	22,2%	15,4%
Unequal inheritance and property rights	9,7%	17,1%	12,7%	23,1%
Infringement of rights in the workplace due to gender, age or having children	6,0%	5,1%	4,8%	7,7%
Other	3,7%	4,6%	4,8%	7,7%

APPENDIX 6. Distribution of various activities at home among family members

	Activities	Only me	Only the partner	Together	Sometime s he, sometimes me	Other family members
1	Collect children in the morning for kindergarten / school	72,5%	1,7%	10,8%	6,7%	8,3%
2	Cooking meal	81,5%	0,3%	4,0%	4,0%	10,2%
3	House cleaning	87,5%	0,3%	3,0%	2,0%	7,2%
4	Washing clothes	89,1%	0,7%	3,0%	1,6%	5,6%
5	Ironing	90,7%	0,7%	1,7%	2,0%	5,0%
6	Pick up children from kindergarten / school in the evening	59,3%	2,2%	7,8%	5%	8,2%
7	Buying food / household chemicals	38,7%	14,3%	13,7%	16,7%	16,7%
8	Home appliance shopping	32,9%	19,1%	19,8%	7,8%	20,5%
9	Shopping for baby clothes	41,1%	11,1%	25,9%	9,3%	12,6%
10	Payment of utility bills	29,5%	26,5%	10,7%	9,4%	23,8%
11	Organization of holidays at home	31,6%	12,2%	26,0%	6,3%	24,0%
12	Organization of holidays outside the home	33,3%	13,1%	25,1%	7,9%	20,6%
13	Attending Parents' Meetings / Children's Parties	54,5%	4,1%	15,0%	18,3%	8,1%

14	Attending Parents' Meetings / Children's Parties	47,5%	6,5%	22,8%	15,2%	8,0%
15	Hospital visits / talking with doctors / buying medicine for adult family members	34,4%	7,6%	19,9%	19,2%	18,8%
16	Home Care for Sick Children	48,4%	1,2%	27,4%	9,5%	13,5%
17	Home Care for Sick Adult Family Members	32,0%	3,5%	17,0%	13,5%	34,0%
18	Visits to social services, government officials, social security, a pension fund, etc.	32,5%	15,0%	13,8%	10,8%	27,9%
19	Distribution of the family budget (decision - who should be spent on that)	29,0%	16,8%	26,2%	4,3%	23,7%