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Layered Stigma and the Semi-Peripheral Governance: Gender, Criminalization, and Drug Use in Central Asia

Abstract: This article examines how women who use drugs (WWUD) in Central Asia experience layered stigma, shaped by gender norms, punitive drug governance, and the region's semi-peripheral position. Drawing on regional reports, emerging scholarship, and professional experience in harm reduction, it shows how Soviet narcological legacies and contemporary criminalization embed moralized understandings of drug use in institutional practice. Through mechanisms such as narcological registries, reproductive governance, and everyday institutional and familial control, women's drug use is treated as a violation of femininity and motherhood rather than a health issue, exposing women to surveillance while limiting access to care. The article also considers how the marginal position of Central Asia in global drug policy debates can make both structural violence and local forms of agency less visible. Finally, it highlights community-based initiatives and narcofeminist organizing as ways in which women seek to reclaim autonomy and dignity.

Keywords: Gendered stigma, Women who use drugs (WWUD), Central Asia, Drug Policy, Narcofeminism.

Introduction

Sociological research on drugs has long focused on power, governance, and marginality (Dennis et al. 2023; Zigon 2019). However, certain regions and subjects remain at the edges of scholarly and policy attention (Fraser & Moore 2011; Stevens 2011). Central Asia is a clear example of this exclusion. The region is central to global drug markets and is also shaped by a mix of post-Soviet institutional legacies and externally funded public health programmes, mainly focused on HIV and tuberculosis. This creates complex and sometimes contradictory ways of dealing with drug use, making the region important for understanding how different approaches to care and control work in practice. Despite this, Central Asia remains largely absent from major theoretical debates (Turaeva 2022; Zabransky et al. 2014). Studies of Central Asia have also noted that research on the region is often shaped by earlier frameworks and external perspectives, which can limit the recognition of local experiences (Laruelle 2021). Common portrayals of the region often reduce it to a “postsocialist periphery”, defined primarily through Soviet legacies of control and a supposed resistance to change. This simplification overlooks the more complex historical and social dynamics highlighted in existing scholarship (Beckwith 2010; Khalid 2015). Such a narrow focus ignores the region's long history as a center of exchange and knowledge production. More importantly, these framings can contribute to narratives

that present Central Asian societies as dependent or ‘backward,’ and in need of external management.

Semi-peripheral regions are located between core and peripheral parts of the world system, combining features of both and mediating between global centres of power and more dependent regions (Wallerstein 2004). In this article, the concept of the semi-periphery is used to describe how global policy models interact with post-Soviet administrative structures in Central Asia. Importantly, this does not imply that the region is analytically or epistemically marginal; rather, it highlights how global approaches and local institutional legacies come together in ways that shape governance in practice. This helps explain the hybrid forms of drug governance observed in Central Asia, where internationally promoted harm reduction approaches coexist with more punitive, control-oriented institutional practices (Isaacs & Marat 2021; Azbel et al. 2026).

This configuration can be understood as narco-governance, a form of governance in which drug control operates through the combined logics of punishment, surveillance, and limited care. In this article, the term refers to contexts where drug governance is shaped by a close entanglement of punitive control, moral regulation, and limited access to care, where care and punishment are closely intertwined (Corva 2008; Stevens 2024). In the Central Asian context, this takes a form in which harm reduction initiatives coexist with practices of surveillance, coercion, and moral judgement. These patterns shape not only institutions, but also how knowledge about drugs is produced and whose experiences are recognized.

Drug policy is shaped not only by formal laws but also by everyday institutional practices that determine how drug use is managed (Stevens 2011). These practices are part of a broader moralising discourse around drugs, in which psychoactive substances are portrayed as threats to national survival, demographic health, and the traditional family. This means that drug use is treated not simply as a medical concern, but as a symbolic attack on the nation’s moral foundation. Women who use drugs are especially vulnerable within these systems. Research in gender and critical drug studies has long pointed to the ways in which women’s drug use is interpreted through the lens of motherhood, care, and social responsibility rather than health alone. Campbell and Herzberg (2017) argue that women who use drugs are frequently positioned as violating gendered expectations, making them particularly vulnerable to moral judgement and social control. This insight resonates strongly with the Central Asian context, where ideas about femininity and women’s responsibility for family stability continue to shape both public discourse and institutional responses to drug use (Campbell & Herzberg 2017). In Central Asia, drug policies intersect with rigid expectations of femininity and motherhood, which place the responsibility for maintaining social and moral order on women (Cleuziou & Drenberger 2016). Feminist scholarship shows that women’s drug use is rarely viewed as a personal choice; instead, it is seen as a violation of normative expectations of femininity (Measham 2002). This is further reinforced by state discourses that frame drug use as a threat to the country’s future, particularly in Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan. By invoking the protection of the gene pool and the stability of the family, these policies justify control in the name of social order (Khowar.TJ 2009; Ministry of Justice 2004; Tokaev 2026).

These patterns of drug policy and moral regulation are also reflected in how women who use drugs are positioned within national systems of care and control. The limited

attention given to Central Asia in global drug policy debates parallels, at a different scale, the marginalisation of women who use drugs within national systems of care and control. In both cases, “peripherality” emerges not as a natural or inherent condition, but as the outcome of epistemic exclusion and governance practices that privilege institutional control over lived experience (Ettorre 1992; Stevens 2024).

To make sense of these overlapping forms of exclusion, this article draws on the concept of layered stigma to describe how women who use drugs experience marginalization as a cumulative, institutional process rather than a singular social attitude. Building on sociological research that views stigma as a product of power relations and institutional design (Link & Phelan 2001), layered stigma accounts for the intersection of criminalisation, medical surveillance, treatment systems, welfare interventions, and family regulation. Women who use drugs are highly visible to punitive institutions, such as police, narcological registries, and courts—yet they are often excluded from the health and social services meant to provide care. This exclusion should not be understood as complete invisibility. Women who use drugs are often selectively visible, particularly within HIV, violence, and reproductive health frameworks, while remaining largely absent from broader drug policy, epidemiological, and treatment research (Kowalczyk & Jerzynski, n.d.). Such selective visibility reproduces gendered forms of knowledge production and reinforces layered stigma. This stigma is not produced solely by the state; it is also reproduced within families and by medical professionals, turning intimate relationships into sites of governance. As research on post-Soviet gender regimes indicates, families often act as extensions of state power by enforcing moral discipline and social conformity (Cleuziou & Direnberger 2016). For these women, disclosure can lead to violence, confinement, or the loss of parental rights, making silence a necessary strategy for survival.

At the same time, this article resists viewing women who use drugs solely as passive subjects of control. Drawing on observations of women-led initiatives across Central Asia, it highlights practices of care and solidarity that challenge dominant ideas about drug use, femininity, and citizenship. These practices are examined through the lens of narcofeminism, understood here not as a theoretical import but as an emergent feminist praxis grounded in the realities of criminalization and stigma (Bessonova et al. 2023; Dennis et al. 2023). Narcofeminism brings together harm reduction practices with feminist critiques of state violence and medical authority, drawing attention to how women who use drugs experience both forms of control in their everyday lives. It highlights women’s claims to autonomy and dignity in contexts where their needs have often been overlooked by both mainstream women’s movements and drug policy frameworks. Taken together, this framing allows the article to explore how women who use drugs in Central Asia experience governance not only through formal policies, but through everyday interactions across medical, legal, and social institutions.

Methodological Approach

This article uses a qualitative, interpretive, and multi-modal research strategy that combines document analysis with practice-based evidence, drawing on grey literature, policy

reports, and ongoing professional engagement in drug policy and harm reduction work in Central Asia. It draws on cumulative experience gained through work in Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan, and Turkmenistan since 2019 as a researcher and consultant. Although Central Asian countries follow different political trajectories, they share important structural features, including the legacy of Soviet narcology, punitive legal frameworks, and the hybrid development of harm reduction under donor influence.

This work has taken place within several regional projects, including SOLID, which focuses on the development of social work as a field of research and practice in Central Asia and China, and the Central Asia Drug Action Programme (Phase 7) (CADAP), an EU-funded initiative supporting drug policy development, treatment systems, and harm reduction through a public health and human rights-based approach. These settings have provided opportunities to engage with a wide range of actors, including policymakers, healthcare professionals, researchers, and community organisations.

Rather than relying on a single dataset, the analysis uses a combination of sources, including published and unpublished reports, needs assessments, expert consultations, and participation in regional meetings and research activities. It also draws on interdisciplinary fields such as psychology, medical anthropology, social work, and public health. This approach brings together practice-based knowledge with sociological and interdisciplinary perspectives to better understand how drug policy operates in practice. To distinguish between forms of engagement and analytical material, [Table 1](#) summarises my professional involvement in the region, while [Table 2](#) presents the main sources used in the analysis.

Table 1
Professional engagement

Project/Activity	My role	Type of work	Geographic scope
Social work and strengthening NGOs in development cooperation to treat drug addiction (SOLID)	Post-doc	Academic supervision, research collaboration, and participation in and organisation of expert meetings and academic events	Central Asia (KZ, KG, UZ), China, Germany
Central Asia Drug Action Programme (CADAP) (Therapeutic Programme development)	Consultant (within CADAP projects)	Roundtables with stakeholders; expert consultations; internal and external reports	Central Asia (KZ, KG, TJ, UZ, TM)
CADAP (Gender & Human Rights component)	Consultant/trainer (within CADAP projects)	Training sessions; stakeholder dialogues; collaborative report writing—assessment of the situation of women who use drugs.	Central Asia (KZ, KG, TJ, UZ, TM)
CADAP (Methamphetamine research)	Researcher (within CADAP projects)	Regional research project; data collection and analysis	Central Asia (KZ, KG, TJ, UZ, TM)
Global Public Health Network (GPHN) (NGO)	Founder / coordinator	Engagement in regional harm reduction initiatives; organisation of events; collaboration with practitioners and NGOs	Central Asia (KZ, KG, TJ, UZ), Global

Table 2

Summary of the main sources used in the analysis, including their thematic focus and types of data

Organisation / Source	Type of material	Type of data	Aims and topics	Regional scope
SOLID	Academic and practice-oriented materials, including publications and expert discussions	Qualitative and quantitative research, expert discussions, and practice-based knowledge	Development of social work in addiction, communicable diseases (HIV/TB), and closed settings; focus on stigma, treatment systems, and regional knowledge exchange.	Central Asia
CADAP	Regional and national reports	Policy analysis, programme data, expert input, stakeholder consultations	Development of evidence-based drug policies and treatment systems in Central Asia; integration of gender and human rights approaches into drug policy; analysis of barriers to care, harm reduction, and institutional responses.	Central Asia
Eurasian Women's Network on AIDS (EWNA)	Assessment reports, programme reviews, advocacy documents	Qualitative data, gender analysis, lived experience perspectives	Community-led research on women living with HIV and women who use drugs; gender inequalities in access to healthcare, HIV services, and harm reduction; gender-based violence, mental health, and structural barriers to care.	Eastern Europe and Central Asia
Eurasian Harm Reduction Association (EHRA)	Regional reports and advocacy documents	Qualitative data, policy analysis, and insights on harm reduction and lived experience	Regional monitoring and advocacy on harm reduction; access to services for people who use drugs; policy environments, human rights, and lived experiences of key populations, including women who use drugs.	Eastern Europe and Central Asia
United Nations Office on Drugs and Crime (UNODC)	Global and regional reports	Statistical data, drug trends, policy frameworks	Global and regional monitoring of drug markets, trafficking, and use patterns; statistical data on drug trends and criminal justice responses; policy frameworks and emerging challenges in drug control.	Global, Central Asia

In addition to the sources outlined above, the analysis also draws on insights developed through direct engagement with practitioners, community organisations, and, where possible, women who use drugs. Working across policy, research, and community settings has made it possible to see how drug policy plays out in practice, often in ways that differ from formal frameworks. Many of the materials used, particularly regional reports and assessments, are themselves the result of collaborative processes involving local researchers, practitioners, and women who use drugs. This shows the realities of knowledge production in the region, where empirical insights are often embedded in project-based and policy-oriented work rather than formal academic publications.

At the same time, this approach has its limitations. The analysis builds on a combination of secondary sources and practice-based knowledge that is not based on systematically collected primary data. The available materials differ in depth and methodological transparency, and access to data is uneven across the region, particularly in the case of Turkmenistan. Available evidence indicates that reliable and up-to-date data on drug use, treatment demand, and related health outcomes in Turkmenistan is extremely limited, with most information restricted to administrative indicators such as drug-related offences or seizures, while population-based data and gender-disaggregated analyses remain largely absent (Central Asia Drug Action Programme 2023). As a result, the evidence base is not fully comparable across countries, and certain experiences may remain underrepresented, especially in more restrictive contexts. While this approach allows for a regionally grounded and practice-informed perspective, it does not aim to provide a comprehensive or representative account, but rather to identify recurring patterns and structural dynamics across the available material.

Historical Legacies and Contemporary Drug Governance in Central Asia

Understanding layered stigma requires situating women's experiences within the broader historical and institutional landscape of Central Asia. Long before modern biomedical and legal classifications, the use of plants with psychoactive effects was part of regional systems of healing, ritual, and everyday care. In some contexts, these practices were also embedded in ritual and spiritual traditions in which women played important roles as healers and shamans (Sultanova 2011). A wide range of medicinal plants were used in household treatment, with knowledge transmitted through intergenerational practice rather than formal medical systems (Eisenman et al. 2013). For example, ephedra (*Ephedra* spp.) was traditionally used to treat respiratory conditions, and the opium poppy (*Papaver somniferum*) was a common analgesic and sedative, deeply embedded in local healing practices (Eisenman et al. 2013). These substances were central to Persian, Islamic, and Central Asian medical traditions, particularly where other forms of pain relief were unavailable. However, with the consolidation of the Soviet drug control regime, this relationship was fundamentally redefined. Plants that had been commonly used in household medicine were reclassified as dangerous narcotics or precursors. Their use was prohibited, and their cultivation became the target of systematic state eradication.

The contemporary drug policy landscape in Central Asia remains tied to the legacy of Soviet narcology. In this framework, drug dependence is treated simultaneously as a medical pathology and a threat to public order—a dual framing that justifies population control and the restriction of individual freedoms as the primary tools for drug management (R. Turaeva & M. Turaeva 2021). At the heart of this system lies the narcological registry (*uchyot*), a state database of individuals diagnosed with substance use disorders. In practice, inclusion in the registry is based on formal diagnosis by state narcological services and can occur even in cases of occasional or suspected drug use.

Registration requires individuals to submit personal information that is then shared across various state institutions. This listing creates significant legal and social barriers that function as structural forms of stigma. According to the Eurasian Harm Reduction Association (EHRA), individuals on the register may face restrictions in employment, limitations on obtaining a driving licence, increased police surveillance (Eurasian Harm Reduction Association 2019a). Under family law, registration serves as a primary justification for the deprivation of parental rights. These exclusions disproportionately affect women, who already navigate institutional discrimination as caregivers and workers. For women, the *uchyot* can trigger travel bans, forced treatment, and the immediate threat of losing custody over their children (Kowalczyk & Bessonova 2025).

These practices are not new but reflect longer patterns in how drug use has been governed in the region. Research on post-Soviet systems shows that Soviet narcology treated addiction not only as a medical condition but also as a moral and social problem, embedding surveillance and punishment within medical practice (Azbel et al., 2026; Elovich & Drucker 2008). The registry reproduces governance logics rooted in Soviet-era forms of centralized control, relying on bureaucratic mechanisms that blur the boundaries between care and control. This interpretation is consistent with broader arguments that morality plays a central role in shaping drug policy (Stevens 2024). Registration encodes drug use as a sign of irresponsibility and social danger, turning this judgment into an official record. In doing so, it separates lives considered worthy of care from those subjected to control or exclusion. While the *uchyot* is formally presented as a tool for treatment, in practice it operates as a mechanism of moral governance, disciplining individuals through the threat of long-term exclusion from social, legal, and family life.

Drug use in Central Asia is largely treated as a law enforcement issue rather than a public health concern, a logic that also shapes instruments such as the narcological registry described above. As a result, policy remains under the control of the Ministry of Internal Affairs and specialized presidential agencies, particularly in countries such as Tajikistan and Uzbekistan (e.g. the Drug Control Agency under the President in Tajikistan or the Agency for Drugs and Firearms Control under the President in Uzbekistan). Across much of the region, possession of even small quantities of controlled substances can lead to criminal liability, although thresholds and legal consequences vary by country. While limited reforms have taken place in Kazakhstan and Kyrgyzstan, including partial decriminalization measures, for example in Kyrgyzstan, where a 2019 legal reform moved small-scale drug possession from the Criminal Code to the Code of Misdemeanors, as well as some expansion of harm reduction services, the overall policy

approach remains predominantly punitive (Prilutskaya 2025a). Countries like Uzbekistan and Turkmenistan maintain especially harsh laws, defined by restricted legal counsel, prolonged pre-trial detention, and frequent human rights violations (Společnost Podané ruce 2023a, 2023b).

Despite the ongoing legacy of Soviet narcology and the continued perception of harm reduction as a donor-driven supplement rather than a core public health strategy, harm reduction initiatives have been present in the region for over two decades. Opioid Agonist Treatment (OAT), a medically supervised treatment widely recognised as a core harm reduction intervention, was established in Kyrgyzstan in 2002 (Bachiredy et al. 2022), followed by Kazakhstan in 2008 (Liberman et al. 2025) and Tajikistan in 2010 (Latypov 2020). A pilot OST program was launched in Uzbekistan in 2006, however it was closed in 2009 (Eurasian Harm Reduction Association 2019b). Other harm reduction interventions include needle and syringe programs, drop-in centres, outreach work, and naloxone distribution for overdose prevention—though their scope varies significantly by country (see table 1). Many of these activities are managed by non-governmental organizations and are heavily dependent on international donors, particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). However, because harm reduction is often funded under the umbrella of HIV prevention, resources remain limited and narrowly focused. While international actors like the United Nations Office on Drugs and Crime (UNODC) and World Health Organization have influenced policy discourse by promoting public health-oriented and evidence-based approaches to drug use, they have not fundamentally changed the coercive nature of drug policy. Currently, reductions in international funding for harm reduction and HIV-related programmes within UN-supported initiatives have worsened the situation, threatening the survival of existing projects. Furthermore, recent political shifts as well as broader tightening of NGO regulations in the region—specifically the implementation of ‘foreign agent’ laws in Kyrgyzstan (in April 2024)—have led to a shrinking civil society and a decrease in the number of active NGOs. Recent regional analyses indicate that organisations working with people who use drugs operate under increasing legal and administrative pressure, often limiting public advocacy and visibility in order to reduce institutional risk (Eurasian Harm Reduction Association 2026). Civil society engagement across Central Asia is diverse and shaped by national institutional contexts. In many settings, civil society activity is monitored by the Ministry of Foreign Affairs, suggesting that these organisations are often viewed as “foreign” actors rather than local stakeholders. In Uzbekistan, for example, state-linked or hybrid actors such as government-organised NGOs (GONGOs) and community-based mahalla, local neighbourhood governance institutions, play a significant role in prevention and social support. In Turkmenistan, civil society activity is largely channelled through state-supported youth, sports, and health-promotion institutions. By contrast, Kyrgyzstan, Kazakhstan, and Tajikistan host more independent organisations that combine service provision with harm reduction, legal assistance, and limited policy advocacy despite increasingly constrained civic space (Masaru 2006; Ziegler 2010). Despite these pressures, the role of civil society remains vital, even as all Central Asian states face ongoing criticism for human rights violations against people who use drugs, those living with HIV, and the LGBTQ+ community (INPUD 2010; REAct Kyrgyzstan 2020).

Table 3
Availability of harm reduction interventions across Central Asian countries

Country	Explicit supportive reference to harm reduction in policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NPS in at least one prison	OAT in at least one prison
Kazakhstan				No	No	No	No	No	No	No
Kyrgyzstan				No			No	No		
Tajikistan				No			No	No		
Turkmenistan	No	No	No	No	No	No	No	No	No	No
Uzbekistan			No	No	No	No	No	No	No	No

Source: Self elaboration based on the Global State of Harm Reduction 2024 (Harm Reduction International 2024).

Gendered Exclusion: Women's Drug Use and Structural Exclusion in Central Asia

Within current drug policy systems in Central Asia, the prevalence of psychoactive substance use among women is consistently underestimated due to long-standing structural and institutional barriers. Official statistics rely almost exclusively on narcological registries, which primarily record individuals who come into contact with state treatment systems or are formally diagnosed within them, thereby excluding many women who use drugs but do not engage with these services. These databases fail to capture the broader population of women who use drugs, creating a significant gap between state records and social reality.

This persistent gender gap in visibility is a direct result of institutional design. Data systems rarely disaggregate drug use by gender, and harm reduction programs have historically been modelled on the routines and needs of men. As Kowalczyk and Jerzynski argue, women who use drugs remain underrepresented in regional evidence systems, particularly outside HIV and reproductive health frameworks, making it difficult to assess the scale and diversity of their experiences (Kowalczyk & Jerzynski n.d.). Funding frameworks remain focused on HIV prevention for men who inject drugs, treating women as statistical outliers (Latypov et al. 2014). Consequently, essential services like needle exchange and OAT are structured around male-centric norms, for example by prioritising patterns of drug use and service delivery models based on male populations (such as injecting drug use and clinic-based treatment structures), leaving women systematically underserved. In most Central Asian countries, OAT programmes are integrated into state narcological systems, meaning that patients are typically registered within the same institutional framework.

In Kazakhstan, for instance, only 1,498 women were registered in the narcological system in 2023, accounting for just 8% of the total (Ahmetjanov 2023). While women make up 18% of those in opioid agonist treatment (Pikirenia et al. 2024), independent estimates suggest that the actual number of women who use drugs in the country may be as high as 22,000 (Mukherjee et al. 2022). A similar pattern exists in Kyrgyzstan: in 2025, only 399 women were registered (6% of the total), and women comprised just 10.5% of OAT clients (Republican Centre of Psychiatry and Narcology Kyrgyz Republic 2025). However, researchers estimate that women actually constitute around 12% of the country's drug-using population (Eurasian Harm Reduction Association 2019c). This invisibility is even more pronounced in Uzbekistan and Tajikistan, where women account for less than 4% of official registries (Chingin & Fedorova 2014; Gazeta.uz 2018). Reliable, publicly available data from Turkmenistan remains extremely limited, and this analysis therefore relies primarily on regional reports and secondary sources (Central Asia Drug Action Programme 2023).

While opioid agonist therapy is legally available in Kazakhstan, Kyrgyzstan, and Tajikistan, female enrolment remains critically low. The barriers are deeply gendered: strict daily attendance requirements are often incompatible with caregiving responsibilities, and childcare is almost never provided. Furthermore, OAT sites are frequently policed as "hunting grounds" for surveillance, where even those with legal prescriptions face stops, searches, and harassment. For women, these environments foster chronic fear, including the risk of sexual extortion and coercion by law enforcement officers and other actors operating within these surveillance environments.

These limitations of the state system are most clearly visible in the contrast between government and community-led care. In Kyrgyzstan, only 25% of women reported satisfaction with state-run methadone programs, compared to over 90% satisfaction with services provided by women-led organisations (AFEW 2015). These organisations typically provide low-threshold harm reduction services, peer support, and advocacy tailored to the needs of women who use drugs. This disparity suggests that state institutions are not only under-resourced but also not well suited to meet women's needs. Consequently, drug-related care is not a coherent system but a fragmented landscape that women must navigate strategically to survive (Lopez 2020). Access to health becomes a matter of individual risk management rather than a social right, a dynamic that ultimately drives women further into silence and exclusion.

While historical narratives of drug use in Central Asia focused almost exclusively on opiate injection, the regional landscape is shifting. Historically a segment of the “Northern Route” for Afghan heroin, the region is now seeing a decline in traditional opioid use, accelerated by the 2022 opium ban (United Nations Office on Drugs and Crime 2024), and a sharp rise in synthetic drugs, including novel psychoactive substances (NPS) and stimulants such as methamphetamine (Grabski et al. 2025). By 2020, over 100 different NPS had been identified in the region, ranging from synthetic cannabinoids to cathinones such as mephedrone and alpha-PVP (United Nations Office on Drugs and Crime 2020, 2024). This transition coincides with a global trend: a narrowing gender gap in drug use, particularly among younger populations and those using synthetic substances (United Nations Office on Drugs and Crime 2024).

The “EPI-NPS-KZ” study, conducted among young individuals aged 18 to 34 in Kazakhstan, found that women were three times less likely than men to report using traditional drugs. However, for novel psychoactive substances (NPS), the gender gap was narrower, with approximately one woman reporting use for every two men. The difference was especially small for synthetic stimulants (Prilutskaya 2025b). Lifetime use of synthetic cannabinoids was reported by 1.5% of young women, while 2.7% reported using synthetic stimulants (Negay et al. 2019, as cited in Prilutskaya 2025b). By 2022, this disparity had narrowed further, with the male-to-female ratio shifting to 1 : 3.6 for synthetic cannabinoids and 1 : 1.6 for stimulants (Prilutskaya 2025b).

Despite this growing convergence in patterns of use, the limited visibility of women in official registries hides the disproportionately high health risks they face. Studies in Uzbekistan, Kazakhstan, and Tajikistan show that excess mortality among women who use drugs is significantly higher than among their male counterparts, and women are more vulnerable to unsafe practices and transactional relationships (Latypov et al. 2014). Women are also more susceptible to specific health complications associated with substance use. They report more pronounced symptoms affecting the skin, gastrointestinal tract, upper respiratory tract (nose and throat), nervous system, and cardiovascular system (Shaw et al. 2022). Substance use among women is often linked to gynaecological and reproductive health issues, including menstrual irregularities, amenorrhea, anovulation, and, in some cases, premature menopause or infertility (Hernandez-Avila et al. 2004; Schmittner et al. 2005). Emerging evidence also suggests that women are more likely than men to experience overdose at equivalent doses, as drugs may reach higher concentrations or remain longer in the body due to sex-specific pharmacokinetic differences (Zucker & Prendergast 2020).

Despite the specific and often higher health risks that women face, regional research and policy remain largely unresponsive, and existing support systems, particularly state-run health and social services, are not adequately equipped to address their needs.

Layered stigma and the Institutionalisation of Moral Control

The patterns described above show that exclusion takes place across multiple domains rather than through a single mechanism. These dynamics can be understood through the concept of layered stigma, which explains how such processes unfold in practice. Layered stigma refers not merely to a social attitude but to a structured mode of governance, translating moral judgment into institutional practice across legal, medical, and familial domains. In Central Asia, this stigma is codified in law and embedded in the design of healthcare and welfare systems. Importantly, women who use drugs are not only stigmatised for drug use itself, but also for transgressing dominant norms of femininity, motherhood, and sexual propriety.

Across the region, women are socially expected to embody ideals of purity, caregiving, and obedience to family structures (Cleuziou & Direnberger 2016). These expectations are reinforced through cultural concepts such as *uyat*—a Kazakh and Kyrgyz term for shame—which looks at drug use as a profound moral failure. In this context, a woman's body is often framed as a “national good,” and drug use is therefore treated as a violation of social and moral order (Ettorre 1992). Consequently, WWUD are frequently labelled as “unfit mothers” or “morally corrupt,” positioning them outside the boundaries of respectable womanhood (Kowalczyk et al. 2025; Kowalczyk & Bessonova 2025).

This form of moral condemnation is further reinforced through narco-governance, where drug use is managed through a combination of control, surveillance, and moral regulation. In Central Asia, gendered stigma is translated into concrete institutional practices, including child custody loss, police surveillance, and inclusion in the narcological registry. These conditions produce internalised shame and fear of judgment, which often lead women to withdraw from services or avoid contact with institutions altogether. In this way, layered stigma emerges as a compounded form of marginalisation, where gender norms, criminalisation, and economic vulnerability intersect (Link & Phelan 2001).

Rather than a single experience, stigma accumulates across different domains, shaping how women encounter both control and care. Women are often highly visible to punitive systems, for example through police surveillance or compulsory registration, while at the same time remaining excluded from treatment due to abstinence requirements, lack of childcare, and the absence of gender-sensitive services. This presents a structural mismatch, where the same systems that identify and monitor women do not provide adequate support. As a result, access to care depends on moral judgments of “deservingness” (Lopez 2020). In practice, this often takes the form of strict expectations of abstinence, requiring women to stop using drugs before receiving support, and denying them help at the moments they need it most.

These intersections become even more acute for those with multiple marginalised identities, such as sex workers, LGBTQ+ individuals, or women living with HIV. For example, a 2023 survey in Uzbekistan found that 76 per cent of respondents would not buy food from a woman known to be HIV-positive (Joint United Nations Programme on

HIV/AIDS 2023). For WWUD living with HIV or engaged in sex work, these stigmas do not operate in isolation; they reinforce one another, intensifying exclusion from both community and state support.

Layered Stigma in the Domestic Sphere

Layered stigma is not only produced through state institutions but is also reinforced within family life, where gender norms and expectations shape everyday interactions. In the narratives shared by women across the region, stigma often begins at home rather than in formal institutions. Family members, particularly parents, in-laws, and husbands, frequently act as enforcers of moral discipline. As described in Moroz (2025), families may respond to a woman's drug use not with care, but with rejection, surveillance, or even forced institutionalisation. As a result, many women conceal their drug use or HIV status from partners and relatives out of fear of violence or of bringing *uyat* (shame) to the family.

This gendered control is reinforced by state policies that effectively outsource disciplinary power to the family. For unmarried women, parents often act as *de facto* custodians, policing their movement and access to services. Women report that even when they attempt to seek help or access services, they are “brought back home” by relatives or denied permission to travel alone (Moroz 2025). As a result, the family functions as an extension of state power, blurring the lines between private coercion and public regulation. Far from being a refuge, the household becomes a site of surveillance and discipline—particularly for women who are poor, single, or have children.

Access to care is further restricted by gendered labour hierarchies within extended households. Research in Tajikistan demonstrates that women living with HIV, particularly in rural areas, are often financially dependent and excluded from health-related decision-making. Many must seek permission from husbands or elders to attend medical appointments, while the burden of unpaid domestic labour limits their physical mobility. Women conceal their status, reinforcing social isolation and treatment interruptions (Kowalczyk & Bessonova 2025).

This outsourcing of control to patriarchal family structures is an important feature of narco-governance in this context. It creates a hierarchy of “acceptable” dependencies: while dependence on a husband, a family, or a doctor is culturally sanctioned, dependence on a substance is viewed as a fundamental violation of the social order (Ettorre 1992). In this framework, state authority is maintained not only through policing, but also through moral regulation within the home.

Criminalization, Governance, and Everyday Violence

Legal frameworks constitute a central mechanism through which stigma is institutionalised. Women are disproportionately affected by criminalisation, with high numbers incarcerated for non-violent, drug-related offences. This pattern is particularly striking in Tajikistan, where an estimated 70% of women in prison are serving sentences for drug-related offences (Central Asia Drug Action Programme 2024). This process extends beyond sentencing, shaping everyday interactions with law enforcement. Across Central Asia,

police frequently use threats, intimidation, and extortion against women who use drugs, coercing confessions or demanding bribes under the threat of arrest (REAct Kyrgyzstan 2020). These practices undermine women's status as rights-holders, positioning them instead as criminals undeserving of state protection.

Legal stigma is further intensified by HIV-specific criminal provisions. In several Central Asian countries, women living with HIV may face prosecution not only for alleged transmission but for "endangerment"—regardless of viral suppression or informed consent. In Tajikistan and Uzbekistan, women constitute a disproportionate share of those prosecuted under these statutes, which reinforces gendered blame for infection and sexual morality. In practice, these laws function less as public health tools and more as mechanisms of moral discipline that deter women from disclosing their status, reporting violence, or seeking medical care (Moroz 2025).

This creates a severe double bind. Women who use drugs or live with HIV frequently avoid reporting domestic or sexual violence due to fear of prosecution under drug or HIV-related laws. Community-led monitoring and qualitative research in the region document cases in which law enforcement officials threaten women with criminal charges related to HIV transmission or drug use when they attempt to report violence (REAct Kyrgyzstan 2020; EWNA 2023). Rather than functioning as protective institutions, law enforcement bodies often reproduce vulnerability through intimidation and surveillance.

Legal violence intersects with gender-based violence (Bessonova 2025) creating a state of compounded vulnerability. Surveys indicate that up to 80 per cent of women who use drugs in Kyrgyzstan report experiencing violence from partners, police, or both (International Network of People Who Use Drugs 2022). For many, drug use is both a cause and a consequence of this violence. Empirical studies confirm this structural relationship: intimate partner violence and post-traumatic stress significantly increase the likelihood of substance dependency, particularly where support systems are absent (Jiwatram-Negrón, Hunt et al. 2018; Jiwatram-Negrón, Michalopoulos, et al. 2018).

This relationship between violence and drug use is clearly reflected in regional research. Findings from the Eurasian Women's Network on AIDS (Eurasian Women's Network on AIDS 2023c, 2023a) suggest that women in Central Asia often use synthetic substances to cope with domestic violence and unmet mental health needs. In many cases, women report being introduced to drugs by abusive partners as a form of control (Gezinski et al. 2021). Once dependent, they become even more vulnerable to coercion, including forced sex or involvement in criminal activities. Drug use thus becomes both a coping mechanism and a site of further control. These patterns are intensified by the absence of protective mechanisms; the fear of losing custody of children or being placed on narcological registries discourages women from reporting abuse (Eurasian Women's Network on AIDS 2023b). In such an environment, survival strategies are criminalised rather than supported, creating a closed loop of trauma and punishment.

Reproductive Governance and Punitive Care

Reproductive health is another key domain in which layered stigma is expressed. Women who use drugs in Central Asia experience reproductive health violence in both direct and

systemic forms (Sauranbayeva 2025). This includes coerced abortions, forced contraception, and the routine denial of medical services, particularly by obstetrician-gynaecologists who often act as moral gatekeepers rather than care providers. In a regional study by the Eurasian Women's Network on AIDS (2025), 56 per cent of women reported verbal abuse during childbirth, while 46 per cent were denied essential medical care, including abortion and pain relief during labour (Sauranbayeva 2025).

These practices can be understood as a form of "punitive gynaecology," where reproductive healthcare becomes a site of control rather than support, and where women are shamed or coerced into medical decisions, often leading to long-term trauma and disengagement from the healthcare system. They are not isolated; they reflect a broader form of layered stigma embedded in institutional practice, where drug use is framed as a form of social deviance and met with medical punishment.

This violence is compounded by the absence of integrated, gender-responsive health systems. Despite international recognition of Opioid Agonist Therapy as safe during pregnancy, most maternity hospitals in Central Asia do not provide or consistently recognise this form of care. Consequently, postpartum women are often forced to travel daily to psychiatric or mental health centres to receive methadone, a requirement that disrupts infant bonding and complicates recovery. Furthermore, a lack of clinical training among physicians perpetuates harmful myths and results in poor pain management during childbirth (Sauranbayeva 2025).

The structural neglect and moralising attitudes within reproductive healthcare represent an institutionalised form of gendered control. Support is frequently conditional, tied to compliance with rigid moral expectations. Women encounter an institutional logic that suggests support is available only if they adhere to normative expectations of "respectable" motherhood. As Lopez (2020) argues, in these settings, even forms of care and compassion can operate as mechanisms of governance.

From a sociological perspective, these harms can be understood as a form of structural violence (Tyndall & Dodd 2020), where social institutions systematically constrain women's reproductive autonomy. These constraints operate through interconnected systems, including narcological registration, the threat of custody loss, and restricted access to healthcare. For women living in poverty or with limited access to education, this creates a situation where survival depends on navigating institutions that treat motherhood as a site of surveillance rather than care.

Gendered Agency in the Semi-Periphery

Within this context, women who use drugs must navigate institutions that combine surveillance, moral judgment, and limited access to care. As a result, contact with institutions often exposes women to risk rather than protection. One of the most enduring consequences of this is silence, both imposed and chosen. Silence emerges as a product of structural violence, but it also functions as a strategy of survival. Women may withdraw from services or disengage from treatment when they anticipate judgment, surveillance, or punishment. This means that silence is not passivity but a tactical response to a system that

penalises visibility. Trust is fragile, and once broken by experiences such as verbal abuse or the threat of registration, it is often difficult to rebuild.

Despite these constraints, women create spaces of resilience and solidarity. Community- and women-led initiatives across the region provide forms of care that are often more accessible, flexible, or responsive than those typically available in state-run or highly formalised systems. Organisations such as women's centres in Kyrgyzstan, including Asteria and Po-druga, combine harm reduction with legal assistance, temporary housing, childcare, and peer support, creating environments where women can seek help with less fear of judgment or surveillance. In Kazakhstan, organisations such as the Revanche Foundation combine peer networks with creative methods like social theatre to challenge stigma (Kowalczyk et al. 2025). Some organisations also engage in advocacy and public education, working with medical institutions and law enforcement agencies to reduce discrimination against women who use drugs. Creative initiatives such as peer-led social theatre and storytelling projects provide spaces in which women can articulate experiences that are otherwise silenced in public discourse.

These initiatives can be read as forms of “everyday resistance.” In a context where drug use is framed as a moral failure, a woman's insistence on her right to health or motherhood constitutes a form of political agency. This is most visible in narcofeminist groups, which explicitly link drug policy to broader struggles for gender justice, reclaiming bodily autonomy and dignity in the face of criminalisation (Bessonova et al. 2023).

Narcofeminism in Central Asia

In Central Asia, narcofeminism is increasingly articulated by women with lived experience of drug use, who frame it as a response to everyday forms of violence, stigma, and exclusion. Narcofeminism emerged as a feminist critical movement that challenges rigid patriarchal stereotypes portraying women who use drugs as either powerless victims or immoral deviants in need of constant protection or control (Bessonova et al. 2023; Chang 2023; Vale Pires et al. 2026). It addresses the specific forms of violence, exclusion, and rights violations experienced by women who use drugs. While its origins lie in Latin America, narcofeminism has gained significant resonance in the conservative social and political contexts of Eastern Europe and Central Asia (EECA). The term itself bridges two domains often constructed as incompatible—drug use and feminism—asserting that women possess the right to autonomy and bodily self-expression, including the use of psychoactive substances (Chang 2023).

In the EECA region, narcofeminism emerged as a transnational movement in 2016, following encounters between women who use drugs and feminist activists at the Association for Women's Rights in Development (AWID) Forum in Brazil. These exchanges revealed shared experiences of gender-based violence and institutional exclusion, particularly regarding reproductive and parenting rights. The movement was consolidated in 2018 and 2019 through regional meetings in Berlin, Barcelona, and Portugal, which allowed activists to more explicitly articulate the entanglement of drug policy and feminist struggle (Bessonova et al. 2023; Eurasian Harm Reduction Association 2019d). The political commitments of the movement were formalised in the Barcelona Declaration (2019). The Declaration frames the global “War on Drugs” as a war against women, describing it as

inherently sexist, racist, and classist. It rejects dominant treatment paradigms as gender-biased instruments of power rather than care, instead affirming women's rights to bodily sovereignty and the use of substances without fear of moral condemnation (Eurasian Harm Reduction Association 2019e).

These principles have taken on particular significance in Central Asia, where narcofeminism functions as a direct response to overlapping regimes of oppression. Regional activists highlight how women are subjected to punitive laws, narcological registries, and moralised expectations that cast them as “failures of femininity, maternity, and citizenship” (Dennis et al. 2023). The figure of the “drug addict” (*narkoman*) serves as a powerful tool of post-Soviet governance, legitimising public shaming and institutional punishment in the name of “national morality.” In this context, narcofeminist activism targets not only prohibitionist policies but the broader systems of gendered control that regulate women's bodies and care work. By framing drug use as embedded in broader structures of inequality rather than individual failure, narcofeminism echoes Ettore's (1992) insistence that women's needs cannot be met through “better policy” alone, but through autonomy and creative resistance (Ettore 1992).

Crucially, narcofeminism advances a positive political vision grounded in bodily autonomy and the right to pleasure. This insistence on pleasure is particularly disruptive in Central Asia, where women's bodies are viewed as sites of familial and national regulation. As Struzik (2021) demonstrates, harm reduction often operates within citizenship frameworks that either hyperbolise pleasure as a threat or silence it altogether (Struzik 2021). For women in the region, claims to pleasure—whether related to substance use or sexuality—directly challenge narratives that equate femininity with self-sacrifice and moral restraint (Bessonova et al. 2023). Activists describe how public resistance intensifies precisely when women assert the “right of an adult woman to smoke marijuana, or drink wine,” revealing pleasure as a flashpoint for patriarchal control. At the same time, they note that pleasure is structurally constrained under repression: poor drug quality, constant police surveillance, and fear of punishment make pleasure inseparable from pain and risk. This tension aligns with Jauffret-Roustide's (2023) argument that pleasure constitutes a form of experiential expertise in drug use, yet remains difficult to articulate within harm reduction systems shaped by prohibition and medicalization (Jauffret-Roustide 2023).

Despite these forms of resistance, narcofeminist organising in the region remains fragile. Activists report harassment and exclusion not only from state actors but also from male-dominated drug movements and mainstream women's spaces that struggle to accommodate women at the intersection of drug use, sex work, and HIV. This fragmentation reflects the layered nature of stigma that narcofeminism seeks to challenge and underscores the difficulty of building collective political space under conditions of surveillance and moral regulation. It also highlights the need to move beyond surveillance-based governance towards forms of care that recognise women as rights-holders rather than objects of control.

Conclusions

The experiences of women who use drugs (WWUD) in Central Asia show how layered stigma operates as a mechanism of social exclusion, produced at the intersection of

punitive policy, gendered surveillance, and medical neglect. This analysis builds on broader sociological work on stigma, gender, and drug use (Ettorre 1992; Fraser & Valentine 2008). As this article has demonstrated, drug use in the region is rarely interpreted as a health practice alone; it is framed as a moral failure that violates dominant norms of femininity, motherhood, and respectability (Measham 2002). These interpretations contribute to women's heightened exposure to criminalisation and institutional control—mediated through law enforcement, narcological registries, and family courts—while simultaneously rendering their specific needs invisible within care-oriented services.

Situating these findings within a semi-peripheral context helps explain how structural violence becomes embedded in the region. In Central Asia, post-Soviet governance systems, including narcological registries and legal frameworks that associate drug use with restrictions on parental rights, closely connect moral judgment with administrative control. This interpretation is consistent with broader arguments that drug policy often combines moral regulation with institutional governance (Stevens 2011; Zigon 2019). While harm reduction systems elsewhere are also shaped by moral assumptions, drug governance in Central Asia relies heavily on law-enforcement-led structures that embed stigma within state institutions. This creates a hybrid system in which donor-funded initiatives coexist with punitive practices, often resulting in a situation where surveillance outweighs care.

Analyses of the region often focus either on vulnerability or overlook local forms of agency (Laruelle 2021). However, as this article shows, women who use drugs are not only subjects of control. They actively navigate, negotiate, and resist these conditions through everyday practices of care, solidarity, and strategic engagement. Community-based, women-led initiatives play an important role in addressing service gaps and responding to institutional violence. These practices align with narcofeminist perspectives, which understand survival, mutual care, and bodily autonomy as political acts.

Paying attention to women who use drugs in Central Asia is not only a matter of filling a regional gap, but of rethinking how knowledge about drug use and care is produced. Currently, institutions privilege medical, legal, and donor-aligned expertise over women's lived experience, treating them as objects of intervention rather than subjects of knowledge (Azbel et al. 2026). Recognising that WWUD produce alternative forms of knowledge is essential for moving drug sociology beyond Euro-American frameworks toward approaches grounded in solidarity and plurality. These perspectives offer important insights into how women in Central Asia navigate a hybrid landscape of post-Soviet surveillance and global health interventions. Embracing “transformative discomfort”—allowing interventions to be reshaped by community priorities—is a necessary step toward decolonising addiction treatment (Azbel et al. 2026). Narcofeminist organising reflects precisely this move: women repositioning themselves not as patients to be managed, but as political actors redefining care, pleasure, and governance.

Treating Central Asia as analytically peripheral has led to its importance being overlooked in broader debates on drugs, governance, and care. The gendered dynamics of stigma and bodily regulation discussed here are not unique to the region, but resonate with patterns observed elsewhere (Ettorre 1992; Measham 2002). Recent shifts in drug markets, including the rise of synthetic substances and changing patterns of use, also mirror broader global trends documented in international reports (United Nations Office on Drugs

and Crime 2020, 2024). At the same time, the region's long-standing use of psychoactive substances in medical and everyday practices is rarely reflected in contemporary policy and research debates, which tend to frame drug use primarily as a public health or security problem. Rather than being a passive recipient of global policy, the region acts as a "translational site" where international health agendas are reconfigured through local authoritarian and patriarchal logics. As a result, it helps us understand how global policy is shaped and changed in practice. As scholars of imperial and post-imperial contexts have argued, perspectives from the margins often generate critical insights by exposing the limits of centre-based analytical models (Gerasimov et al. 2012). Attending to this context helps reveal how global governance and local institutional legacies interact in practice, and why ignoring such settings risks reproducing existing epistemic hierarchies. Taken together, these findings suggest that understanding drug use in Central Asia requires attention not only to policy and institutions, but to the lived experiences of women, through which layered stigma and its effects become most visible.

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