SRH Landscape:

What is to be done?

Who is to blame?

Study of barriers to youth-friendly sexual and reproductive health services delivery and reception

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**Table of contents:**

1. Introduction
2. Research methodology
3. SRH Actors
   1. International organizations and development agencies
   2. Family Institute
      1. Family members’ understanding of SRH concept
      2. Dominant practices of (re)production and maintenance of SRH
      3. Different family members’ self-identification in the SRH (re)production cycle
      4. Patterns of communication on SRH or SRH family discourse
   3. Institute of Education
   4. Institute of Health
   5. Institutes of Civil Society (NGO)
   6. Religious institutes (Islam)
      1. SRH and expertise of religious figures
4. Paradoxes of Power and Responsibility in SRH Sphere: What is to be Done and Who is to Blame?
5. Conclusions and Recommendations
6. Glossary

**Introduction**

For many years, there are continuous discussions on sexual and reproductive rights and education in the Kyrgyz Republic. The legal, moral and political battles on admissibility of women’s right to choose abortion, citizens’ right to freely identify their sexual orientation, to use contraceptives and to family planning have divided the society into many groups with pronounced two radical poles – the national patriots calling to highly and proudly carry the banner of normative heterosexual culture bequeathed by fathers, and the liberals calling for equal rights, opportunities and results.

On the background of these serious fights, the real sexual and reproductive activity of the population is going on: the fertility rate of the population is increasing (from 2.8 to 3.2 for 2008-2013), the proportion of women using contraceptives is decreasing (from 33% in 2008 to 30.1% in 2010), and contraceptives use coefficient is also decreasing (for the last five years - by 1.8 times), and the proportion of early, teenage pregnancy and abortion is increasing[[1]](#footnote-1), although the level of induced abortions has remained unchanged for the last 30 years[[2]](#footnote-2).

Despite numerous SRH studies held in the KR, today it is difficult to imagine the picture or landscape of the sexual and reproductive behavior and culture.

Who and which actors today protect the sexual and reproductive rights and freedoms of women and men, and how do political agendas occur, and why are barriers formed in SRH? The present research is an attempt to answer these questions and explain the causal mechanisms of changes taking place in the society.

**2. Survey Methodology**

The data presented in this report were the result of the research carried out with use of qualitative research approaches, namely the focus-group discussions method, in-depth interviews and sample purchases. Empirical information was collected in four cities of the Kyrgyz Republic: Bishkek, Karakol, Kyzyl-Kiya, and Osh, as follows:

* 16 FGDs with representatives of young people from 15 to 24,
* 8 FGD with parents of children from 15 to 24,
* 12 semi-structured interviews with doctors, teachers, religious leaders,
* 4 sample purchases of reproductive health services.

Field work took 6 weeks, and data collection took place from February 3 to March 16. Below is information on the qualitative survey procedures.

***FGD with young people***

The FGD with young people from 15 to 24 had an objective to study the following:

* image of the future of young people,
* perception of sexual and reproductive health and family planning concepts,
* motivation to preserve and strengthen reproductive and sexual health,
* attitude to intimate life before marriage,
* reproductive tenets (preferred number of children),
* attitude to childbirth and abortion,
* contraceptive use and related decision-making process,
* awareness of the STI diagnosis and treatment,
* gender aspects of access to sexual and reproductive health information and services,
* trust in health workers.

In addition to questions, the FGD scenario developed by the research team included a number of associative and projective techniques. The average duration of the focus-group discussions was 2 hours. In addition to involvement in the discussions, each participant filled in the FGD questionnaire containing socio-demographic questions as well as questions about contraceptive methods, channels of information on sexual and reproductive health and their credibility. Socio-demographic characteristics of the FGD participants are presented in the diagram below.

Diagram 1. Social and demographic characteristics of young people participated in the FGDs

In each of the surveyed cities, 4 separate FGDs were held with girls and boys in two age categories: from 15 to 19 and from 20 to 24. In total, 136 respondents attended the discussions, and on average the respondent focus group consisted of 8 people. FGDs were attended by young people who use the YFC services in the field and those who did not receive or use those health facilities services. Such qualitative research scheme has revealed major differences in the level of awareness of reproductive health between two groups of young people.

All FGDs were recorded on the digital audio media for further analysis. There was also a transcript of conversation records, which was used for qualitative data analysis using the Nvivo10 SW.

***FGDs with parents of children over 15***

FGDs with parents of young people from 15 to 24 had the following objectives:

* description of their role as mother and father and the degree of involvement in maternity, paternity,
* motivation for reproductive tenets and practices,
* nature of their relationship with children,
* image of an ideal mother and father,
* image of the ideal woman and man,
* perception of the sexual and reproductive health, family planning concepts,
* motivation to preserve and strengthen reproductive and sexual health,
* attitude to intimacy before marriage,
* attitude to childbirth and abortion,
* contraceptive use and related decision-making process,
* awareness of the STI diagnosis and treatment,
* trust in health workers.

In addition to questions, the FGD scenario included a number of associative and projective techniques, both generic and specific for mothers and fathers. The average duration of the discussions was 2 hours. In addition to involvement in the discussions, each participant filled in the FGD questionnaire containing socio-demographic questions as well as questions about contraceptive methods, channels of information on sexual and reproductive health and their credibility. Socio-demographic characteristics of the FGD participants are presented in the diagram below.

Diagram 2. Socio-demographic characteristics of the participants of FGDs with parents of children from 15 and above

In each of the surveyed cities, 2 separate FGDs were held with fathers and mothers. In total, 59 respondents attended the discussions, and the average size of the respondent focus group was 7 people.

All FGDs were recorded on the digital audio media for further analysis. There was also a transcript of conversation records, which was used for qualitative data analysis using the Nvivo10 SW.

***In-depth interview***

By results of the survey, 16 expert interviews were held. In each of the sampled settlements, teachers, health workers, reproductive health service providers, as well as religious leaders were interviewed.

The following objectives were pursued by the in-depth expert interviews with professionals:

**Interviews with health workers**

The objectives of the in-depth expert interviews with health professionals were to measure the Professional burnout syndrome, and to explore the opinion on the role of healthcare system in promoting SRH.

In this research, the Professional burnout syndrome (PBS) is defined as a set of emotional and energetic, physical and mental exhaustion, which develops on the background of chronic job stress. The workers whose job involves communicating with other people: health workers, teachers, social workers and others are subject to this syndrome.

Health workers who participated in the survey were asked to complete a questionnaire consisting of 22 statements about the feelings and experiences related to their work, and to specify how often they have such feelings.

This technique is intended to diagnose three PBS indicators:

* Emotional exhaustion, which is defined as fatigue and decreased emotional background,
* Depersonalization, which is manifested in the increase of negativity and cynicism in attitude to patients,
* Reduction of professional achievements, which indicates low self-esteem, their professional achievements and opportunities.

**Interviews with teachers**

Interviews with teachers helped to answer the following questions:

* How often the SRH issues are discussed in schools? Why? In what format and who conducts such discussions and on whose initiative? Which topics are discussed?
* What are the challenges faced by teachers in discussing such issues?
* How do teachers assess their competence in SRH? What topics can they discuss and which they cannot discuss? Which resources are available for teachers?
* What is teachers’ attitude to the introduction of the compulsory subject on reproductive and sexual education, and why?
* Which approaches and methods of teaching of reproductive and sexual health basics are most suitable for teenagers?

**Interviews with religious leaders**

Interview with the religious leaders had the following objectives:

* Identify the attitude of religious leaders to the need for reproductive and sexual education of youth,
* Explore views on the role of religion in the reproductive and sexual education of adolescents,
* Identify the most preferred approaches and methods of teaching the basics of reproductive and sexual health.

***Sample purchases***

The essence of the “sample purchase” method is that information about the practice of providing reproductive health services is collected in the process of applying for services. The respondent accompanied by the surveyor, applies for services anonymously, with the rights of an “ordinary recipient” and without declaring the survey purposes. He/she passes all (or some of) the steps of services - from search for information about the rules to getting the result - and records his impressions of the process of receiving services, problems, issues and ways to resolve them. The consumer reports to the representative of authority in any form (by telephone, in writing, by personal meeting, etc.).

In total, 4 sample purchases were made in cities of Osh and Bishkek: with 2 boys and 2 girls. In Osh city, the sample purchases were made for the following services:

- Prenatal care: a girl visiting a gynecologist,

- Education / awareness about sanitation and hygiene procedures: a boy visiting an urologist.

In Bishkek city, purchases were made for the following services:

- Treatment of chronic reproductive diseases: a girl visiting a gynecologist,

- Counseling on family planning: a married couple visiting a gynecologist.

During each sample purchase, the surveyor filled in the form. The form included questions about the time and financial costs of the respondent, on the information support in the facility, description of admission premises and workplace of the specialist, interaction with the specialist and information support via Internet. All data from observations were also recorded in the form of essays, detailing all the steps of receiving the service.

**3. The sexual and reproductive health actors**

Social practices of observance of the sexual and reproductive relations norms in society are maintained by different persons and units - actors.

Based on common sense, people distinguish those who are “responsible” for compliance of different categories of the population, especially young people, with the behavior standards and regulations in the field of sexual and reproductive relations. The obvious actors in this field may include the following:

* Family institute, where presumably an individual should receive basic knowledge and information in this area, and absorb the behavioral patterns;
* Institute of Public Health, which aims to prevent and treat abnormal consequences of sexually deviant patterns of sexual and reproductive behavior in accordance with the letter of medical science;
* Institute of Education, which aims to provide expert functional knowledge to an individual and to provide the ethics concept of sexual and reproductive behavior;
* Civil society institutes (NGOs), which protects the individual’s rights for access to basic health, education and other services supporting sexual and reproductive health and awareness;
* Religious institutes (Islam), which ensures transfer (production) of cultural values and knowledge of sexual and reproductive behavior “norms” and appropriate strategies and tactics to maintain health in this area;
* A distinguished actor is a group “youth” as the primary recipient of SRH-services: boys and girls of different age cohorts (in this survey - two, for more details please refer to sampling in the methodology part);
* The category of non-obvious actors may also include international donor organizations and development agencies that formulate normative concepts and standards of sexual and reproductive health, mainly based on the human rights concept.

Practices of the abovementioned and other non-obvious actors in the field of sexual and reproductive health and behavior are formed as a system of different networks, power relations, manifested and practiced interactions of material resources and individual \ collective knowledge.

This chapter of the report focuses on the study of strategies and tactics in (re)production of the sexual and reproductive relations used by each of the actors.

**3.1. International organizations and development agencies.**

The category “international organizations and development agencies” in this survey is uncritically generalized because this range of actors may include a variety of structures promoting often conflicting values. Part of the units can be represented directly in the country – as incorporated into the local institutional landscape, and the other part can be present in the field of reproductive sexual relations in our society through the products of their activity - formal agreements, conventions and other instruments. For local actors, the list of structures that can be categorized as “international organizations and development agencies” will vary depending on the actor’s disposition. Nevertheless, there are dominant structures of international donor organizations.

“Mainstream” of this category is represented by the European and American organizations, and sub-structures, especially EU and UN. It is through these organizations, the SRH definitions and approaches are adopted, local SRH standards are developed and implemented; according to the civilizationist initiatives of these organizations, the KR reports on implementation of the SRH policies, presenting the “front stage” products of activity. “Actorship” of international organizations and development agencies is expressed not only in “formulation of agendas” of the national government and local authorities activity, but also in providing resources for this activity. In addition, the symbolic capital provided by these structures allows a country to be more or less successfully incorporated into the global processes of resource allocation and political support.

However, for various reasons there is a significant gap between global practices of implementing the SRH-oriented methods and approaches and the localized actual policies and practices. It lies in the fact that despite the manifested tenets, through active cooperation of international organizations, local NGO and the Government of KR, the SRH practice is basically reduced to strictly protocoled and medicalized approaches, which often disregard the cultural, social components of modern society of the KR.

For example, according to the WHO definition, “Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes, including reproduction and harmony in psychosocial family relationships.” [[3]](#footnote-3) Local reproductive health standards are reduced to the health of citizens of fertile age (motherhood, childhood, male reproduction) and do not include social determinants.

For the population, gap between the manifested and practiced activities is not just misperceived, but creates the simulated reality in which the political and nationalist quasi-religious rhetoric justifies the apparently negative statistics on maternal mortality and abortion among teenagers.

* 1. **Family institute**

Since in this chapter we aim to demonstrate the features and details of how this or that institution functions as an actor in (re)production of SRH, the key aspects in this paragraph include:

* Family members’ understanding the SRH concept
* dominant (re)produced practices of maintaining SRH
* self-identification of different family members in the cycle of (re) production of SRH
* SRH communication models or family discourse of SRH.
  + 1. **Family members’ understanding of SRH concept**

According to the survey respondents, the normative composition of the “appropriate” family life in recent decades has undergone major changes. First, this is reflected in understanding of the meaning of family and marriage life, family planning, sexuality of children and parents, and the risks of sexual and reproductive health. The focus group discussions revealed that quite a significant portion of the participants either had no idea about the SRH, family planning concept at all, or had a rather vague and inadequate knowledge about it.

Despite the “sexual revolution” and liberalization of sexuality, in all societies, there are still stereotypes of thinking about sex, according to which sex “may be redeemed if performed within marriage for procreation purposes and if the pleasurable aspects are not enjoyed too much.” [[4]](#footnote-4) A large portion of our respondents “draw” a normative model of sexuality as inseparable from reproduction occurring within marriage and not pursuing the enjoyment of pleasure.

Discussing sexuality and reproduction, the respondents invariably switched to debates about the meaning of marriage and the family. Sometimes it seemed to the respondents, particularly from the older age groups, that even the question about the meaning of sexuality realization in accordance with the statutory canons of the family and marriage relations is inappropriate.

Interestingly, in most dialogues, family relationships are replaced by domestic economic situation and relations, which is the synecdoche technique used when the whole is reduced to its parts, and the argument is built on this basis. As the researcher Ushakin notes, the logical operation is usually characteristic of the (post-)Soviet tradition of functionalistic interpretation of family and society. “... Through a series of reductions, a sequence was built “family” – “farm” – “working hands” – “men's labor force”, where the quantitative logic is applicable. Thus, the family turns into a kind of a “labor artel” aimed at the biological and material self-reproduction.

Since in everyday life each participant faced the childbirth facts, heard or had been involved in any capacity in the abortion story, the abortion and childbirth categories perceived by the participants are universal and well-defined. However, a more detailed examination of understanding of these terms indicates the absence of definitive unambiguousness of concepts in the respondents’ minds. So, below is a summary of questionnaires for FGD participants interpreting the concept of “childbirth”[[5]](#footnote-5) that were clustered into four dimensions : 1) feelings; 2) the degree physiologization or deification of the delivery process; 3) evaluation based on the criterion of “providence, holiness” or “human work, everyday life”; 4) evaluation of the temporal continuum.

Scheme 1. Range of definitions of “childbirth” by the respondents



**Future**

**Perspective**

**Length**

**Moment**

**Point**

**Secular**

**Labor**

**Miracle**

**Sacral**

**Sacrament**

**Birth of a living being**

**Increased population**

**Dehumanization**

**Happiness**

**Happiness, joy, miracle**

**Unbearable pain**

**Suffering**

As can be seen from the scheme, the respondents’ rates vary quite dramatically: for someone it's pain and suffering, for others - happiness (and one of the respondents – male, distancing himself, noted that it is “motherhood happiness”); some respondents focused on the delivery process, describing it in terms of a dehumanized as “physiological process of fetus coming out from the womb”, while others defined the delivery process in terms of the sacred – “sacrament of birth of human being”, and the thirds talked about the impact of –“increase in population.” Many respondents placed delivery into time continuum in which delivery could be assessed as a “point, moment of happiness”, as the beginning stage of “human formation” or as a forward-looking process of “procreation.”

Diagram 3. Quantitative proportions of associative definitions of childbirth by respondents, by their gender

The respondents also had variable understanding of the term “abortion”. There were the following interpretations:

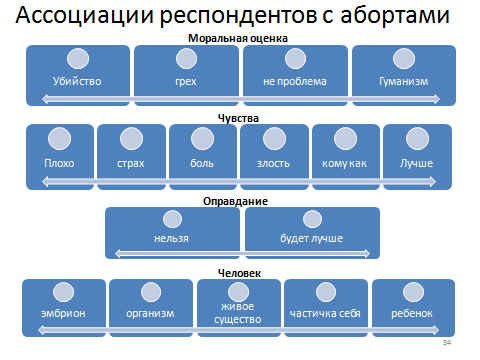
1) those who were focusing on moral judgments of abortion, often in religious terms or in terms of human rights,

2) those who described the range of emotions caused by this phenomenon and the term,

3) those who have tried to find an excuse or condemn, as well as those who are focused on assessing what \ who is being aborted – an embryo or a human being.

Scheme 2. Continuum of associations with the term “abortion”, a summary for survey respondents

**Moral judgment**

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**Feelings**

**Justification**

**Human being**

**A child**

**Part of oneself**

**Living being**

**Organism**

**Embryo**

**Will be better**

**Prohibited**

**Better**

**Not the same to everyone**

**Malice**

**Pain**

**Fear**

**Bad**

**Murder**

**Sin**

**No problem sm**

**Humanism**

The diagram below represents the gender disaggregated data on the associative definition of abortion by the survey respondents.

Diagram 4. Associative definition of abortions by the respondents

Some monologues in focus group discussions about deliveries and abortion allow you to see that in fact, even such routine procedures and phenomena as delivery and abortion are inadequately understood by many citizens, but such inadequacy and illiteracy are well placed to choose the polar position - advocate for women's right to choose their reproductive strategy, or against abortions (prolifers) without explicit knowledge and reasoning.

Interesting fact: despite generally negative attitude to abortion, only in a few cases, it has been interpreted in terms of woman guilt.

The diagram allows noting high proportion of intolerant, negative views of abortion among women. It is women who dominated in such interpretations as: *“abortion is a sin”, “abortion - is the death of a child”,* and only women presented the category of opinions *“abortion is the deprivation of life to those, who could be useful to society in the future.”* At the same time, in a number of response categories that tried to go beyond the stigma, women were more activ*e: “abortion - is the solution”* (here we see an attempt to routinize, symbolically reduce the emotional color of abortion and equate the unwanted pregnancy to economic problems); *“abortion is an act which may be desirable or undesirable, but it is not murder.”* According to results of the study, contradictive and ambivalent reviews of abortion demonstrated by women during this survey are typical of the majority of female population in the world, and besides, they significantly differ from the actual behavior of men and women who faced unwanted pregnancy as a personal problem.

Commenting on the “ambivalent” results of the survey of public opinion on abortion in different countries at different historical intervals, the famous researcher Rosalind Petchesky notes that there is a radical difference in the responses to questions of a public opinion survey and the actual behavior of the respondents, when they face unwanted pregnancy of their daughters, girlfriends, wives and sisters. Fragility of ethical attitudes to abortion as a woman's choice correlates with the regime of discrimination, stigma, and reflects the massive ideological struggle affecting the very concepts of motherhood, women's sexuality, family and the state.[[6]](#footnote-6) Thus, considering the attitudes and perceptions of respondents on SRH allows us to conclude:

* Most respondents are uncritically guided by the stereotyped, groundless judgments-clichés, which sometimes hides lack of any understanding or inadequate understanding.
* Level of understanding of the SRH concept is not correlated with age and presence of marital and family status of respondents that is likely indicative of non-reflexive sexual and reproductive experience.
* Reasons for non-reflexive sexually reproductive experience have not been studied, although as a hypothesis one can formulate, that this is due to the ideological tradition of taboo of anything related to human sexuality and lack of language and culture of speaking “about it.”
* The sexual and reproductive health including the concepts of abortion, delivery and family planning are the core of a great ideological struggle in the state and society, in which there are forces who intend to somehow design woman’s sexuality, motherhood and the family itself as a “cell” of the state.
  + 1. **Dominant practices of (re)production and maintenance of SRH**

The key characteristics of SRH practices maintenance in everyday life may include the reproductive needs, attitudes, motives and actions of the respondents. Under the present survey, the reproductive behavior components were identified: respondents’ subjective presupposition to the parenthood (fertility, having children), use of contraceptives, as well as strategies to prevent the reproductive health risks, including STI.

Specialized literature, especially in the study of demographic processes pays great attention to reproductive behavior. Among the factors that, according to demographers, affect the reproductive behavior the following are the priority ones: socio-economic situation in the country, predominant lifestyle of the respondent's family, as well as value factors (consideration of the mother and child life protection), which may affect more than such factors as low security and social vulnerability of the family.

**Scheme 3. Causal graph of factors determining the reproductive behavior[[7]](#footnote-7)**

**Abortion denial**

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**Orientation to having many children**

**“Expected” number of children**

**“Desired” number of children**

**Spiritual and moral reasons preventing reproductive planning**

**Social and economic reasons preventing reproductive plans**

**Having many children**

**Attitude to delivery**

**Abortion enabling conditions**

**Age**

Recognizing the functional meaning of marriage predominantly as a pragmatic pledge (*“To have someone to give a glass of water in old age”*), the respondents respectively form their reproductive attitude to the ideal (desired) and planned (expected) number of children: the ideal model would be many children, without specifying the gender proportion of children (often religious explanation is – *“whom and how Allah will give”*), and planned from 1 to 3-4 children, with priority for the boys. In the focus group discussions with different age groups of men and women, we noted higher gender difference in the planned parenthood among young girls and boys.

Boys and young men have often articulated a desire to have one - two children due to difficulties with their material support – the function that they automatically delegated to themselves as a sex-role requirement.

Among boys, there were many of those who, in principle, recognized the need to have children, but in their conversations about the future, the children were not an attribute of real desire - with detailed descriptions - but they just called them a general concept “children.”

In focus group discussions, the boys often confirmed that children is an adult male’s attribute of life, it is important to have them, but to be with them, to participate in their development – is not important for men.

Fertility parity coefficient among girls who participated in FGDs, on average, is higher than among males. There are a number of pictures, which also shows the “normative” family with two - three children, which, as a rule, draw very clearly the material objects, which should become an integral part of women's life. In the context of explanations of their reproductive principles, the respondents clearly articulate several provisions: family, marriage and the birth of children - forced, imposed from the outside (society), an unwanted project. Achieving the material wealth accompanied by change of marital and family status of young girls, is designed to compensate the imposition of a project from outside, and its costs.

Due to the fact that among the respondents – boys, there was none who would articulate and draw their reproductive plan to have many children, we wondered why the girls who tend to frequently perceive childbirth as pain and suffering and other “costs”, nevertheless, to some extent, tend to plan a large number of children in the future. As a hypothesis, we may say that the high fertility parity coefficient adds to the status of women in marriage, provides women with more rights and power in the family and that is why it becomes an essential factor of reproductive guidelines and behavior.

Another important aspect of reproductive behavior and attitudes - is the respondents’ attitude to the reproductive diseases and the strategies they use to protect SRH. Identified in the focus group discussions, awareness and knowledge of respondents about the diseases, including STI, as well as the male and female SRH protection strategies are full of myths and fantasies, often ignorant and have high risk of discriminatory practices against anyone, especially women.

In discussions, Bishkek and Karakol mothers of the mature children mentioned the diseases that were not mentioned in other focus groups, and probably, other respondents were not informed of them. They included the following: chlamydia, human papilloma virus, genital herpes, syphilis economica, thrush.

Women mentioned the following consequences:

“Infertility, sometimes leads to death, full of discomfort”, “infertility, then cancer. For women, the first thing is a cancer, followed by inflamed cysts, inflamed epididymis, ovaries, and they cut everything there. A woman cannot give birth, she did give birth to one child, and that’s all, she will never become a mother – that is the risk. And this is dangerous for young people, because when a woman lives with somebody already, she somehow communicates more with those who are sexually active, while young people do not know. They do not know and it is dangerous for them, that they will not have children.”

Despite the general concerns of respondents of getting infected themselves or that young children will be infected with sexually transmitted infections, young men also expressed views and opinions, which can be attributed to the model of risky behavior.

SRH protection strategies, practiced by the respondents differ significantly by age and gender categories.

Position on contraceptive use varies greatly depending on the region, so there are age and gender differences.

Thus, the position of the religious-minded groups of youth FGD in Kyzyl-Kiya in response to the need to use and distribute contraceptives is categorical:

“No, we should not. Our nation is ranked as disappearing, so we should not use contraceptives.

During the discussion about contraception among boys in Karakol (19-24), a solidary idea was expressed:

"In some Muslim countries, it was banned. There is and increased the number of sex infections, STIs, there was such case. If we prohibit selling condoms, the government may set a target. Why has the birthrate fallen? Because condoms are sold – there may be such propaganda. They may prohibit selling condoms, but then we will have the boom of communicable diseases”.

Decision on the use of contraceptives and responsibility for their use depends on the type of contraception, according to Karakol men:

“Depending on the type of contraception: if this is on the female side, let them do it, if it on our side, we will do. On our side, it is condoms, on women’s side it involves, for example, IUD, contraceptive pills, and it's woman’s responsibility to apply them, with consultation with a gynecologist.”

Understanding of the methods and effects of different methods of contraception sometimes is far from the truth, and mythologized or demonized:

“There are also magic pills. Or IUDs ...”

“Well, it's for a year or two. And anyway, if she would wear them, fallopian tubes with clench and will never unclench.”

“Well, it functions a little bit differently. The sensor is placed in the uterus and removed if necessary. That is, when it is time to have children, the hormonal form is restored. As far as I remember, it’s a month. And that’s all.”

“Well, anyway, these tubes do not unclench”.

Study of the reproduction and SRH maintenance practices among the respondents groups allows to make preliminary conclusions:

* The planned childbearing coefficients differ significantly among young men and women which is due to socio-cultural contradiction of “norms” for status of a man as a provider and the family breadwinner, and by the symbolic capital of a woman, which is multiplying proportionate to the number of children born in marriage.
* Despite the religious values of unlimited fertility in marriage, actively promoted in a number of discussions such factors as: socio-economic situation in the country, the quality of life of respondents, taking care of your mother's life protection, effect the reproductive and contraceptive practices and principles.
* Hypothetical patriarchal attitudes to sexual and reproductive practices are not the guidance for personal experiences of the respondents, when their own health or that of their neighbors are concerned.
* The level of knowledge and awareness of the reproductive diseases risks, effective strategies for SRH reproduction and maintenance, does not depend on age, gender of the respondents and their family and marriage experience.
* Mythologization of consciousness becomes an objective result of the respondents’ limited knowledge of SRH.
  + 1. **Different family members’ self-identification in the SRH (re)production cycle**

In the course of the research, authors of the report repeatedly changed their assessments of different family members as actors in the SRH reproduction cycle.

While reflecting on the girls’ and young women’s experience of discrimination (in particular, bride kidnapping, forced marriages and forced child delivery, limited opportunities to adopt family planning related decisions, the use of contraceptives and abortions), as well as expressed opinions regarding the experience of creating a family and forced marriage coupled with problems, we decided that this category of family members are neither subjective with regard to sexual and reproductive sphere, nor are actors in the SRH reproduction cycle. However, a number of cases that have been collected during the research, and the fact that adult women in families are often the centers of power and decision-making on SRH, made ​​us to reconsider previous hypotheses about non-subjectivity of young women and girls. The same dynamics in the assessment was also typical for another category of respondents - boys and young men. From the idea that they are the decision-makers on SRH, we came to the conclusions based on the obtained data that they can hardly be called as valid actors. To justify these estimates below is analysis of men’s and women’s roles on SRH reproduction cycle in the family based on self-identifications of the respondents during the research in the following dimensions: understanding of their (gender) roles in the family by the respondents, understanding of gender ideals and practice of establishing the relations between generations in the family.

Most mothers of adult children, who participated in the focus group discussions in Bishkek and Karakol perceive themselves as centers of the family, its “sun” and “soul”, while being often dehumanized (even as the image of the “cloud”). They call ideal mothers as supermoms and then humbly acknowledge that “all mothers are perfect”.

Mothers in focus groups in Kyzyl-Kiya and Osh refused to draw the image of the ideal mother, they provided verbal descriptions: in their view, ideal mothers are their own mothers (and even mothers-in-law), those, who are able to bring up their children, they are well-bred, caring, exemplary and are models for others, are keen and observant, believers and follow pillars of Islam.

Summarized list of features of the ideal mother see below in the following Chart “Ideal mother is ...”:

Chart 1. The list of features of the ideal mother



Caring, attentive to family and relatives

This is my mother

Happy

Spiritual link

Fireplace keeper

A true believer

A role model

Loves her family and children

Ensured upbringing and well-being of her children

Wise

In answer to the question how women assess themselves as mothers, the following responses were received, which were almost identical with the characteristics of ideal mothers (in drawings and verbal definitions):

* I am kind, smart and happy,
* I take care of the family and work like a squirrel in a wheel,
* I am loving and kind,
* I work for the sake of my children
* I am quick-witted,
* I am fair,
* I am a friend and protector for my children,
* I am tough and do not spoil my children, I work for their benefit
* I am gentle and caring.

It is important to note that there was almost no difference in responses of women from different regions: the lists of mothers’ virtues, irrespective of their place of residence, age and nationality were quite similar.

An interesting thing was the comparison of female respondents’ answers to questions about their associations and perceptions about who a true woman is.

Summarized list reflecting the hierarchy of the most frequent definitions see below in the chart “A true woman is …”:

Chart 2. List the characteristics of a true woman



Life partner

Sturdy, has patience

Happy

Good looking

Educated

Self-sufficient, active

Decent

Caring, loves her family

Kind, understanding

Desired

Comparison of summarized charts shows that there are not so many coincidences in the definitions of the ideal mother and true woman: kind, understanding, happy and caring – is the exhaustive list of “coincidences”. The definitions of a real woman include characteristics of ideal mothers (fireplace keeper, truly believing) that are opposite to paternalistic qualities and properties of the sexual object (desired), subject of their own lives (self-sufficient / independent, socially active, business-like, self-sustaining). It seems deeply symbolic and symptomatic that in characterizing themselves as mothers, women almost did not include features that from their point of view were relevant to a true woman. As a hypothesis it can be assumed that women intentionally stick to a mythological image of mother voluntarily renouncing signs of sexuality, autonomy and desire, as it is the image of a mother that gives greatest benefits and promotes adoption of power authorities of women in the family. This way, over-emphasis and idealization of maternal qualities of the women is a purposeful rational model.

Indirect evidences of such interpretation are evidences provided by the Bishkek and Karakol female participants of focus groups about traumatic experiences of mothers and daughters relations and conflicts that do not cease with acquisition of mother status by daughters.

Another indirect indicator of purposeful rationality of the mythologized image of the mother is the will and desire of women without children to obtain the status of a mother. Thus, in the course of FGD participants repeatedly told about the life of some women, whose life scenario did not fit the norm, either because they were not married and / or could not have children.

The gender-role ideal father in the family is defined by male respondents in a less diverse way. For example, FGD participants - fathers from Osh formulated the concept as follows:[[8]](#footnote-8)

* through responsibilities - “to serve as an example in relation to children, wife, parents”
* by maintaining “normative masculine” characteristics - “keep the word”, “be tough”, “do sports”, “be respected”
* through “human dimension” of the relations - “have trust relationships with children”, “be honest”

Chart 3. List of characteristics of an ideal father



Caring, loves his family

Happy

Smart, purpose-driven

My father

Kind

Has integrity

Authority

The most demanded and frequently mentioned characteristic of the ideal father - the authority - paradoxically was dependent on mother’s role in the family. As noted by one of the FGD participants in Osh, *“father's authority depends on the mother”*. In fact, it means that father’s image is neither independent, nor powerful, as the key characteristic of the image are not formed by him.

Fathers’ care and love to children is also important in shaping the image of an ideal father. Here, in describing the way and extent of father’s care for their children, there are two radical oppositions: one - the traditions of patriarchal image of breadwinner, who works for the good of children (this motive prevails in the southern focus groups) and has to interact with children indirectly through mothers of the children (i.e. the wife) and the second – with an attempt to redefine, reinterpret father’s image as the main person in the family, who takes care of the children.

So, during focus group in Bishkek, the most frequently provided characteristic was “caring father”. One of the participants even used a perverse metaphor – a bird father, making a nest, breeding, protecting and feeding the chicks.

Despite the apparent difference between the two approaches to ideal fatherhood[[9]](#footnote-9) - traditional breadwinner and non-traditional care giver and guardianship - they belong to one and the same normative scenario of masculinity implementation and prescribing house–family, tree, son (offspring).

* + 1. **Patterns of communication on SRH or SRH family discourse**

For the vast majority of the respondents home and family were not the place where they ever discussed SRH. Like one of the mothers in Bishkek, many young girls, young men and fathers in all focus group discussions stated that no one ever raised this topic.

In rare cases when there was communication on this topic, it was held in such a way so that boys and girls remembered the trauma of such communication for a long time. For example, one of the participants from the group of mothers in Bishkek recalled the following:

“For example, the topic about menstruation and puberty, I remember my aunt, who was three years older than me - I was 13 years old and she was 15. She decided to make a joke on me and said that menstruation lasts for one month and three days you have no menstruation. I cried for 3 days. It was very cruel, I still remember it. My aunt told: “I was joking, and you are so naïve”. My mother never told us about such things; it was the period of USSR. All information came from elder aunts or from the street...”; “P2: in the place we live people do not speak about this, for some reason they are afraid. As they say, “there was no sex in the USSR, but for some reason kids appeared”. When I had menstruation for the first time, my mother said: well, now you would be able to give birth to children. I was shocked and I'm still in shock. I remember that I was 13 years old. I was scared when the menstruation started one morning, I was so afraid – I was bleeding and could not understand anything, and my mother was so short and I blurted out the above words, which I remembered for the rest of my life”. In one case as a result of improper communication, a young girl of 15 years old could not overcome the fear of gynecologist and nurses: “I had an anecdote in my life. I mean they did not tell us about this - I had delayed menstruation, I went to the Issyk-Kul, and apparently it was the effect of climatic differences. I had no menstruation and I went there with my boy-friend - they do like that and you will not feel anything, it means that you are probably pregnant. She did not explain me anything properly - go immediately to the doctor, well, I went to the doctors. This is true, I am telling this like an anecdote, I went to the registry office and told that I need to see the doctor. They asked me - which doctor? I do not know - I have no menstruation. They sent me to any gynecologist, who is not busy now. I come into the doctor’s room, there is a dull girl standing and the doctor rebukes her, then the girl leaves. Then the doctor turns to me and asks: did you come to see me, what is the problem? I say: you know, I have no menstruation. The doctor says: with whom do you live? I say: with mother, father and brother. You see, she asked whom do I live with? – these are two different things, two thickets. I was standing with such an expression on my face, mother dear, where did I come, I came to find out why I have no menstruation and the doctor asks whom do I live with. I say: mother, father and brother. You know, I liked it, there was a midwife, she told me: baby, you come here and lie down on the chair, I tried to find the chair, then this midwife told: take off your panties. I say: why, I started shaking like that, I was almost loosing my consciousness. The doctor took the mirror (later, when I became adult and delivered a child I learnt that it was a mirror), and came up to me, but there is no way. You know, I still remember - the doctor threw the mirror and there were tables, so something was broken. The doctor started shouting at me, I do not remember what, I jumped in the chair, I got off and went out wet, I had a stress, I came home, felt pain in the lower part of the belly and menstruation started. Since then, for about 15 years I did not ever come close”.

Boys and men spoke about their experience of communication about sexuality with their parents. Typically, this communication is in one direction (from adult to the younger) and limited to vague hints about the risk of STIs and aims to warn about the need to use condoms or abstain.

Many older respondents repeatedly noted that for parents speaking about “this” to teenagers is not just difficult, but impossible. And there may be many reasons for this:

* Some parents believe that children receive enough information and it is useless to focus once again on this.
* Other parents find it impossible to discuss the topic of sexuality and reproduction; they do not know adequate language.
* A certain group of respondents can not talk about this with their children, because they are not sure in their knowledge.
* Some respondents, mostly fathers, redirect communication to other persons and bodies: mothers, schools, doctors, in fact, taking off responsibility for the reproduction and SRH maintenance among young people.
* Some respondents - fathers were against verbal education on sexual development and reproduction, no matter from which sources. They believe that the most effective way of communication is to show the technique and model of relationships between men and women complying with the “anti- risk” aspects.

During the survey, we found an important feature of communication about SRH: there are difficulties of speaking about sexual and reproductive behavior not only between parents and children, but also between peers - young girls and boys with their friends.

Sisterhood experience for communicating and receiving information on SRH was quite a common strategy among girls.

For young men and boys brotherhood was not indicated as trustworthy structure that facilitates effective communication on SRH. Sometimes uncles - younger brothers of fathers acted as older brothers – they already had appropriate experience and could find “adequate” language for informing (as stated by one of the respondents above – the dirty language).

Texts of the focus group discussions were analyzed using qualitative information processing program NVivo, in order to identify key lexical elements (words and phrases) that are used by the respondents in talking about SRH. The results of this analysis are presented below in the form of semantic maps and obviously represent lifestyle specificity, values ​​and communication practices of the respondents depending on gender, age and place of residence.

As clear from the map 1, the key terms used by fathers to discuss SRH related problems and issues, were the following 10 words: *children, very, relationships, now, time, must, child (with variations: children, child), health, father, abortion*.

Semantic map 2 with SRH discourse by fathers from the North is a bit different and most commonly used words were: *now, children, will be, very, may, before, I think, need, time, parents.*

Among the words that have meaning in the researched context, the difference in the semantics used by fathers in the South can be noted - ***attitude, health, father, abortion***; in the North – ***will, may, before, I think, parents.***

The most commonly used words in the discourse of mothers from South (Map 3): ***children, very, needed, attitude, child, now, must, woman, try, life, work.***

The most commonly used word in the discourse of mothers from North (Map 4): ***may, now, say, very, will, children, woman, time, need, relationship, marriage*** - focused not on the woman, but on relationships and purposes (marriage).

Semantics used by categories of respondents from North (Map 5) is most often as follows: ***may, will, now, girl, health, children, abortion, male, marriage, need.***

Semantic continuum in discourse on SRH among young women from the southern regions (Map 6) comprises the following most frequently used words: ***need, must, health, children, will be, very, abortion, now, time, studying.***

The most frequently used words in FGD of young men from the South are: ***health, girl, abortion, should, need, studying, certainly, time, children, birth.***

Young men from the north often used the following words: ***will be, need, may, I think, now, children, abortion, health, family, must.***

Each semantic map has its dominants:

* Time aspect is important for men, they often use words designating time changes - before, now, then, time - fall in the “top ten”. This diachronism is relevant to an acutely voiced nostalgia in fathers FGDs (especially northern) for mythologized past, when fathers had unquestioned authority, and children were obedient.
* It is typical for women’s FGD discourses that there is no such time extent as in fathers FGD: “now”, where “a woman must, tries, works (for the sake of children \ child)” and it is time to get married, but most important are the relationship that mothers reproduce in the family, including the SRH maintenance.
* FGD among girls despite all differences in the regional context summarizes that the focus is on health, marriage and children; they are concerned by abortions, and there are too many imperatives in the life – need, must...
* FGD among boys emphasize other aspects, in addition to obligations and duties - birth, family, girl, children, and abortion that is a standard “male sexual reproductive scenario”.

This way, the following conclusions can be made:

* There is a tremendous need for effective communication on SRH in any generation, regardless the gender;
* There are significant problems and gaps in the current communication. Constrains to communication on SRH in the family are:
* Ignorance, own functional illiteracy on SRH related issues among elder generation,
* Inability to use language that could help overcome embarrassment, shame of tabooed topics and the lack of culture of speaking about SRH,
* Unpreparedness to assume responsibility for functional education of the younger generation, removal of this responsibility reduces parenthood to providing of material conditions, but not the development related to moral and values,
* Lack of trust in discussing SRH related issues between generations, within generations, which is presumably due to the repressive practices of upbringing the youth and relationships in the family, in particular.
  1. **Institute of Education**

Teachers define the scope of reproductive and sexual health as purely biological related to medicine, danger zone and crime.

Teachers perceive the essence of reproductive and sexual education through the prism of key topics. The list of key issues as follows:

* physiological changes and sexual development, including menstruation and wet dreams
* early sexual life and its consequences
* ethics and morality in the relations between boys and girls
* the culture of behavior of boys and girls
* the problem of abortion
* abstinence
* STI and HIV / AIDS
* hygiene by gender

Teachers’ work focuses on girls, whose puberty and maturing is faster than that of the boys. Teachers often reproduce traditional gender stereotypes about how a girl should behave: she should not be immoral and easily accessible, but be modest and do not allow touching her body. Girls must be saved from sexual activity until marriage. “Purity” before marriage is the guarantee of a happy life for girls.

The main barriers faced by teachers that prevent them from declaring their expertise are the lack of resources, such as appropriate vocabulary, knowledge in this area, ability to talk and discuss such topics. Teachers also justify their failure as experts by their workload, “Muslim culture”, “culture of teacher’s behavior”, complexes and shame. Thus, teachers of biology often ask children to independently study certain chapters in the textbook on the anatomy of the reproductive organs, and shift the responsibility to the doctors. According to teachers, doctors have adequate level of competence in order to discuss SRH related issues.

Teachers assume that due to lack of time and shame parents do not discuss SRH with their children and shift this responsibility to the parents. On the other hand, teachers believe that children themselves do not dare to discuss “this” with their parents, because they are afraid of parents’ reproach and expect that they will be under more close parental control.

Despite this, teachers believe that parents are primarily responsible for the control of the sexual life of the child. The role of teachers is usually reduced to monitoring children’s behavior and informing parents of potential problems and threats (such as snazzy appearance, suspicion of early sexual activity).

The respondents most commonly use the following words about teachers and school: ***need to, school, time, will be, must, explain, I think, life, class, must not.***

Teachers in their interviews most commonly used the following words: ***I tell, need to, teachers, questions, may be, now, very, discuss, parents, school.***

* Teachers use active verb - action “I say”, one verb in indefinite form “discuss” and the modal verb “need to”. Time is indicated by one word “now”.
* According to the respondents, teachers “must” and school “needs to”, but there are certain topics that “must not” be discussed.

**3.4. Institute of Health**

Starting from the time during the Enlightenment period in Europe the concept “health” was shifted from the category of individual value in a religious context to a socially significant issue requiring accounting, control and “normalization”, SRH has become a part of a closed, autonomous medical “empire” and an element of the medical expertise.

Medicalization of sexuality and reproductive behavior is based on the biological subordination of human bodies to social progress (immunizations, medical checkups, hygiene and birth control). That is why SRH related issues are without doubt perceived by the majority of the population as areas of expertise and responsibility of medicine, thus healthcare institutions are obvious actors in SRH.

Confirming the definition, healthcare institutions provide men and women with the following functional legal offers - medical services:

* diagnosis of SRH status and identifying reproduction related problems (in rare cases - sexuality)
* treatment of diagnosed diseases of the sexual and reproductive system
* disease prevention, including informing the public about the risks of sexual and reproductive diseases.

In recent years, given commercialization and patriarchalization of social relations, and in particular the strengthening virginity institute, medical workers began to provide illegal and quasi-legal services such as (respectively): examination of hymen integrity and hymen restoration surgery.

Statistics which shows that there are problems in this area and zones of inefficiency of healthcare institutions prevent medicine from absolute expertise and appropriation of SRH sphere. In particular, the most unsafe motherhood in Eurasia is observed in the Kyrgyz Republic, as evidenced by the maternal mortality rate – this is a sad “leadership” in the list of countries with the highest infant mortality rate, as well as the growing level of cancers of the reproductive organs and the dominance of abortion among family planning tools and strategies.

What does healthcare sector as SRH actor experience in such an ambiguous situation and how this position is reflected in the practices of health professionals? The attempt to answer these questions in this research is made through the prism of studying professional perception of health workers working in SRH sphere (in-depth interviews, specialized surveys-tests), as well as public opinion expressed during the focus group discussions involving different age and sex categories of the population.

One of the factors most commonly used as an explanation of zones of ineffective performance of medicine is weak institutional capacity. At all levels of government and society they say about the outflow of competent doctors and demotivation of specialists due to low wages and other aspects of weak professional capacity. In order to understand circumstances of work of the doctors in SRH, the PBS (***professional burnout syndrome - see details in the methodological section***) among doctors in three localities was measured, which enabled to obtain the following data (Table 1):

Table 1. PBS measurement results

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Locality** | **Age** | **Experience** | **Profession** | **Level of emotional exhaustion** | **Depersonalization / Cynicism** | **Reduction in professional achievements** | **Integral burnout indicator** |
| **Osh** | 49 | 20 | Gynecologist | 16 low | 12 high | 46 low | 5 moderate |
| **Kyzyl-Kiya** | 43 | 20 | Gynecologist | 16 low | 5 moderate | 41 low | 4 moderate |
| **Kyzyl-Kiya YFC** | 50 | 28 | Obstetrician Gynecologist | 21 moderate | 11 high | 36 low | 6 moderate |
| **Karakol** | 52 | 26 | Venereologist | 14 low | 12 high | 46 low | 5 moderate |
| **Karakol YFC** | 47 | 23 | Obstetrician Gynecologist | 17 moderate | 9 moderate | 48 low | 5 moderate |

As clear from the table, all respondents had low indicators of the professional achievements reduction and the level of emotional exhaustion varied between low and moderate. Three out of five medical workers had high levels of depersonalization and cynicism, i.e. abstraction from human qualities of the patient. The general PBS integral level is moderate. It is noteworthy that there is a positive direct proportional linkage between the level of PBS and work experience, i.e. the higher the experience, the greater chances of professional burnout.

In order to identify areas of responsibility understanding for SRH and SRH concept interpretation in general, two health workers were identified - a gynecologist working in public healthcare facility in Osh and obstetrician-gynecologist in Karakol working in YFC. Below are the key indicators characterizing professional attitudes and views of the respondents.

The Table comparing knowledge, awareness and values ​​of health workers in SRH area (see in the Annex).

The following can be noted to summarize the difference in knowledge, awareness and values of the compared health workers:

* YFC doctor more positively assesses her workplace in terms of material conditions, friendly atmosphere in the team and in relations with the administration. She positioned herself as a provider of services, she recognizes that the main factor affecting the results of their work is clients’ and patients’ trust, and that sexual education of children is the responsibility of health workers;
* Responses of the doctor from the state medical center, who, based on the research results, demonstrated the highest level of depersonalization and cynicism among the respondents showed the following:
* dissatisfaction with working conditions and remuneration
* complaints of overload, which is a barrier to provision of good quality services to the clients, evidences of informal payments and normalization of bribes;
* the problems of interaction with the administration, disrespect and lack of recognition of the competence of the head, as well as shifting the responsibility for sexual education of children first to the family.

This way, comparison of differences in the perceptions shows that well-being and values ​​of health workers with approximately the same length of service and competence are linked to the model of management in the medical institution and degree of its market orientation.

Since among healthcare institutions there are not so many structures that in practice focus on the needs and interests of patients, the problems with trust arise in the relationship between doctors and patients.

The researcher Temkina notes: “Medical interaction and medical field in general are areas of risk, uncertainty and imbalance of power between medical experts and patients dependent on them. Medicine provides the so-called credible goods, usefulness of which is not self-evident, and payment is made prior to obtaining the results. Therefore, trust in professional competence of health workers and in achievement of the desired result is essential for the interaction. In the course of interaction trust manifests itself in the face to face contacts between a doctor and a patient. These interactions are imbued with relations of inequality primarily due to disbalance of professional expertise. Interactions are contextually conditioned. Though a doctor serves a patient individually, their interaction is mediated and managed by organizational, economic and cultural contexts. New technologies in diagnosis and treatment, commercialization, fragmentation and bureaucratization of medical services, changes in rules of organization of medical institutions and payment for services - all these affect the interaction between doctors and patients”.[[10]](#footnote-10)

Focus group discussions involving men and women (fathers and mothers of mature children, young men and women of different ages) showed paradoxically conflicting perception and volatile trust to health workers and to healthcare institutions in general depending on the situation.

Thus, young men from the Bishkek FGD in answer to the questions about the ideal source of information on family planning and reproductive health responded as follows:

“I think that the most ideal source of information are hospitals”

“TV and the internet can tell a lie, especially in our time they can say anything, for example that certain pills can help, but in reality they affect adversely”

“Full trust only to medicine”

In answer to the question in what sources of information on family planning and reproductive health do respondents trust most and why, young men responded:

“Health workers. People should definitely trust only them”

“Because they swore Hippocratic Oath”

Girls from Karakol support confidence of boys. So, in discussing the same issues, they responded the following:

“I think organizations, so that people could understand more about contraceptives. If the doctor will say, this will be taken more seriously. I think that separate approach should be applied to every age category. Adults to adults, teenagers - to teenagers”

“It turns out that we have to convince ourselves that if he said it, it is like that. We think so. But if the doctor said “no way”, this is a suggestion as well”

At the same time, the discussions showed the whole range of reasons for respondents’ distrust to doctors and medical institutions. Among the main complaints and grievances of the respondents were complaints ***about hyper diagnosis, doctors’ moral impurity and lack of professional ethics***.

Another reason for the respondents’ distrust to doctors and hospitals was poor quality of the provided services.

Each respondent told at least one witnessed story, when medical facilities either do not operate in good faith, or do not provide good quality services.

Another major problem of modern medicine in the KR is non-confidentiality of services.

“If your gynecologist is a friend of your mother and you want to share with the gynecologist some things - it seems to me that you can not trust gynecologist”

“Yes, I also heard a lot of such cases that girls visit their mothers’ gynecologist and later heard everything back from their mothers

It means that health workers do not keep secrets?

Maybe in case of some problems, although the girl asked not to tell anything to the mother, the gynecologist thinks that she knows better and if she does not say this to the mother it would be her responsibility”

Low level of health workers’ competence is another crucial factor of mistrust.

The complaints about discomfort, unfriendly attitude of medical staff and indifference are often among the main claims of the respondents to health workers.

Despite areas of inefficient activity of health workers and healthcare sector in general, the respondents and health workers do not seek to completely marginalize expertise of the medicine in SRH and remove responsibility from the health workers.

The respondents continuously treat health workers as bearers of expertise and customary apply to health workers trying to find new and effective mechanisms. A. Temkina explains that “consequences of the deficit of trust do not necessarily lead to a total disruption of life, it can facilitate social changes and create new solidarities. Under the deficit of trust individuals develop strategies to achieve predictability and reduce risk that would provide access to resources and services they need”.

The first strategy to overcome distrust to health workers reported by the respondents is that when necessary the respondents go to commercial health services, presumably customer-market-oriented, with better service.

“The best specialists work there, where the money is paid”

“They have better equipment, which can not be found in an ordinary clinic, it means that they will make the analysis better and state the correct diagnosis”

In addition, based on their experience the respondents noted that quite often the apparent high cost of services in commercial clinics is comparable or even more beneficial compared to the amount of informal payments in the state “free of charge” clinics:

“There is not enough information. Now there is Internet and people may learn everything. For example, men do this to a lesser extent, as they say; these are more or less the concerns of women. I know that there is the “Asylbekova” clinic on the Isanova street, many women go there to give birth to a child. It is like a public hospital – women do not need to give bribes, they pay based on the receipts. Each doctor-gynecologist has her own rate depending on the level of professionalism, and the lowest rate is 200 dollars, you pay 200 dollars only and nothing more. The payment includes medicines and diapers as needed. In the state clinic you have to pay $200 plus more to each health worker - the nurse, the head doctor”.

According to some respondents, another way to overcome distrust to doctors is to improve one’s own functional literacy through self-education and use of sources that would enable to judge doctor’s competence and approach.

“I will look at what she told me. I anyway read something, some information and if she told me about it and I feel that it is a real doctor. If the treatment helped me, I will definitely visit this doctor. The important thing is the result. Human factor, of course, also affects, but you can tolerate it. I personally read information in the Internet, including the “diesel forum”. Currently I do not have a gynecologist; there is a gynecologist at the factory I work for. I will visit this doctor and draw up my opinion and will still look for another gynecologist”.

Another strategy to overcome distrust to doctors used by patients is to visit different doctors and compare the diagnosis and treatment methods; the respondents from YFC called this alternative unconditional.

“I have just received a consultation in your center. I visited the gynecologist in a private clinic and went to the gynecologist in my clinic No 5. I came to your center and was surprised that there was a table; I did not understand for what purpose, I thought it was simply a gynecological chair and an arm-chair, where the doctor writes down some data. I came to your center and was shocked that they talked to me. I spent one and a half hour; I forgot everything what I was told in such a nice manner. I was very pleased and surprised that there are consultations like that. I received treatment in two clinics, but they never provided me with any consultations. They only prescribed treatment and showed the results of checkup, but never explained before or afterwards why the disease appeared or show contraception means, I was very surprised. At 24 years old I learnt about contraceptives, I was excited”.

“I know there is a YFC clinic, which you can visit and will not hear the words like “you are so young and already started sexual life”. Another advantage of this clinic is that it has 2 entries and exits, because many people are shy to visit it. People will not visit this doctor in the clinic, because there is a large corridor and one door. All people stand in the queue, they look at you and already think “he is so young and already came here”. This clinic has 2 entries and exits. You can enter using the back door and get out from the other door. Health workers treat you well, you just visit them and they do not say “you go there, I have a queue”. This has never happened, they treat you in a polite way, even if you are younger, and this is a pleasant environment in difference to the state clinic”.

This way healthcare institutions as SRH actors are in an ambiguous situation:

* on the one hand, the tradition of medicalization of issues related to sexual and reproductive education and behavior reproduces expertise of the medicine in the opinions of the population and is self-evident for health workers.
* health facilities functions and services are often aimed to enhance this very medicalized perception of SRH
* at the same time, zones of ineffective healthcare in recent years significantly undermined the capacity of the medicine to continue power and expert relations, to appropriate the SRH sphere from other actors making it the field of autonomous “expert knowledge”.
* inefficiency zones are directly linked with the model of management in healthcare institutions system and the degree of market-oriented approaches.
* a significant proportion of medical doctors who are in a situation of conflicting influences of managerial and economic models of medical institutions development experience negative emotions, psychological pressure and gain the professional burnout symptom. These health workers tend to have doubts regarding the responsibility of healthcare institutions for the results of sexual education of children and youth, and transfer the responsibility to other SRH actors.
* the key factor in the relationship between customers-patients and health workers is trust. Trust depends on a range of factors, among which the respondents, based on their subjective opinions, identified the following: poor competence and overall poor quality of the provided medical services, corruption and unfair treatment, disloyal attitude towards patients, hyperdiagnosis and earning money through “patients” in violation of the basic principle “do not cause any harm”, the lack of guarantees of confidentiality etc.
* the crisis of trust to health workers and hospitals led the respondents to the need for reviewing the principles of life organization and formation of new solidarities, which the respondents do in practice in order to improve predictability of interaction with healthcare institutions.

**3.5. Institutes of Civil Society**

During the years of independence a complex system of civil society institutes (NGOs) has developed in Kyrgyzstan that provide protection of individuals’ right to access basic healthcare, education and other services to support SRH. NGOs have to operate in an unstable environment with often conflict situations by virtue of contradictions between the liberal agenda promoting human rights, and construction-in-progress nationalist agenda, which opposes all “unconventional” things.

The newly created “traditionalist” agenda is often found in the form of opposition to any innovations without providing justified reasons or alternatives. “Traditionalist” agenda is in great demand in the political arena, as the main task of the actors that use it is appropriation of the “voice of the people”, i.e. the opportunity to speak on behalf of the people promoting their own political interests. The leading motive of the struggle between two agendas is accusation of the attempt to impose cultural hegemony through imposing its own norms in all spheres of life (“morally decaying” Western countries) and the loss of national identity.

Since the policy regulating sexuality and reproductive behavior in the KR has some contradictions and the rhetoric differs significantly from the practice of law enforcement, the SRH sphere is being actively occupied by other structures-actors, including civil society institutes.

Among civil society institutes dealing with sexual and reproductive rights there are a few heterogeneous clusters of organizations:

A number of NGOs deal mainly with medical aspects of SRH, and are the most recognizable among broad masses of the population. This category may include the following:

* PA “Alliance for Reproductive Health” (RHAK)
* PA Kyrgyz Family Planning Alliance (KFPA)
* PA “Youth Peer Education Network Y-PEER”
* PA “Family Harmony”.

The respondents covered by this research were more familiar with the activities of RHAK, although undoubtedly the fact that organizers of field research in the region were the RHAK staff and about one third of respondents were clients of YFC clinics played its role. Therefore, it is impossible to provide objective assessment of the relevance and effectiveness of this NGO’s activities in this category.

Another cluster of NGOs working to protect sexual and reproductive rights represent youth feminist (SQ-Skew) and LGBT (Labrys, Oasis, Thais +, etc.) organizations in Bishkek. Their agendas are perceived as radical and their actionism raises serious debates in the society and threats from, as they call themselves, national-patriotic groups.

Finally, the third cluster of NGOs that somehow deals with SRH related issues is a large group of mainstream female and gender organizations that strive to combat violence against women, promote equal access for vulnerable groups to health services in support of SRH and to inform the public about the SRH related risks and rights of social minority groups. Ideologically, these organizations are not homogeneous, and relevance and sustainability of specifics of their activities depends on donor priorities and project cycles.

Due to the task set forth before the researchers and by virtue of the obtained data, this section provides a more focused discussion of only RHAK as SRH actor.

The most important challenge for RHAK is to work in conditions of unrealizable rights and choices of sexuality models and reproductive behavior. The reason for this unrealizable rights and choices of models is the collision of the above agendas and political influence groups benefiting from the inclusion of the agendas in their political struggle.

Researching the mission, goals and objectives of the organization showed that they are based on the principles of priority of individual’s rights in society. However, among the national-patriotic and religious youth groups, the agenda, goals and activities of RHAK cause extreme aversion. RHAK and YFC projects and programs supported by RHAK are called as locus of defilement of the Kyrgyz youth and negative publicity is organized against RHAK’s information products.

In this unfavorable and disloyal environment the challenge to organizational culture and structural unity of the RHAK has heightened. As shown by the focus group discussions involving RHAK volunteers and observations over RHAK activities during the fieldwork, most of the respondents learned the rhetoric of human rights for sexual and reproductive self-determination, gender equality, openness and freedom of speech, however in practice and in more local communities they demonstrate examples of patriarchal behavior.

RHAK has extensive experience of analytical research of the environment, risks and opportunities for improving its performance, but it overlooks the fact that young women and girls, more immersed in the life circumstances of patriarchal society are unable to make a choice in favor of values ​​promoted by RHAK. For these women, the terminology used by the organization is irrelevant. For example, such key concepts as “**un**desirable pregnancy, **sex**ual education” for women is unacceptable, because according to the cycle of family SRH reproduction their pregnancy can not be undesirable, on the contrary, it serves to improve the status of a young woman-*kelin* or is a disposition of Providence.

Moreover, the YFC concept, more focused on quality health care services primarily to girls and women, as well as offering the same set of medicalized attitude towards a female body, does not provide any ideological alternatives to the existing conservative medical institutions that are far from the rights concept. The fact that YFC usually neither recognizes sexualized male body, nor works for its “normalization” is not discriminatory, but rather confirms normativity of every man’s sexuality at the symbolic level.

For the vast majority of the involved young women and men the work for NGO did not provide with the opportunity to gain an adequate language of speaking about sexuality and reproduction that would be understandable for the environment. Volunteers are still at the crossroad - being attracted by actionism and bright project activities, they still neither understand, nor distinguish between the ideological contradictions, patriarchal perceptions and “traditionalist values” and liberal values ​​of human rights and freedoms.

Such contradictions and the need to live in the environment of struggle between two agendas lead to the fact that activists-boys from the NGO do accept humanistic rhetoric, however when the question comes to personal choice, they reduce their views to the same patriarchal perceptions.

The discrepancy between the practice and rhetoric of activists can be the basis of discrediting the NGO’s activity. This can affect both the level of international cooperation (Western donors will see the opposite result of activity), and local level causing frustration in the civil society. Particular risk is associated with possible conflict escalation in the family, when parents due to misunderstanding and rejection will be against children's involvement in activities of RHAK projects.

NGO faces a non-trivial challenge: how to make parents (especially fathers) to cross the threshold of YFC or parents’ school? Families fully involved in the activities of the NGO (for example, in the offices in Karakol) are more likely to positively assess the concept of promoting YFS than those who are familiar only with the terminology used to send messages to the society. The latter category feels the threat of losing control over the fertility asset (girl’s corporality) and, accordingly, the threat to “social capital” accumulated by generations.

Thus, the challenges of the day for RHAK and other NGOs working on the basis of the human rights concept is not only the need to struggle with external actors from the conservative camp, but also the risks of internal disintegration and weakening of the organization due to the lack of actual strategies for developing a language for speaking about sexuality taking into account the cultural needs and perceptions and promoting values ​​of equality and justice. The key direction of the organization’s activity should be institutional strengthening of its structure, investment in human capital development, as well as investments in nurturing a loyal partner environment.

**3.6. Religious institutes (Islam)**

**3.6.1 SRH and expertise of religious figures**

Islam in Sunni interpretation of the Hanafi law school (“mazhab”) is defined by the SAMK as corresponding to historical beliefs of the Kyrgyz. High ability to adapt of the Hanafi law school allows inculcating Islam to virtually any local cultural setting, including to those that are typical for the KR.[[11]](#footnote-11)

SRH being one of the fundamental sphere of human life deserves special attention of the Islamic religion, as it is integral to education and reproduction of Muslims. Based on the opinions and assessments expressed by Islamic ministers during this research, the Islamic religion in KR claims to be the main and the only institution designed to promote awareness, knowledge and belief in the SRH sphere. The logic of the argument behind such statements of the “spiritual” respondents can be split into three categories:

1. universal knowledge that can explain all issues and problems in the SRH sphere
2. adequate language for teaching “true knowledge” about SRH to men and women
3. “legal “ aspect in the Islamic canonical knowledge.
4. According to religious leaders covered by the research, Islam is a comprehensive source of information affecting absolutely all spheres of human life. Thus, the interviewed religious actors from all four regions stated that Islam provided answers to absolutely all questions without neglecting any scientific information or historical norms - Islam incorporates all areas of knowledge.

Interviewed religious actors refer to the Islamic canon, which accumulates numerous literature that regulates the lives and interaction between men and women.

The respondents argued that canonical knowledge of Islam could provide answers to questions from different ideological fields and positions.

Universality of knowledge and the ability to explain not only general, but also specific aspects of daily life of men and women, allow religious ministers arguing that this knowledge should be circulated universally through all channels of education and information, including secular state educational institutions.

1. The uniqueness of Islam as a key actor in SRH is the way the religious leaders have adapted the language to communicate their messages. **Adapted language** appropriate to the needs of the “clients” does not cause any rejection. This is evidenced by the willingness and ability of religious leaders to transfer all kinds of information, including extremely sensitive and intimate, preliminarily processed in the context of Islam. A big difference in terms of the language of speaking about SRH is showed the fact that it uses not only the pillars of verses and suras of Koran, which require understanding of religiously educated adept, but also widely appeal to the symbolic stories of the hadith. Hypothetically, it can be suggested that such approaches and language of explanations based on examples and models are close to Kyrgyz people, who are raised on the basis of *sanjyra* and epic literature.
2. Inclusion of new adherents in the Islamic movement and Islamic education, including active women with leadership capacity is largely due to a strong discourse of human rights in Islam. Since the **human rights discourse** is inevitably present in one form or another in the market of religions (or other social order doctrines), Islamic religious leaders use the rhetoric of equal rights as an effective means for improving attractiveness of the religion and a special marketing move. Islamic principles of equality between men and women in terms of abstinence before marriage, equality in matters of SRH related education, policies and strategies in favor of women's health in relation to abortion and birth control etc. refer to values ​​of equality and justice.

**The right to abortion** as one of the fundamental rights of women in SRH sphere is also reflected in the rhetoric of religious leaders.

*“- No, according to Sharia this is also haram. Allah does not like this.*

*If a woman cannot have children for medical reasons, congenital diseases, if the child will not survive?*

*- If it affects health of the mother or child Sharia allows abortion.*

*And what about cases of rape?*

*- You can give birth to a child.*

*- Give birth?*

*-Yes.*

*- Is it allowed to make abortion?*

*- Well, if there are rumors and it is shameful, you can do the abortion, but according to sharia it is also undesirable”*[[12]](#footnote-12) *-* ***religious figure in Karakol***

“I believe that contraceptives are more harmful than useful. On the one hand, contraceptives provoke adultery; on the other hand, we should not limit the birth rate. Of course, you need to be examined by doctors, take care of your health and give birth to children with some intervals. You need to plan, so that children were born healthy” - **religious figure from Bishkek**.

In the rhetoric of equal rights and justice of Islam, religious actors attach great importance to imperatives of **sexual gratification** of wife by a husband.

The permission to use contraceptives is interpreted by religious actors through the prism of the legal approach. **Contraception** as a means of birth control can be used, however, only within the marriage effected in accordance with the Sharia, which legitimizes sexual relations.

Thus, claiming to have “universal” knowledge of SRH and language, which can be used to speak about SRH in a moral and sinless way and integrating the rhetoric of legal democratic approach, the Islamic religion and its ministers attempt to appropriate the SRH sphere.

Given the realities of the widespread infrastructure of Islam (according to information there are 2200 mosques in Kyrgyzstan), we can talk about trends of monopolizing the space of speaking - actions in the SRH sphere.

**4. Paradoxes of power and responsibility in SRH sphere: WHAT is to be DOne? and who is to blame?**

When the state becomes weaker, the very concept of politics, its place and means change as well, and the political potential of the risk society is increasing. The German researcher Ulrich Beck identified the risk society as a “constructed uncertainty” generated by “collective irresponsibility”. Social actors and the society of risks and uncertainties are individuals, social organizations and communities that are able to avoid state control.

In SRH sphere, where a strong state practiced the tradition of sexuality repression, “normalization” of bodies, biologization and medicalization for decades, the current weakness of the state policy, inability and unwillingness to regulate these areas in the same volume and under the pressure of global processes gave rise to active and chaotic activities of other institutions. These institutions due to different resources and skills attempt to define the horizons of SRH development. Immersion into theological field and creating the basis for mechanical reproduction of the Muslim version of SRH - these are the desired SRH horizons for the Islamic religion. Maximal medicalization of sexuality in order to secure power of healthcare institutions over the bodies of boys and girls, but at the same time ignorance and inability to reduce the negative scenario of development of the key SRH indicators places this actor in a situation of greater uncertainty. Having a monopoly right to voice and knowledge the institute of education is unable to invent a language that would be adequate to local situation and realities and it does not intend to become a ruler of young people’s minds and, therefore, this actor is in great perplexity. Family, which is obviously under the crisis of rethinking and redefining against the background of collision of conservative and liberal political agendas and increased mobility of its members, continuously follows the tradition of tabooing and extruding the experience and knowledge about sexuality and reproduction of men and women. Groups of young people, who have the desire and dream of pleasure, are not willing to continue the tradition of taboos, while other groups of young require going back to old ethics and traditions, so that the actor-family also faces the problem of uncertainty. Finally, NGOs, with values ​​and approaches diametrically opposed to Islamic ones, claim to invent a language and vision of the future of our sexuality, but not everyone can hear and understand these proposals.

In response to inability to control the SRH area as it was done by at one time powerful state, each of the actors attempts to find rational explanations of his innocence. Family, to which the society addresses the question - why the family is the place where violence occurs with no mechanisms for transferring traditional or innovative knowledge and sexual and reproductive skills? – shifts its responsibility to the health and educational institutes. The logic is simple: in essence, SRH is specific knowledge and it can and should be reproduced by a specialist, who is able to treat bodily illnesses and the flaws of mind.

Education, to which the society addresses the following question - why school does not produce the desired bodies - modest and skillful, restrained and passionate in appropriate institutions and why girls give birth without getting married and before achieving lawful age? - argues that there is a lack of competence and authority to regulate freestyle boys and girls.

Healthcare institutes, to which the society addresses the following question - why, despite the increasing public costs for supporting SRH, so many women die in childbirth and the risks of dangerous diseases grow? – reply that they may only combat the consequences of what was sowed by the family and school...

Thus, all three key actors use the same technique - rationalization of uncertain future and present problems through the mechanism of removal and shift of responsibility from themselves to another institution.

Scheme 3. Mechanism of responsibility removal and shift

The society does not address any questions to SRH actors - NGOs and international organizations; the society tries to interpret their work in terms of ideological influence and national/economic (someone's) interests and stigmatize them.

The only one SRH actor, to whom the society does not address any questions, which formulates questions itself is the religious institution. It has a winning position – it can criticize actors with a clear functional mandate and clear financial policy, but it claims to be a monopoly in the field of education and discipline for the expansion of Islamic type SRH practices.

**5. Conclusions and recommendations**

Except for civil society and religious institutes, for which SRH sphere is one of the principal components of activity, other formal actors, such as the institutes of family, education and healthcare face certain challenges in SRH sphere.

Thus, factors that constrain communication on SRH in the family are: functional illiteracy in SRH of the elder generation, inability to use the language that could help to overcome embarrassment, unpreparedness to take responsibility for functional education of the young generation and deficit of trust in SRH related issues between the generations and within generations.

Inability to use proper language, shame and tabooing this topic and lack of the culture of speaking about SRH is also a barrier for school workers in the area of ​​sexual and reproductive education.

Healthcare institutes as an SRH actor are in an ambiguous situation. On the one hand, the tradition of medicalization of issues related to sexual and reproductive education and behavior reproduce expertise of the medicine in the opinion of the population and are self-evident for health workers.

At the same time, the recently formed areas of inefficiency of healthcare institutes significantly undermined the capacity of the medicine to continue power and expert relations.

At the same time, all categories of actors indirectly support the repressive mechanism of control over youth SRH, where free, rational and pragmatic disposal of one’s own body is impossible due to social pressure and threat of punishment.

As a result of these strategies and practices, vulnerability of girls - the most unprotected group in terms of SRH - perpetuates. Barriers to personal growth of the girls are one of the most acute barriers to YFS aimed to protect SRH.

At the same time, boys often lack opportunities to choose a reproductive model, the main component of which is a financial burden. Due to this restriction in options, boys try to delay the paternity phase as much as possible, thereby entering into a phase of reduced control and responsibility. During this period, young men feel conditional freedom of choice implemented in the form of hedonistic consumption.

Medicalized control of SRH deprives the term and the corresponding legal (preventing a pragmatic choice – from family planning to childfree) and humanistic (in accordance with the WHO’s definition) phenomenon of its meaning. Sexual satisfaction and reproductive rights / choices are relevant for a society, where women’s subjectivity is constructed as a set of equivalent alternatives: to be or not to be a mother (and if yes - under which model of motherhood), whether to choose the “career” of marriage or not, to be the attribute of a man or not, whether to implement sexuality without fear of stigma or not.

Girls’ subjectivity can be observed at the extremes of the adaptation continuum to the regime: it is self-mutilation or suicide as the last option of the available choices, or commercialization through marginalization up to escape / migration or prostitution, where one form of intolerable exploitation is replaced by another, but with a simulated pseudo-choice and conditional, but at the same time symbolically obvious, benefit.

NGO faces a non-trivial task: how to make parents (especially fathers) cross the threshold of YFC or parents’ school? Families fully involved in RHAK’s activities (the example of the office in Karakol) are more likely to appreciate positively the concept of YFS promotion than those, who are only familiar with the terminology used to communicate messages to the society. The latter category feels the threat of losing control over the fertility asset (girls corporality) and, accordingly, the threat to “social capital” accumulated by generations.

Thus, if men gain skills to take care of women’s bodies (wives and daughters), this will promote the development of their loyalty to individuated projects (sexual satisfaction and reproductive choices). Development of female subjectivity that does not meet any rejection will serve as the basis for generating a positive feedback for the men forced to remain in ambivalence between being lost due to lack of communication skills and the practice of “masculine” use of direct violence.

The revealed unique position of the Institute of Islam in KR demonstrated expertise with the largest distribution network. Moreover, this network is remarkable not for its territorial coverage, but for penetration into the mental structures of the formal actors in the field. The main approaches to SRH are: advocated abstinence until marriage for both men and women, voluntary marriage and allowing the couple to choose contraception methods and decide on abortion, which generates simulated gender equality at the level of rhetoric. At the same time, it is due to lack of hegemony in the cultural space of the KR, thus forcing religious leaders to use original marketing solutions in a wide field of religions market. However, Islam is adamant in its integrationist strategies: the family should be included in the Institute of Religion and the basis for this is control of SRH in the context of broader subordination to Islamic principles. Given the realities - penetrating infrastructure for spread of Islam (there are around 2200 mosques in Kyrgyzstan), we can talk about trends of monopolizing the space of speaking - actions in SRH sphere.

For the vast majority of the involved young women and men the work for NGO did not provide with the opportunity to gain an adequate language of speaking about sexuality and reproduction that would be understandable by the environment. Volunteers are still at the crossroad - being attracted by actionism and bright project activities, they still neither understand, nor distinguish between the ideological contradictions, patriarchal perceptions and “traditionalist values” and liberal values ​​of human rights and freedoms. Such contradictions and the need to live in the environment of struggle between two agendas lead to the fact that activists boys from the NGO do accept humanistic rhetoric, however when the question comes to personal choice, they reduce their views to the same patriarchal perceptions.

Thus, the challenges of the day for RHAK and other NGOs working on the basis of the human rights concept is not only the need to struggle with external actors from the conservative camp, but also the risks of internal disintegration and weakening of the organization due to the lack of actual strategies for developing a language for speaking about sexuality taking into account cultural needs and perceptions and promoting values ​​of equality and justice. The key direction of the organization’s activity should be institutional strengthening of its structure, investment in human capital development, as well as investments in nurturing a loyal partner environment. Another important thing is revising the strategy of the organization’s activity and shifting from healthcare (medicalized) approach to functional family education.

**6. Glossary**

**Actors** are acting social actors, sometimes also organizations and institutions.

**Depersonalization** is manifestation of negativity and cynicism toward patients.

**Discourse** - enshrined in the language of the way of organizing social reality.

**Perversion** is distortion, deviation from the norm, unnatural behavior at symbolic communicative level.

**Reduction of professional achievement** means decrease in self-esteem, professional achievements and opportunities.

**Reproductive health** is a state of complete physical, mental and social wellbeing rather than merely absence of diseases or illnesses in all matters relating to the reproductive system, its functions and processes, including reproduction and harmony in psychosocial relationships in the family (WHO definition <http://www.euro.who.int/ru/health-topics/Life-stages/sexual-and-reproductive-health/news/news/2011/06/sexual-reproductive-health-throughout-life/definition>)**.**

**Synecdoche** means using the words in a figurative sense, namely, replacing a word meaning a known object or group of objects with word meaning part of this object or individual object.

**Stigmatization** means associating some quality (usually negative) with a specific person or group of people, although there is no link between them or the link is not proved.

**Subjectivity** is quality acquired by an actor, if s/he takes active position in the course of activity; this is the highest level of human development manifested in the form of active transformation of the environment and him/herself in accordance with one’s own intentions.

**Hanafi mazhaab** is one of the four law schools in the Sunni Islam. It is the most widespread among all law schools. Hanafis live in Central Asia, Kazakhstan, Azerbaijan, Turkey, Syria, Egypt and other countries.

**Emotional exhaustion** is defined as fatigue and decreased emotional background.

**WHO** - World Health Organization.

**SAMK** - Spiritual Administration of Muslims of Kyrgyzstan.

**STI** - sexually transmitted infections.

**YFC** - youth friendly cabinet.

**PBS** - professional burnout syndrome.

**SRH** - sexual and reproductive health.

**YFS** - youth friendly services.

**FGD** - focus group discussion

1. <http://stat.kg/index.php?option=com_content&task=view&id=24&Itemid=101> [↑](#footnote-ref-1)
2. Results of the Demographic and Health Survey of the KR

   <http://www.measuredhs.com/pubs/pdf/FR283/FR283.pdf> [↑](#footnote-ref-2)
3. <http://www.euro.who.int/ru/health-topics/Life-stages/sexual-and-reproductive-health/news/news/2011/06/sexual-reproductive-health-throughout-life/definition> [↑](#footnote-ref-3)
4. Gayle S. Rubin. Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality. <http://tobeq.by/?p=554> [↑](#footnote-ref-4)
5. Rapid questionnaires included a single “open question of the respondents’ associations with the term “delivery” [↑](#footnote-ref-5)
6. R. Pecheski. Abortion and Woman’s Choice: the state, sexuality and reproductive rights. \\ p. 145 [↑](#footnote-ref-6)
7. M. Lastochkina. Modeling the population’s reproductive behavior of the population.\\ Demography. <http://www.ecfor.ru/pdf.php?id=2007/4/09> [↑](#footnote-ref-7)
8. All adult males refused to draw any projective drawings, as drawing seemed to them a procedure that unsuited to their status. [↑](#footnote-ref-8)
9. In fact, it is not the attitude to the ideal, but to real and concrete fatherhood, because many males, as well as females, directly stated that they were ideal fathers [↑](#footnote-ref-9)
10. “I do not trust doctors”, but ... Overcoming mistrust to reproductive medicine. Elena Zdravomyslova, Anna Temkina (published in the book: Health and trust: gender approach to reproductive medicine / ed. Zdravomyslova E. and A. Temkina. - Publisher of the European University in St. Petersburg, 2009. P. 179-210) [↑](#footnote-ref-10)
11. Mufti: in Kyrgyzstan, we will spread hanafizm only, 09.04.14 <http://www.vb.kg/268326> [↑](#footnote-ref-11)
12. It is noteworthy that the opinion voiced by a religious respondent about care for women's health was very similar to the medicalized position of health workers and some of the FGD respondents from the generations of parents and families. [↑](#footnote-ref-12)