Women, Health and Transition in Uzbekistan

by
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Submitted in accordance with the requirements for the degree of
Doctor of Philosophy

University of Kent at Canterbury
School of Social Policy, Sociology and Social Research

April, 2004

Acknowledgement

I gratefully thank the following individuals for their special contributions and support during my work on thesis.

Professor Larry Ray, my supervisor, for his advice and suggestions on my work.

Yuldus Abduganieva, Chief Specialist of the Counsil of Ministers of the Republic of Uzbekistan, for putting me in touch with the governmental bodies and institutions in Uzbekistan, from which I was able to collect necessary data and for her help to find the unfindable.

Nodira Azimova, Chairman of Social Centre 'Sharkh va Tavsiya', and Anatoly Belov, a member of the Centre, for their generously given time, good ideas, advice and tough criticism on my work.

Abdurahmanov Uktam, Coordinator of the Centre of Economic Research, and Muhtaram-opa, member of the Centre, for their assistance during the initial period of my field work.

Yelena Kalyuzhnova, Director of the Centre of Euro-Asian Studies in Reading University, for her critical comments on my final draft.

Shahida Gafurova, for her enormous help, her trust in me and courageous endeavours to enhance my work.

Suraya and Roqiya Abdullaevy for their moral support and practical help during my field work in Uzbekistan.

My husband, Jalol Khaydarov, for persuading me to undertake this study in England and for making it a reality, for his generosity, his faith and for encouraging the best in me.

All my friends in England: Nigora Nasirova, Diloram Ibrahimova, Gulmira Ryskaly, Nelli Charcharkyan, Elena Robson, Alan Mckenna, Stephan Fagbemi, Junko Ishiguro, Sean Ireton, Kayhan Delibas, Roslinah Ali, Chandra Kanagasabai, Samiha Khalil were good critics and kind advisers to me.

I am also in irreplaceable debt to my dearest friend Togzhan Kassenova, who spared her time, energy, and effort to give me enormous and careful help with checking my spelling, correcting my style from the very beginning to the end. For her encouragement, devotion, and her ability to steadfastly stand by me, during all the ups and downs of my research work. Without her help and support all along it might never have come into being.

I dedicate this work to my parents Roza Unusova and Abdulahad Abdullaev and my son Erkin Khaydarov, whose only existence inspired me to undertake good deeds.

Abstract

Substantial social and economic changes that took place in Uzbekistan after the collapse of the Soviet Union have had an impact on people's health and well being. The transition period has brought many changes in both living conditions and lifestyles, an increase in poverty and social stress on women in Uzbekistan. The findings suggest that deterioration of women's status is related to socio-economic deprivation. This qualitative study examines the context and meaning of health related experiences showing the complexity of social factors that contribute to the potentially negative consequences on the health of women. The study contributes to understanding how Uzbek middle class middle age women perceive their health and how health is affected during the transition process. Such issues as choices of treatment, lifestyle habits, employment, household responsibilities, and religion are analysed to develop understanding of the quality of women's lives in Uzbekistan. The examples drawn from the research cohort illustrate a manifestation of the distinctive features of Uzbek women simultaneously revealing similarities with other cultures. The findings of the study reveal that socially constructed gender roles, cultural norms, and economic circumstances, all influence women's health-seeking behaviour. The shift towards a market economy has resulted in increasing socio-economic differentiation, insecure livelihood, and declining health and well being among the Uzbek population. Economic tensions and rapid social and cultural transformations have subjected women to constant stress and tension, which threatens their health and well-being. However, the study also provides the examples of successful coping strategies, strong will and adaptability to new socio-economic conditions. It illustrates women's experience of living in new conditions of transition as well as contributes to understanding the general position of women in society and explains the construction and maintenance of patriarchal order in Uzbek society.

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Chapter 1
Introduction

1.1. Introduction

The changes that took place in Uzbekistan after the dissolution of the USSR had an enormous impact on the lives of ordinary Uzbek people. 'The collapse of the Soviet system was followed by a dramatic and sustained fall in incomes and employment' (Clarke, 2002:194). During the transition the subsidies that were provided by the central government, to which the Uzbek government had become accustomed during the previous seventy years, ceased, the inflation rate, as well as unemployment, began to grow steadily, universal social protection to ensure social guarantees for the entire population was suspended. The country faced 'declining of social services, infrastructure and growing destitution of population' (Biergerson, 2002:120). As a result, the economic arrangements of many households were destroyed. Many found themselves functioning under the new socio-economic circumstances without any precautions or the ability to anticipate the future. The most vulnerable part of the population - women, children, disabled people and pensioners - found themselves in a most deplorable situation. The end of subsidies and price control has consequently created extreme hardships for the population, as socio-economic changes have led to the growth of poverty, increasing social inequality and the deterioration of living standards. In Uzbekistan, as in other countries undergoing transition, a drastic decrease of the population's income has been associated with a deterioration of people's health (UNDP, 1999; World Bank, 2003).

Scrutinising the socio-economic and political developments in Uzbekistan since independence, and their effect on the lives of ordinary women, one can conclude that there are hardly any positive changes in most women's lives during this decade. The transition to a market economy and the economic hardships suffered in Uzbekistan during the last thirteen years have had a number of negative consequences on women's health and well being (ABD Report, 2001).

At first, the disappearance of old patterns of state control seemed to offer new opportunities and freedom of choice; however this freedom has brought about anxiety and a re-evaluation of what women have gained as a result of these new changes.

Women, who were born in the Soviet Union, and took a free health care system and free education for granted, today have face a society – in which the transition process has brought about a decline of social welfare. The deterioration of the economic welfare of women is conditioned not only by the general economic situation, but also by:

- their decreasing economic activities
- reduction of privileges and subsidies
- increasing dependence of women on reviving religious and traditional views on the role of women in the family and society.

Consequently, women have been exposed to great health risks during the transition because of the economic recession and overall societal transformation. The process of transition initially entails changes in social status, income level and cultural shifts. As noted above, women took their right to economic independence and legal equality with men as well as their social benefits for granted. However, in the new social circumstances it became difficult to maintain these privileges, so they had to learn from anew how to fight for their right to work, maintain the stability of their family life, and how to stand up for their position gained during the Soviet years. After eighty years of a communist ideology that generally encouraged women to participate in public life, the new economic situation generates pressures to restore domesticity and patriarchy. Today fewer women participate in the political life of the country. According to the Human Development Report (1999) only 19 per cent of members of Oliy Majlis (parliament) are women compared to 30 per cent during the Soviet times.

The new economic situation changes the balance of power in interrelations inside the family. Many women find it difficult to combine work and domestic responsibilities, as there are fewer pre-school facilities for children available or affordable. Consequently, women have become more disadvantaged at work, particularly if they are mothers. These women have become 'particularly vulnerable to redundancy' (Chenet, 2000:183). The problem is exacerbated by the fact that as salaries in the state sector are very low, many women prefer to stay at home with their children, thus losing the opportunity to develop their careers.

Hence, the question of whether women in Uzbekistan are likely to change their lives and participate more fully in economic development, or retreat to lives dominated by domestic concerns under the pressure of economic and political forces, remains open. The present study has made an attempt to study how women's lives are affected by the restructuring process of their society.

Funk and Muller, (1993) and Chenet, (2000) emphasise that during the last decade the economic hardships in the post-communist world after the demise of communism have led to a disproportionate decline in women's status and well-being. Based on this point, I proposed the hypothesis that women's optimal health and well-being has been seriously deteriorated during transition. The purpose of the research has been both to test this hypothesis and to reveal other applicable factors to generate additional concepts and conclusions.

Taking into consideration the changes in the evolution of the Uzbek society in the last decade I decided to concentrate my research on women, as the most vulnerable members of the society. I focused on their health, as it is one the most important factor of human life, and on women's responsibilities as health providers for their families. Another important issue related to the theme of this research are the coping strategies women have adopted during the times of hardship that transition produces, especially in relation to health, because at any time "health is an issue of central concern to women" (Abbott and Wallace, 1990:94). Therefore, I will try to analyse how women - being providers and mediators in their families - organise their lives and the lives of their families in times of upheaval, and the ways of coping with hardships they confront during the changes in the country and in their own lives. Few studies have attempted to investigate relationship between health and women's experiences connected to transition in Uzbekistan.

Although women make a substantial contribution to the process of development, they cannot always make use of the opportunities to contribute to their own development due to their lack of power. Therefore, this study examines women's oppressed position and the strategies devised by women to resist it. It aims to establish alternatives to subjection, and thereby contribute not only to a general theoretical perspective on gender inequality, but to the growth of consciousness among the subjects of the research.

The questions of health and quality of life have gained importance among sociologists. The association between socio-economic circumstances and indicators of health status has been a focus of research among Western scholars (Oakley, 1987; Payne, 1991; Popay, 1992; Roberts, 1992; Miles, 1991). These writers include social, environmental factors, economic prosperity and political stability among the main issues relating to health. 'Health' becomes 'so encompassing' that the analysis of health can 'yield far-reaching insights about the wider culture and society' (Lewin and Olsen,

1985:19). Under conditions of transition health along with education and occupation acquires the role of a leading factor of socio-economical development. It is important to explore to what extent an individual should take care of their own health and that of their family. How does the meaning of maintaining the optimal health correlate with social standing and economic order? What place does health occupy in the hierarchy of an individual's values?

The main aim of my research is to study the changes that might have occurred as a result of a decade of independence and to examine the impact of these changes on the lives of women in Uzbekistan concentrating particularly on health issues. In order to analyse the social factors, that determine the situation in the health sector it is essential to look at the socio-economic and political and cultural peculiarities of the country. This kind of analysis requires examination of the historical background, and the social, economic political and cultural development of the country before independence. Hence, any attempt to understand the lives of Uzbek women must incorporate a historical perspective.

The study is divided into two parts. The first part concentrates on the objective background data about the social context and events in contemporary Uzbekistan as well as preceding historical circumstances. These data help to set the scene and inform the reader for the second part of the study which reflects women's subjective experiences.

The literature review focuses attention on several important issues related to the theme of the research. Firstly, I analyse the Western approach to the question of gender inequality. There are different approaches to the gender relations in the Western feminist thought. The intention is to illustrate the extent of definition of gender inequalities and possible implications of these theories for research that is presented in the dissertation. Furthermore, I look at how gender inequality in the Soviet Union was perceived by Western authors and Russian dissident writers.

In recent years there has been a growth of interest among researchers who draw attention to the conditions that affect women's health (Annandale and Hunt, 2000; Falik and Collins 1996; Kane 1991; Doyal, 1995; Miles, 1991; Roberts, 1991). There has also been a growth of interest in women's role as caregivers and health providers for their families (Graham, 2000b; Lee, 1998; Macintyre, 1993; Martin, 1987; Oakley, 1993; Lober, 1997; Smyke, 1991; Roberts, 1990; Lewin and Olsen, 1985). All these works are

strongly related to the research and contain explicit and implicit considerations of the significance of health-related problems.

However, it seems that the topic of women as mediators of health in Uzbekistan has attracted very little attention from social scientists. There have been no significant attempts to uncover the social context of women's health in Uzbekistan. There are some statistics on this subject, which are not always reliable. The written sources are mostly concerned with the status of women in general and include surveys on poverty; gender relations in labour market; and research into the influence of traditional and religious cultural practices on women (ABD Report, 2001; UNDP Report 1999; Reproduction Health Care in the Republic of Uzbekistan 1991-1996). Because Uzbekistan was closed to Western researchers for a long period of time very little information is available regarding health care in Uzbekistan and women's health, in particular. However, some writers mention the emancipation of women in Central Asia and their participation in the agricultural labour force (Lapidus, 1982; Allworth, 1990; Akiner, 1997; Griffin, 1996; Olcott, 1991). Several works describe the lives of Soviet women in general (Bridger, Ray, Pinnick, 1996; Jancar, 1978; Heitlinger, 1979; Mamonova, 1988; Lisutkina1993; Possadskaya,1994). Many of these works developed argument without reference to detailed empirical data. In this respect, I believe that empirical research on the issue of Uzbek women as health providers for themselves and their families is necessary.

In the chapter on the 'Historical Background' I briefly analyse the pre-Soviet, socio- economic and political situation with the intention to uncover the peculiarities of the development of the Uzbek state before the Communist expansion. Although it is not the purpose here to cover these issues in detail, their general influence must be taken into account. The review of the historical background can help to shed light on how the pre-existing social and political development of the country had been interwoven into the state socialist system, and what impact it had on the status of women.

Consequently, I attempt to reveal the impact of the Soviet command system on the formation of the Soviet Socialist Uzbekistan. The socialist regime and the current transitional period should be understood as specific types of socio-economic development in order to understand the impact of state socialism on the development of the country. Moreover, in order to understand contemporary health care patterns and problems one must first refer to the facts of the historical development of those issues.

During the Soviet era women were encouraged to participate in production and public life. However, socio-economic changes in the country slowly tend to shift the discourse about women's position in society in favour of her natural domestic role. As Moghadam (1993:4) argues the 'resurgence of patriarchal discourse is a striking feature of present transition in Former Soviet Union'. In Uzbekistan, in particular, the patriarchal attitude to women in the family had not been totally eradicated by the seventy years of socialism. Although women enjoyed many advantages like financial independence, generous social benefits, cultural facilities, their relations within the family have hardly been affected. For this reason it is useful to examine the status of women in the family in relation to the mixture of preserved traditional Islamic norms and the modern Soviet way of life, paying special attention to gender inequalities. The patriarchal structure of the family could affect the health status of women due to their economic and emotional dependence on their husband, and could also influence her attitudes towards her own health care. The thesis also attempts to link the ambiguous nature of social relations in contemporary Uzbek society to the changing demands of transition. In this respect, attention has been paid to the expanding influence of Islam on the lives of women and the shift of values in the social reality.

The disintegration of the Soviet System and the rapid change from the communist ideology towards a market oriented economy caused a cultural disorientation among Uzbek population. The Russified Uzbek intelligentsia, alienated from their own national heritage, is trying to find roots in the new social culture. The process is very complicated, and even the most educated and sophisticated individuals often become trapped between the traditional and the new. The Uzbek people embraced the religion of Islam in order to find their cultural identity. Moreover, the Islamic heritage and its influence on people's lives deserves a special attention, because 'Islam is more than a religion' for Uzbek people. Islamic principles and moral values unite 'non-religious and non-practicing Muslims' around its traditional structures (Biergerson, 2002:132). Thus, people follow religious observations and call themselves Muslims without considering themselves as believers.

An important contribution could be made to the analysis of women's domestic health responsibilities through the attempt to uncover and explain how and in what guise Islam was preserved in the society. It is impossible to separate Islam from the ethnic 'tradition' because all aspects of Uzbek social or cultural life necessarily include the Muslim tradition. The structure and organisation of households, family

relationships, living conditions, personal hygiene, sanitation, food preparation, ritual observance, all these have evolved under a mixture of Islamic and modern Soviet norms. The ambiguity of the situation lies in the fact that the Islamic practices followed by Uzbek Muslims evolved under the strict Communist regime. People had no opportunity to observe the rituals openly. Moreover, due to the fact that all religious publications were prohibited, most of the population was not familiar with Muslim norms as practiced in other Islamic societies. However, 80 per cent of the population consider themselves Muslims (UNDP, 1999). Therefore, it is necessary to review more broadly the Islamic factor in Uzbekistan in terms of its possible impact on the health status of women and gender relations.

The situation of women's health cannot be understood without an understanding of the state of the health care system as a whole. Development of the Health Care system during the Soviet period and the Health Care reform after independence deserves to be scrutinised, in order to find out in what way the situation with health and medicine has changed and how it can influence the well-being of women. Moreover, the study of a society's medical culture can tell a great deal about social organisation of the society in general. I intend only to touch briefly on this aspect in order to provide some background on social conditions in which Uzbek women live.

Presenting the general situation in the country, a central question for the thesis is how all these changes and transformations have affected the lives of women. As Miles (1991) states when attributing the causes of illness one must consider the connection between general social issues and ill health. The study demonstrates and emphasises the importance of examining the influence of cultural and social structures on women's health and health seeking behaviour, because disease, health, healing and health care are all related to the structure of society and must be analysed in relation to the social structure of society.

The section on research methods deals with the nature and methods of the empirical part of the study and this is following the second part of the work, which is devoted to explanation of the quality of women's lives as it relates to health. This will be done by examining all spheres of their lives as a whole, their personal health behaviour and their own subjective evaluations of the circumstances they found themselves in during the last decade. The analysis of the empirical data that has been collected from interviews is the focus of the chapters on Women's Health Status that discuss women's health patterns and behaviour, what medical treatment women choose

as well as women's health responsibilities, coping strategies and main concerns. Women's endeavours to manage their illness and maintain optimal health as well as the impact of other circumstances on women's health-seeking behaviour are explored.

The chapter on Choices of Medical Treatment focuses on women's own perception on what illnesses were considered most problematic, the treatment of illness, including both conventional and unconventional treatment methods, and explanations of disease causation. The chapter investigates the relevance and appropriateness of health promotion strategies and health service delivery. The relationship between conditions of labour and the occurrence of health and illness is discussed in the chapter on Employment and Household based on comparison of different work roles and its impact on women's health. The following chapter is devoted to revealing the influence of religious practices and norms in regards to health and health seeking behaviour. As religious healing and practices become a substitute for health provision by the deteriorating state institutions, they contribute to peculiar pattern of women's health. The chapter on Religion contributes to an understanding of how religious norms and sanctions in the country influence the health outcomes for individuals.

Such topics as choices of medical treatment, lifestyle habits, employment and household responsibilities, religion, all have a significant influence on women's health and health seeking behaviour. In the chapter on Women's Health Patterns biomedical experiences, self treatment, medical knowledge, the utilisation of health services, family health responsibilities are scrutinised and analysed to develop concepts on the quality of women's lives during transition. Habitual and cultural factors influencing women's health like smoking, participation in sport, diet are also been included in the analysis. The examples are not exhaustive of all health problems and situations, the research mainly focuses on the concepts that invariably manifested themselves during the interviews and data analysis. The presentation and analysis of the data helped to conceptualise health-related issues, draw them into the discussion on women's status in the society and into a broader feminist discourse on gender inequality, and particularly on inequalities in health.

In the Discussion chapter the other relevant theoretical frameworks are discussed to develop integrated theoretical perspectives on the current research. The continuing feminist debates on gender and health matters with their considerable attention on gender inequalities provide the basis for revealing gender issues whose peculiarities are potentially hidden in the peculiarities of specific cultures. This feminist discourse is

used as the basis for scrutinising the intricate situation of Uzbek indigenous women. In this respect the dissertation attempts to explore and interpret the position of women, the changes in the country with respect to health and socio-economic conditions, using an interdisciplinary approach, to illustrate women's defined roles, constraints and potentialities in the spheres where the potential risk to women's health and well-being has been indicated more clearly. The examples drawn from the researched cohort illustrate a manifestation of the problems shared by women from different cultures and simultaneously uncover some distinctive features of indigenous Uzbek women.

The present study is an attempt to understand the patterns and structure of the health experiences of Uzbek women through their lives and to determine the variations and flexibility of women's health practices. The study seeks to contribute to the understanding of the effects of social, economic and cultural factors on the health of women in mid-life, as information on that subject is limited. Although potentially negative consequences of transition on women's health have been identified, the research also revealed that as elsewhere in the world Uzbek women take responsibility for maintaining optimal health of themselves and their family members. They realise that adherence to a healthy lifestyle – good nutrition, exercise, etc, are crucial for maintaining good health, however, socially constructed gender roles, cultural norms, and economic circumstances act as a barriers for women's endeavours to lead a healthy lifestyle.

1.2. Topic and Aims of Research

From the start my main interest was in women's health. Very little attention has been paid to differences in the health experiences of Uzbek women by social scientists. Therefore, I chose health of women as a particular area of my study.

My intention is:

- to look at women's individual health
- to look at women's role as a mediators and health providers of health in their families.

While focusing on health as a major determinant of women's well being I have made an attempt to examine the factors affecting the health-related quality of life in women faced with the challenges in the period of transition.

A review of the literature concerning health and illness revealed the fact that the majority of ill health is dealt with within the family (Graham, 1984, Kleinman, 1980; Lewin and Olsen, 1985). In most parts of the world women were recognised as the main potential healers for the bulk of the population (Oakley, 1993). However, we still know little about the ways in which Uzbek women have provided, negotiated and mediated their own health and that of their families. The provision of family care is a significant aspect of everyday life in many societies (Lee, 1998). The burden of family care falls most heavily on women and it is a difficult burden, "which falls inequitably on women at a time when they are experiencing increased pressure from other roles" (Ibid, 111). Abbott and Wallace (1990:95) point out that "there is evidence to suggest that when resources are limited women do without in order to ensure that their husbands and children are adequately provided for". Therefore, the research explores the strategies that women have adopted to survive the times of upheaval and where possible to take their own control to define their own lives where men have given up. The family and domestic sphere have crucial significance in the analysis of women's health, because attitudes towards health are embedded in domestic activities (Graham, 1984:153). Women are considered to be primarily responsible for maintaining the health of their families, and "as informal, unpaid carers they play a major role in caring for sick, the disabled, the elderly and other dependant groups" (Abbott and Wallace, 1990:111). The study aims to look at domestic responsibilities in which the traditionally defined gender roles are manifest. "Women are the principal carers and they have a particular concern for the health of children and families. They make choices about diet and, have a substantial influence on life style and behaviour" (Calman, 1998:194). In Uzbekistan the obligation of doing work in the home falls largely on women, and is probably a factor contributing to their physical and mental well being. Therefore, it is essential to conduct the research within the family, as woman's health responsibilities inside the home are significant. Through an examination of the available data the range of women's choices and actions, concerning their daily health routine has been identified.

My research shows that there has been a significant change in the attitudes, beliefs and behaviour as a result of the influence of the market economy and Westernisation, since independence. Women have discovered their importance in the situation when they have been left without any state support, their privileges were lost, and they can no longer rely on their husbands. A relatively unexplored area is how Uzbek women perceive themselves and their lives and how they feel and interpret their own experiences. The need for concrete evidence in this area is obvious as enormous

social changes bring about very different attitudes, feelings and experiences in women's lives. This study seeks to describe and analyse the above issues and at the same time explore the hidden strategies whereby Uzbek women maintain their health and the health of their families as they take control over their lives.

Despite many positive developments in health care during the Soviet period, (the crude death level fell, life expectancy stabilised at around 68 years for men and 73 years for women, and infant and maternal mortality and morbidity rates fell), there remained serious health problems related to women's poor nutrition, the unhealthy environment and frequent births (ABD report, 2001; McKee and Chenet, 2002). Poverty and the decline in health services accompanying the transition to a market economy exacerbate all of these problems. All these issues remain largely under researched. Therefore, to begin to fill this gap in knowledge the following topics have been included in the study:

- The cultural construction of health in Uzbekistan
- The factors which affect the health of women and their family members
- Traditional approaches and everyday habits to illness and sickness
- Health care utilisation and practices
- Choosing the form of treatment – state care, alternative therapy or treating with home resources.
- Lifestyle habits
- Women's daily domestic health work or household health provision (looking after sick family members, taking children to clinics or hospitals, feeding and medicating ill children and other family members.)
- Women's coping strategies

There is a need for a greater understanding of the perceptions and experiences of health and illness of Uzbek women, and how these perceptions and experiences fit into their social context. Therefore, the purpose of my study is to provide detailed information about women's domestic responsibilities, how they affect their health and health of their families, and to relate these issues to the evolving social process.

With this objective a qualitative study explored women's health issues, their experiences with multiple roles, and their health care behaviour. The study was conducted among 20 urban, middle-aged, middle-class Uzbek women.

1.3. Literature Review

1.3.1. Introduction

The research for this study has been conducted using an approach that showed that the development of beliefs on the principles of women's emancipation in Uzbek society could be slightly different from that presumed by a Western feminist standpoint. However, at the beginning of the literature review, the introduction of basic ideas relating to the Western feminist outlook seems to be appropriate, as number of points have significance for the present research.

First of all, I examine the approach of Western feminists to the question of gender inequality in society, as gender inequality is a fundamental aspect of most human societies (Lee, 1998). A review of the work of all feminists is, of course, beyond the scope of this study. Consequently, I considered only briefly some general aspects of feminist concepts.

Secondly, due to the fact that the focus of the study on Uzbek women, in particular, it seemed appropriate to review the literature on gender inequality in Uzbek society before and after independence. However, this literature, as well as that which deals with domestic health issues of Uzbek women, is limited. The most extensive investigation of issues relating to women's health mainly seeks to identify local health problems among Uzbek women. Thus, the literature written by Russian feminist writers has been used to draw out the facts on these issues.

Thirdly, I believe that it is necessary to refer to the literature which deals with issues concerning ideas of women's health and in particular the literature discussing the biomedical and lay perspectives towards women's health, as it has a direct bearing on the aims of the research.

1.3.2. The Western Feminists: Debate on Gender Inequality

The trends in feminist thought that I am going to analyse below are based on a shared understanding of the general gender inequality in society, although different authors see different causes of this inequality. Feminist thought remains critically important today.

Although the interests and methods of different feminist writers are diverse, they all share the aim to eliminate the subordination of women. There are different trends with regard to the analysis of problems of gender inequality. Abbott and Wallace (1990) point out that "while all feminists are agreed that it is necessary to understand women's

subordination and to emancipate women, they are not agreed on the causes of that subordination or how emancipation is to be achieved" (p. 212).

The feminist critique of social relations goes back to the history before the present century. Feminists stress that women being 'part of humanity' historically were 'largely excluded from, making war, wealth, laws, governments, art, and science' (Kelly-Gadol, 1987:16). Thus, feminist theory considered the claims regarding gender inequalities and the subordination of women as fundamental to social analysis. In the recent decade there has been a considerable development of Feminist theories in the West, triggered, by the feminist wave of 1960-1970. Diverse categories of feminism have been identified: black feminism, lesbian, and post- modern feminism.

I consider only three traditions from which all other feminist orientations take their roots:

- Radical
- Social/Marxist
- Liberal

Although radical feminism is not a unified area, it could be defined in general as a movement that developed and elaborated a theory of patriarchy (Millet, 1977; Firestone, 1971). The term 'patriarchy' remains widely used and refers to the systematic 'organization of male supremacy and female subordination'. Thus, to radical feminists - patriarchy is a social system of male supremacy (Beasley, 1999:55). In their discussion of this theory they provide a more complete analysis of women's oppression through the recognition of the especially powerful economic hold which men have over women. Their main argument is that it is men who exploit women. Further they argue that women's biological attributes are the basis for women's oppression. The analysis of reproduction is also of crucial importance for radical feminists, because they believe that patriarchy uses reproduction to restrict women's opportunity to enter the sphere of production (Humm, 1992).

The most extreme radical feminist Shulamith Firestone (1971:232) argued that in order to overcome gender inequalities women must readjust their biological differences with men. She claims that biological differences between women and men produced the fundamental inequality and thus "men and women developed only half of themselves, at the expense of the other half". She suggests that women must free themselves from their reproductive responsibilities by all available means. She means contraception, state child-care centres, and even artificial reproduction, which could give women

independence, economically and emotionally, and thus will make them equal to men. Furthermore, she calls for the elimination of all male/female and child/adult distinctions by giving everybody full sexual freedom. When she argues with Marxist theories she claims that the class theory of inequality has some limitations. She states that because Engels "can see sexuality only through an economic filter, reducing everything to that, he is unable to evaluate in its own right" (p. 5).

In the analysis of radical feminists, capitalism per se is not the important factor. They argue that capitalism is just another economic system in which the oppression of women takes place. Thus, instead of struggling for changes in the capitalist world, women must come to terms with their emotional sexual world, and identify their negative experiences with the opposite sex. As Bryson (1999:29) puts it "women must learn to take responsibility for their own lives and combat injustices rather than wallowing in the masochistic pleasures of shared victimhood." Radical feminists include historical and economical aspects as well as psychological process in their analysis.

Although it can be accepted that Firestone's explanation of gender inequalities, has some rational elements, however, the historical experience shows her theory is clearly deficient, as demonstrated by the example of Russia in 1920 when there was an attempt to eliminate the institution of the family. Thus, the approach of radical feminists has its limitation, because it is not biology alone that explains gender inequality.

By contrast Marxists' feminists (Mitchell, 1984; Hartman, 1981) view capitalism as the main source of women's oppression. Marxists primarily concentrate on the collective class interests and stress the priority of economic and social rights. They offer an explanation of the development of human history in terms of class struggle. They argue that the actual causes of the oppression of women are located in social class. Women workers have been characterised by Marxists as an additional labour force. When workers become surplus to the requirements of capital, they can once again be expelled from the workforce. 'These changes, usually were interpreted as part of a humanitarian struggle to improve the conditions of life of the working class' (Hart, 1985:27). However, the Marxist approach has been criticised for failing to explain why "women are excluded from the public sphere and are the main unpaid workers in domestic sphere" (Abbot and Wallace, 1990:214). In other words, it does not explain why even when women were used by capitalists as cheap female labour to reduce the cost of production, women but not men still had to work in domestic sphere. Despite

these, Marxism made a major contribution to our understanding of the interaction of gender and the economy.

Lise Vogel (1983) in her book *Marxism and the Oppression of Women* provides an insight into how women's full participation in all areas of social life can be achieved by creating the material conditions, like the provision of maternity leave, lighter work during pregnancy. She also supports the idea that "the establishment of effective social equality between men and women in socialist society meets an obstacle in the real differences between them, particularly in the area of childbearing" (p.174). She rejects the idea of some radical and social feminists, which came forward with the drastic demand for the abolition of the family. She argues that "historical materialism poses the difficult question of simultaneously reducing and redistributing domestic labour in the course of transforming it into an integral component of social production in communist society" (p. 175).

Marxism was of course central to the Soviet system and one has to admit that the Soviet system made significant progress in Central Asian States towards elimination of gender inequality. However, the cultural peculiarities also had a specific effect on the patterns of relationships between men and women. Even where the state established a new social order, through institutions and law, it was a much more difficult challenge to change cultural and traditional patterns. People were reluctant to come to terms with the necessity to alter the historically rooted perspectives on gender relations.

Liberal feminists present another perspective on gender inequality, although there are different viewpoints within the liberal feminist approach (Friedan, 1983; Eisenstein, 1981). Liberal feminism aims to achieve equal legal, political and social rights for women. Their goal is to eradicate gender stereotyping but not by replacing traditional forms of gender relations, such as heterosexual marriage, with alternatives (Humm, 1992:181).

They believe that gender inequality is socially constructed, and thus differences between males and females are not the inevitable consequence of biological characteristics. Consequently, neither men nor women can benefit from sexual inequality.

Eisenstein's (1981) *The Radical Future of Liberal Feminism* is particularly interesting. Eisenstein (1981) admits that liberal feminism recognises the struggle for formal equality between men and women within the law as central to the women's

liberation, "the problem is that when these liberal feminists say they want equality with men, they gloss over the fact that men are not equal in the capitalist class structure" (p. 231). Eisenstein broadens the scope of liberal feminism by predicting its 'radical' potential, which, she suggests, stems from the connection it makes between capitalism and patriarchy (Humm, 1992:184). The weak point of liberal feminism is that inequality is not an abstract concept and there is no way to challenge ideology without challenging the state.

Feminist writers have been keen to use different approaches in an attempt to explain the subordinate position of women. As has been outlined above these approaches vary in their assessment of biological, cultural and historical factors of relations between men and women. While analysing the theoretical assumptions of different feminist authors the genuine disagreements over political strategy became evident. The discrepancy between radical and liberal feminism is stark given that the former assumes the body as a critical locus of oppression for women, while the latter on the contrary reduces the attention paid to bodies. The difference between radical and Marxist feminism is that Marxists consider that the earliest forms of class division gave rise to male dominance in society. Radical feminists, on the other hand, believe that sexual oppression predates class power (Beasley, 1999:57).

Therefore, it became evident that feminist strategies could vary according to changing political circumstances. No single perspective offers completely satisfying answers to the issues of the origin of gender equality. There is no social or cultural approach alone that can explain gender inequality. Neither should we underestimate biological factors. The combination of all factors could yield significant insights. As a result, when discussing gender inequality, one must bear in mind, that there is no total identity between male and female since there are functions that men are not able to fulfil. However, it seems that in times of economic hardship women can assume far greater burdens than before. Political actors in almost all societies exploit that ability for their own purposes, to assign different roles for women depending on the political or economic situation in the country.

Despite the contradictions between different feminist approaches, they all contribute to the understanding of the subordination of women, reveal the causes of their subordination and could be helpful in women's perception of their own status and aims.

Uzbeks have a different cultural value system from people in Western societies. It would not be appropriate to simply apply Western feminist models and ideology to Uzbek society because of Uzbekistan's own peculiarities and different historical development. However, one cannot reject the impact of Western feminist thought in the last decade on the perception of feminism in Uzbekistan.

1.3.3. Overview of the Soviet Period Thoughts on Gender Inequality

I intend to review some key works which attempt to examine and explain gender relations in Uzbek society, which were developed during the Soviet period, because Uzbekistan was part of the Soviet Union for seventy years, much of the literature review on this subject focuses on basic trends of Russian feminist thought, in order to provide insight into the societal context in which Uzbek women lived before independence in 1991.

There were no official feminist movements in the Soviet Union. All the inadequacies and shortcomings in the status of women had been resolved by the "intervention of various official organizations such as trade union, the young communist organization and the Committee of Soviet Women and the local women's soviets" (Holt, 1985:238). Although there was an underground feminist movement it was not of significant scale, and involved mostly circles of the Leningrad intelligentsia.

After the Socialist Revolution in October 1917 the new government legislation declared equal rights for men and women in the USSR. The new government granted women the right to vote in political elections, equal employment rights, equal pay for equal work for men and women, equal access to education, healthcare and welfare services, and the right to initiate divorce. One of the basic principles of social and economic construction was equality of women in all spheres of political, social, and economic life. The soviet regime declared right from the start that one of its main goals was to achieve full equality between men and women. It should be mentioned that as Wolchik (1993:32) states 'the goal of women's equality was not chosen voluntarily by population, but rather was adopted by political leaders and imposed from above.' For seventy years it was repeated that the USSR had successfully accomplished full sexual equality in all spheres of social and economic life. Mezentseva (1994) emphasised that the logic was quite simple: if sex discrimination was forbidden by law, then it did not exist. The official view of the Soviet policy was that the issues of concern to women were solved in the USSR. However, formal equal rights for men and women

proclaimed in the constitution and in other laws, certainly did not ensure equal rights in practice (Voronina, 1994:38).

Women in the USSR accounted for 51 per cent of labour force in the state sector and 52 per cent on collective farms (Heitringer, 1979:79). The proportion of women in the party, governmental and trade union and other social organisations constituted 30 per cent, due to the establishment of a quota for every political body. Maternity leave, family benefits and childcare arrangements were highly developed (Chenet, 2000:183). Indeed, the progress of women in the socio-economic sphere was quite remarkable in the USSR. However, can we state that Soviet women achieved real equality in all areas of life?

Soviet feminist and dissident Tatiana Mamonova (1989:138) argues that equal rights in the Soviet Union existed only in theory, both in the work place and at home. In her opinion the communist regime not only failed to establish gender equality, but also created new methods for the exploitation of women. Equal opportunity in the industrial sphere actually led to a broader form of inequality. Domestic and family responsibilities had become as a second burden on the shoulders of women. The scarcity and inadequacy of goods and services turned into torment for Soviet women in their everyday life.

The general task of the Soviet government was to give women political rights and economic freedom. During the first decades after the October Revolution the entire population was considered as cheap labour. Employment became a compulsory duty. Many occupations that were considered suitable for men had been opened up to women. The equality of women took the form of active participation "alongside and on par with men in industrialization, collectivisation and other areas of socialist construction" (Voronina, 1994:46). However, when labour becomes forced it transforms liberation into enslavement. The process of drawing large numbers of women into the workplace was a result of the need to provide labour for industrialisation. The state required women as workers and that guaranteed women access to education and ensured the formal proclamation of equal rights under the law. The reliance on female labour was based on Soviet ideology according to which the full entry of women into social production held the key to genuine equality (Lapidus, 1982). Thus women gained relative economic autonomy, however, the traditional patriarchy continued to flourish under socialism (Posadskaya, 1994).

The equality was undermined by the fact that women were mostly concentrated in certain types of economic activity. In industry women were employed in low skilled, non-mechanised and poorly paid positions. In agriculture, women were engaged in heavy manual labour, while men occupied newly mechanised jobs. Consequently, women earned considerably lower wages compared to men. Women were unevenly represented in certain sectors of the economy. The sectors outside manufacturing were highly feminised. Production sectors based on low levels of technology coincided with the large–scale employment of women in unskilled jobs. The proportion of professional women with higher and vocational secondary education was comparatively high. However, a considerable proportion of professional women remained at the bottom of the career structure, despite their level of education and professional experience (Mezentseva, 1994:112). Kostakov (1982) points out that women in the Soviet Union were disproportionately underrepresented in leadership positions both in the economy and political institutions:

> "Among managers of enterprises and their subdivisions only 16 per cent were women and only 25-29 per cent of the principals of secondary schools were women. The proportion of women among state and collective farm managers remained only 4 per cent." (p. 58)

The proportion of women in the workforce was highest in such sectors as health (84%), trade and procurement (76%), education (73%), communication services (68%), state and economic administration and management (64%), and science (50%) (Sonin, 1982:24). The average wage level in these branches was below average. Women were segregated at their places of work through the establishment of certain areas of "women's profession". These professions were always low-paid and of low prestige. A decrease in the prestige of such occupations as health care and education resulted from its gradual feminisation. The higher the proportion of women employed in a particular sector of the economy, the lower the average pay.

Due to the fact that men in the Soviet Union were "breadwinners" it was not unusual that men received higher wages for the same job (Voronina, 1994:39). Mezentseva (1994:113) also points out the massive discrimination over pay. She argues that in the 30-39 and 40-49 age groups over 12 per cent of women earned the lowest wages, whereas for men the figures were just over 3 per cent. Only 9 per cent of women were highly paid, whereas 25 per cent of men were in this category.

The situation in the Central Asian Republics was slightly different, although, as Ubailullaeva (1982) states, not in a manner that favoured women. In Uzbekistan, for example, industries experienced a shortage of labour, despite the high natural population growth. The proportion of women in the workforce of the republics of Central Asia remained lower than for the Soviet Union as a whole. This was due to the fact that a high proportion of women were employed in household work and in agriculture. Although women appeared to have been fully integrated into the workforce, their domestic role did not change as much as the government propaganda suggested. Large families and a lower level of development of the service sphere resulted in greater household workload borne by indigenous women. In addition, a number of historical, traditional, ethnic and other factors decreased the mobility of the female population and reduced their capacity for acquiring specialised knowledge and experience in industry. Further, she states that in Uzbekistan about half the women working in industry performed manual labour, and 12 per cent of them were employed in arduous manual jobs. Likewise in agriculture most women were engaged in manual work.

The Soviet economy was structured in favour of the manufacturing sector. The whole system was subordinated to the solution of technological and production problems. Priority had been given to heavy industry, construction and transport, whereas the service sectors (education, health care) were considered to have low priority. As Mamonova (1989:138) puts it, Marxism made a mistake in considering only industrial work to be productive labour, rendering domestic duties as something having no intrinsic value.

The resources allocated to the consumer sphere and to the socialisation of housework were wholly insufficient. Equal opportunities had been granted to Soviet women in the workplace, however the burden of family and domestic responsibilities led to a broader form of inequality (Heitlinger, 1979:131). Everything had been sacrificed to the collective ideal of class interests. Everything that did not serve the historical mission of the communist victory was considered useless.

Pilkington (1992:188) gives her explanation of the oppression of women which was "arrived at by referring to women as the victims of state mobilization policies which move them in and out of the labour force according to demands of Soviet economy."

Concerning inequalities in education, Voronina (1994) argues that in 'prestigious' universities and institutes there were limited quotas for female entrance. She points out

the hidden discrimination against girls at schools where girls were mostly oriented towards family responsibilities and women's jobs, but not knowledge. "Thus, by rigidly tying women only to children, family and everyday life and by linking the family's well-being with the women alone, society reinforced powerful socio-sexual stratification: the home is the place for women and the world is home for men" (p.40).

Voronina (1994) believes that women in the Soviet Union were subject to the harshest exploitation, that they were the 'internal slaves' of socialism and that for many years the economy of the country was totally dependent on women's cheap labour and unpaid female family work. Further she argues that the antagonism and inequality between sexes would be eradicated only when masculinist ideology and the patriarchal principle of social organisation were overcome.

In political speeches, official documents and in mass media women were shown as a passive mass without a stance of interest of their own (Mezenseva, 1994:110). She writes that women became sexless figures, trapped in a double exploitation at work and at home. Socialism granted women equal rights of employment without releasing them from household burdens. This meant queuing and hunting for goods which were generally in short supply, followed by struggling with the duties of private housework, i.e. preparing meals, washing, cleaning, and nurturing children in the cramped houses with poor facilities in kitchens and bathrooms. Shopping was extremely time-consuming. Women had to spend hours queuing in long lines (sometimes lines stretched out from the small shops into the streets) after a hard working day. Women were liberated, but not from patriarchal morality. Soviet men were unwilling to undertake an equal share of housework and the heaviest part of the burden in families was carried by women. As Heitlinger (1979:92) puts it, modern facilities such as central heating and gas freed men (they no longer had to chop wood for the fire), but did not really solve the problem of women.

Women became economically independent. However, men continued their traditional roles as head of the family, preferring to spend their time reading the newspaper or watching TV after a hard day at work, while their wives and mothers performed all of the housework without the aid of machines (Mamonova, 1989:138). The household continued to be viewed as primarily a female domain and the family as a female responsibility.

As Mezentseva (1994) argues, many women overwhelmed with their many social roles and functions regarded their jobs as something forced on them by purely financial

considerations. Women were not concerned about achieving equal opportunity at work. They viewed their various labour entitlements and social benefits as being more important. However, women who were psychologically and professionally ready to take advantage of equal opportunity came up against official and unofficial obstacles and widespread prejudices in the family environment, which limited women's access to higher positions.

Another Soviet feminist writer, Lissyutkina (1993), argues that due to the fact, that women were emancipated against their will, the majority of Soviet women reacted negatively to feminism. For them the idea of feminism and emancipation had been associated with the images of masculine women in construction or factory workers. Therefore, liberation for Soviet women was perceived not as an opportunity to demand work, but on the contrary as the right not to work. Thus at the beginning of perestroika, the majority of women linked the idea of liberation with the inspiration to return to the family and to the home. They sought to throw off the senseless and unattractive burden of work in order to have a chance to look after their children who had been brought up by communities like pioneer or *komsomol* organisations.

It should be taken into consideration that the above writers are émigrés or dissidents and therefore their views must be taken in the context of their doubtless more negative attitudes towards the question of women in the USSR. Perhaps the best way to validate and justify the opinion of the above authors is to look at various ways in which the subject was described.

The book written by Barbara Jancar (1978) *Women under Communism* provides more diverse insights on these questions. The aim of her study was to understand the impact of the Communist system on the status of women. She argues that the women that were interviewed, even émigrés, complained about injustice on the "monolithic state, tyrannical and ruthless bureaucratic Party hierarchy, religious and racial discrimination, and lots of other ills, but not discrimination on the basis of sex"(p.199).

One must admit that, on balance, the Soviet system had positive rather than negative impact on the status of women, especially as far as Central Asian women were concerned. The Soviets had done a great deal for women through legislation and the provision of communal facilities. The Soviet heritage should not be rejected wholesale. Shirin Akiner (2002:17) emphasises that one of the most important socio-cultural changes to take place in Central Asia under Soviet rule was the emancipation of women. Thus the Uzbek woman who was obliged to wear *paranja* (a cover from head to toe)

and forbidden even to leave the house except with the permission of her husband, entered the workforce, and became a family breadwinner on an equal footing with her husband. Women were encouraged to seek education and employment outside their homes, and consequently a significant proportion began to take an active part in public life. These facts can be considered as emancipating, taking into consideration the status of women in Uzbekistan before the Revolution.

However, despite many attempts by the Soviet government to eradicate any gender inequalities among Central Asian population, patriarchy still retains its hegemony in Uzbekistan. Despite certain progress made by certain women that progress remains both conditional and limited. The conception of the position of women in contemporary Uzbek society must be re-evaluated in order to challenge the patriarchal ideology.

Patriarchal ideas about women's place in the family and at work were common in Soviet society. Women were considered less work motivated and less career- oriented than men. The notion that women were no good at making decisions and did not want to bear responsibility for them was also widespread. Moreover, Barbara Jancar (1978) points out the degree of antifeminism among Soviet women. Her survey shows that a political career was viewed negatively by Soviet women. She argues that women themselves preferred and willingly accepted propaganda and education based on a continuing conservative view of the role of women by the reason of "social origin and force of habit" (p. 192). She concludes that the "female self-concept remains firmly anchored in tradition" (p. 204), and explains women's political passivity by the facts that, first of all, political participation made a great demand on women's time. Secondly, women traditionally have not developed political skills. Thirdly, political career meant a commitment for life, in other words there was no way to withdraw voluntarily, if you happened to have been engaged in a Party career. Thus, "the political structure would seem to set too great a cost at too little benefit to encourage women to risk..." (p. 118)

Nevertheless, despite the opinion established among some authors that emancipation of Soviet women was an ambiguous question, the Soviet regime provided legal social and practical support for women to change their position (Akiner, 1998). Under socialism women were raised to be economically independent and to find satisfaction in their work and had broader contact with the larger world, of which Uzbek women were deprived in the pre-revolutionary period. Although many writers express

the opinion that socialism had not succeeded in making women free and equal, in relation to Uzbek women one can trace a huge leap from an economically dependent, totally submissive to the family, almost illiterate creature to an intelligent, educated, professional, independent, competitive woman. Many Uzbek women proved themselves to be capable of doing their outside job even under the hard pressure of the dual burden. Whatever the reason for this, be it because of a manpower shortage that opened up the positions to women, or the actual pressure on women to fill the jobs abandoned by men, Uzbek women actually became much more liberated and emancipated during the years of socialism. The question is why the majority of women continued to follow a traditional pattern of life, refusing to take an advantage offered by a new social order. One thing is clear - Uzbek women were less conditioned by social demands than by the responsibilities they had for their families. It could be argued, that the domestic responsibilities of women at home might have prevented them from accepting occupations involving higher responsibility, thus limiting their upward mobility in their career.

The Soviet system had made significant progress in Uzbekistan towards the elimination of gender inequality. However, the cultural peculiarities also had a specific effect on the patterns of relations between men and women.

In regards to the contemporary situation Marfua Tohtakhojaeva (2000) argues that the objective political process in women's consciousness clashes with Islamic propaganda and with the 'resistance of male structures' (p.204) in Uzbek society. Women's state organisations and committees are not strong enough yet, which could be due to the fact that people who are in charge of such organisations often try to solve women's problems using old methods, with the help of instructions, recommendations, and slogans. The development of the contemporary state stratifies women. The lack of experience among women to defend their social interests, the hardships in everyday life during transition, the lack of faith in the successfulness of the public and social activity inherited from the past, all these impede the emergence of the strong and influential women's organisations.

Our knowledge of the status of women in Uzbekistan is incomplete. There are issues, which remain relatively neglected in the literature. The fact that women may prove more resourceful than men in the household economy has not been exemplified in detail in the literature. In order to overcome these limitations an empirical approach

that has not been used before in the research of Uzbek women's health will be used in this study.

1.3.4. On Women as Health Providers and Mediators

Analysing the literature on women's health it becomes clear that the definition of health is an extremely difficult question, and that there is no single way of defining 'health'. There is no generally accepted interpretation of health as a concept. The literature dedicated to one or another aspects of health, contains a great deal of categories, based on different methodological principles. The diversity of opinions and unsuccessful attempts to provide a single coordinated assessment of this category, could be due to the fact that health itself is a very complex phenomenon.

In the biomedical model ill health or disease is defined as the "deviation of measurable biological variables from the norm or the presence of defined and categorised forms of pathology" (Blaxter, 1990:3). The bio-medical model assumes that the individual body works as a machine, and that malfunctioning parts of the body can be repaired or even replaced. The implication is that ill health is a technical matter and can be restored by medical intervention, by surgery and drugs. Many sociologists have objected to this narrow explanation of health and illness (Illich, 1976; Navarro, 1976; Mechanic, 1978) and argued that health must be considered as a socially constructed concept (Miles, 1991; Scambler, 1997).

Besides, different authors use different approaches to identify the concept of health. Some of them take the subjective conditions of the individual as the main criterion, where to be healthy means to feel good physically and morally. Others appeal to objective criteria, where health is seen as a physical condition in a constant adaptation to environment, and disease - as a breach of normal conditions. However, the estimation of people's state of health seems possible only on the basis of a complex evaluation of a variety of all factors.

The popular perceptions of what constitutes 'health' by lay people are much broader. Lay definitions of health include variously geographical, historical and cultural circumstances. Scambler (1991) emphasises that understandings and responses to health issues vary not only within "cultures, subcultures and communities, and even within household, between generations"(p.33). Lay people make an attempt to seek an explanation for the concept of health from different sources of information, including

biomedical, '...lay people have become more aware of tests, medications, the causes of different illnesses, treatment alternatives, and likely outcomes' (Lober, 1997:96). Therefore, the notion of health and illness for lay people is deeply embedded in their social context. Thus, for some being healthy means being active and physically fit, for others it is only to be able to get out of bed and cope with their everyday routine. On the other hand, some people consider themselves healthy even though they may be badly diseased (Aggleton, 1990:13). Thus health issues including concepts of health and illness are perceived by diverse categories of people differently according to age groups, social status, gender and ethnic differences and are influenced by social standing and material circumstances. The lay definition of health is "a valuable source material for the understanding of individual and social experience" (Miles, 1991:38). As Good (1994) states "lay medical culture is the precipitate of rational, adaptive behaviours of individuals, and it takes the form of more or less accurate beliefs, which are held in individual minds"(p. 42).

The subjective estimation (in other words self-estimation) of health, and an objective medical examination are both equally important for the evaluation of health of the population.

Reviewing the works of the above authors leads to the following conclusions:

- there is no consensus on the issue of health. Health is a complex notion to define, because "health means different thing to different people" (Miles, 1991:37);
- the lay definition is no less important than the official definition. As Annandale(1998) puts it: "health, like illness, it would seem, needs to be approached from the reference point of the individual concerned..."(p. 262);
- health is a relative quality and its perception depends on the surroundings and circumstances in which people live (Aggleton, 1990).

Mildred Blaxter's book *Health and Lifestyles* (1990) provides assessments of people's own opinions and attitudes towards health and health related behaviour. Blaxter makes an attempt to build up models of the relations between lifestyle and health. Such factors as life circumstances and people's experiences, social support or isolation, economic and social insecurity, are likely to affect quality of life and consequently health. Thus 'employment may have a direct effect on health through the fall in income' (p. 87), and be associate with stress-related diseases such as depression. 'Social loss or social isolation are particular forms of stress which have been shown to be particularly dangerous to health' (p. 103). On the other hand, family relationships

and close bonds of kinship can be very protective in relation to higher self-esteem, confidence and certainty. Such behaviour patterns as smoking, the consumption of alcohol, exercise, and diet were selected for more specific scrutiny as the life style habits and personal behaviour patterns with a major impact on health. Other characteristics such as sleep patterns, hygiene, taking dietary supplements, use of preventive medicine services etc, are also considered to be relevant to health. The former behaviour patterns are presented in the study as more important to be analysed, because smoking and drinking heavily and the neglect of diet and exercise can generate such an unhealthy lifestyle, that other habits (including even the use if preventive services) are 'unlikely to compensate' (p. 114).

The major finding of Blaxter's book is that people's lifestyles are usually mixed in terms of healthy and unhealthy habits. The effects of both behaviour patterns have to be considered in context of social and environmental circumstances. There are healthy and unhealthy people in all classes and circumstances (p. 237). Women's health appeared to be more vulnerable to the social environment and the diet of women was more affected by income (p. 236). 'The ability to choose is inevitably restricted by living and working conditions' (p. 243).

Blaxter tries to find out which is more important in relation to health - social and economic circumstances or more voluntary aspects of their lifestyle, i.e. the choices that people make about their behaviour and especially about their consumption of food, tobacco and alcohol. She also emphasises that not only material aspects such as income or a favourable environment may be protective mechanisms in relation to health, but also personal and social circumstances such as feelings of social support and integration.

Thus, an indicator of health status depends on the changing interaction between political, economic, social, cultural, scientific, technical and psychological factors. Decisions that are made in the spheres that do not have an immediate bearing on health care, could still affect the health of the population indirectly.

The subject of how the health of women is different from that of men has been studied by Doyal (1995) and resulted in findings according to which women suffer more illness than men but live longer. There is no straightforward explanation for why women live longer in most societies if they suffer greater morbidity than men. One of the explanations given by Kane (1991) is that it may be due to the fact that because of their reproductive capacities, women see doctors more frequently. Therefore, women

are more likely than men to be examined, and their health threatening conditions are discovered and they take preventive measures and thereby prevent conditions that otherwise could lead to death (Doyal, 1995; Kane, 1991). However, living longer does not necessarily mean a higher quality of life. As Christina Lee (1998) emphasises, women have poorer health with few differences between developed and underdeveloped counties, due to the social disadvantages by comparison with men. In her book *Women's Health* (1998) she shows that women have disadvantages in terms of education, income, outdoor employment and in social and political power. Therefore she claims that "women's health can only be understood in their social, cultural and political context" (p. 172).

Women's health does not merely mean the absence of illness and disease, as the biomedical model explains it, but it is a continuous biological, physiological and psychological process, which allows individuals to carry out their normal social lives. Moreover, it is profoundly influenced by social and economic factors and cultural beliefs. Therefore, consideration of the cultural, social and economic contexts of the country where the research is undertaken is very important for understanding the health care patterns of that country.

A great deal of literature is concerned with the effects of cultural beliefs on the perception of health (Payer, 1990; Stern, 1986; Kleinman, 1980; Helman, 1984). According to these authors different cultural beliefs can crucially affect not only the lay perception of health but also the practice of biomedicine in different countries. As Payer (1990) puts it "it is society's values which ultimately determine the rights, privileges, obligations, and prerequisites of the health care establishment" (p. 9).

Thus values and value systems, concepts of health, illness, and disease as well as concepts of suffering, pain and death vary in different countries. Research on health needs to take into account that medical practice differs significantly from country to country. Individuals in a particular society perceive health and react to illness in a very different way to other societies. Cultural values and customs of a particular society shape individuals' view of the world, and provide individuals with specific rules of behaviour. Each culture develops distinctive features of its own, and acquires a different perspective on the organisation of a daily life. Sargent and Brettell (1996) argue that health and illness must be understood in a cross-cultural context.

> "It is culture that marks and gives meaning to certain biological changes. It is culture that defines both health and ill health. It is culture that defines

> different gender roles for men and women and hence different evaluations of the biological process" (Sargent and Brettell,1996:10).

Culture is a very important aspect of daily live, but it is also a very complex factor. Many cultural concepts like diet, clothing have been inherited and transmitted from one generation to another and have been strongly preserved in a particular society. However, external changes like migration or exposure to new information through mass media, may lead to changes in cultural perceptions. Thus cultural perceptions are not static and may vary depending on external and internal factors. The concept of culture and cultural differences are crucial to this study. It can help in understanding how women with a culture that differs from that of Western societies perceive their health, why they choose different patterns of health behaviour, and how cultural norms and traditions influence their decision-making when they or the members of their families are ill. Some patterns of health behaviour may appear to be seen for Western readers as peculiar or anachronistic. The explanation of cultural differences could elucidate and clarify misunderstandings from the Western point of view. This is especially true for health–seeking behaviour of the indigenous Uzbek population, because 'traditional' medicine and 'folk' treatment, as opposed to biomedical treatment, are more widely accepted in Uzbekistan than in Western countries, despite the existence of a highly developed modern health care system.

Kleinman (1980:51) states that "self-treatment by the individual and family is the first therapeutic intervention resorted to by most people across a wide range of cultures". The perceptions of health and illness in different cultures could be so far apart that they contradict each other.

The issue of how social and cultural variables affect the pattern of disease and modes of healing is discussed in Cecil Helman's book (1984) *Culture, Health and Illness*. He demonstrates the significance of cultural and social factors, in illness and health, in preventive medicine and in the actual delivery of health care. He analyses the complex interaction between cultures, disease, and health care. His book offers considerable insight into diverse health problems that are impacting people in different cultural environments. Sargent and Brettell (1996) also discuss this issue in the book *Gender and Health*. The authors examine the kind of problems that occur when health is narrowly defined in biological terms, and sickness is removed from the broader cultural and social contexts.

The experience of women as recipients of care and women's work as providers of health care has begun to receive considerable public and academic attention in the last decades (Oakley, 1993; Graham, 1984; Roberts, 1990; Smyke: 1991, Lewin and Olsen, 1985). Previously the topic had not been studied much by scholars whose work concerned the health of women.

Liwen and Olsen (1985:9) argue that "some significant phenomena, notably related to the informal and 'hidden' aspects of health-care delivery, remained under investigated because the traditional conceptualisations failed to recognise them." Although many writers use radically different ways to analyse the health of women, they all agree on the common issue that women are subject to economic forces and pressures in which they did not choose to live. Therefore, their lives and experiences could not be separated from the social, cultural, political and economic context.

The literature that discusses causes and conditions that affect women's health in their social and cultural environment is of particular relevance to this research.

In the book *What Makes Women Sick: Gender and the Political Economy of Health* Lesley Doyal (1995) emphasises that obstacles which include inequalities of income, environmental degradation and local upheavals fall upon men and women equally. However, access to the distribution of health resources is structured unevenly in all societies. As an example she points to the additional burden of household responsibilities. Moreover, at work women face occupational challenges like low pay and low status. All these factors have a great impact on women's well being and consequently can be transformed into ill health. Doyal (1995) also explores how food, tobacco, alcohol and drugs help women deal with the stress in everyday lives. She concludes that despite similarities in the health needs of all women, the differences in economic, cultural and social circumstances affect women differently.

Agnes Miles (1991) *Women, Health and Medicine* provides good insights into how different aspects of women's lives affect their health. Thus, such factors as paid employment, domestic work, unemployment, marital status can have both positive and negative influences on the health of women. By examining inequalities in health she shows the strong correlation between low socio-economic status and poor health.

She emphasises the growing trends of the medicalization of women's life. Family relationships, domestic life, reproductive processes, all these became increasingly medicalized areas. She argues that the social expectations place responsibility on

women for their own health and the health of their family. She takes the view that "medicine affects women more than it does men because a greater part of the female experience comes into the medical orbit" (p. 183). Thus, women have been the main target of health campaigns and advertisements, which put a great responsibility on women for their health on the basis that they must "adopt healthier life-styles and habits in order to lessen the risk of illness" (p. 46). This consequently puts an extra burden on women and increases their potential for blame and guilt.

The provision of family care is a significant aspect of everyday life in many societies. However, it is traditionally expected that care giving is "naturally" the obligation of women, women perform such duties effortlessly and should always be available. Thus, care giving becomes invisible "neither costed nor appreciated at a political or policy level" (Lee, 1998:111). Lee states that the difficult and intensive care giving burden falls inequitably of women's shoulders, whereas men's role is to provide financial support, discuss the options and alternatives of treatment and appreciate the 'work that mothers carried out' (p. 122).

Caring becomes the category through which one sex is differentiated from another (Graham, 1983:18). In other words, caring has been given to women traditionally, and according to this tradition, men are defined through their relation to the labour market, whereas the identity of women is related to their caring relationships (p. 19). Thus, contemporary society is structured in such a way that men work to support a family financially while women have all their time available to serve the needs of others. The formal support from the social services becomes less adequate due to economic cost. Many countries 'promote the ideology of family care', consequently 'the extent of family care giving appears to have increased, at least in Western countries', which enhances the arduous burden of women who are already 'experiencing pressure from other roles' (Lee, 1998:111). Ann Oakley (1993:5) argues that "to call women's household work by the name of 'housework' is to ignore an extremely important aspect of the domestic division of labour".

Ojanuga and Gilbert (1992) point to the fact that women in developing counties are frequently confronted with innumerable socio-cultural factors which create obstacles to the appropriate utilisation of health care services. Institutional, economic and educational barriers can negatively affect women's well being and lower their living standards. They argue that women in developing countries are usually silent recipients of policy initiatives and programme interventions. Thus the introduction of new medical

technologies in developing countries has 'been intrinsically inequitable because they benefit only a small minority of urban, affluent women'. Poor women have not only have less access to them, but 'often have no knowledge of these resources' (p. 615). In relation to Islamic countries women's powerlessness and submissive position contributes to poor health outcomes even for women who are not poor, due to the effects of traditional seclusion and exclusion. Such cultural variables may have a great impact on women's health seeking behaviour and their health status. The authors advocate the idea that income, legal rights, social status and education may prove far more important determinants of women's access to health care than the provision of technology and government strategies (p. 616).

Puentes-Markides (1992) discusses the issues arising from the general socio-economic crisis that has affected most developing countries during the last decade. She argues that economic instability influences the health status of women and their health-seeking behaviour. Depending on how the society values women and perceives their requirements it will provide and satisfy women's needs. If women's requirements are perceived as almost exclusively related to their reproductive roles, the health care system would respond by providing services in an inappropriate manner without a real understanding of women's concerns. Thus 'the traditional health indicators play a key role in determining women's satisfaction of health needs' (p. 620). Further she argues that women's economic status such as employment, behavioural issues such as motivation, perceptions of illness as well as cultural variables such as education, religion, age influence access to health care services and health seeking behaviour.

The various studies outlined above elaborated on a wide range of aspects which in different parts of the world affect the approach to health and health-related issues. The identification of similarities and differences with the situations in the other parts of the world, in other words in what way the situation of Uzbek women is different or similar to those of others, will be discussed further below.

The literature that deals with health issues of Uzbek women is limited. The Ministry of Health of Uzbekistan with the support of UNDP Bureau has done the most extensive investigation to date of issues on women's health. These studies have been aimed at identifying local health problems among Uzbek population.

1.3.5. Summary

A review of the literature on women's health and gender inequalities shows that women's health and women's domestic responsibilities are interwoven with

traditionally defined gender roles. The three main Western feminist approaches recognise that men and women are unequal almost in all societies and that despite cultural differences almost all societies have a patriarchal structure. The Soviet system declared the full equality of sexes after the Revolution, however, Soviet feminist writers showed that inequality still existed in society despite some positive achievements in this field. As we can see there are profound differences between the goals of Western and Soviet feminists. Western feminists strive for the right to equal opportunity for work, education, equal wages, etc. Soviet women had all these opportunities, in some regions even against their own will. Therefore, for a majority of Soviet women the ideas of feminism and emancipation were associated with unattractive images. Central Asian women, and particularly, Uzbek women, valued family responsibilities more than participation in social activities. They were reluctant to take economic responsibility for their families. That could be explained by educational practices to bring up girls in a more traditional way that discouraged them to obtain higher positions than their husbands. After the dissolution of the Soviet Union Western feminist thought started to penetrate Uzbek society. However, the perception of Western ideas will be affected by the complex social and cultural context of the society, which has developed under the influence of modern Soviet and patriarchal Muslim ideologies simultaneously. A review of the literature reveals convincing evidence showing the very high rates of women's participation in the labour force during the Soviet period. According to the dominant communist ideology, labour was the path to women's liberation. However, despite substantial female achievements in professional employment communism clearly did not result in gender equality, especially in Uzbekistan, where gender stereotypes in family life had very deep cultural roots. Due to the undeveloped service sector and male patriarchal attitudes an enormous burden of domestic labour rested on women's shoulders, leaving women with little opportunity to improve their professional training. Whilst it is not within the scope of this study to propose a solution to the general problem of gender inequality, it is relevant to consider how the burdens of health care responsibilities are distributed in the family, and how complex relations between traditional (Islamic) and modern (feminist) trends influence them. Although, the social role of women has been dictated by the patriarchal ideology of family life, which has maintained their subordinate position, the changing demands of the market economy will probably shift the nature of the social relations in the contemporary Uzbek family.

Examining women's health will also demand an explanation and understanding of the context within which Uzbek women live. The literature on culture and health

suggests that health and illness cannot be understood without an appreciation of socio-cultural contexts. Gender stereotypes and family patterns have deep cultural roots. Moreover, women's health in the reviewed literature has been defined much more broadly than just women's reproductive capacity. Arguments have been made for the importance of understanding domestic health responsibilities. The context of everyday domestic life is crucial in understanding health beliefs and behaviour within the broader social context of Uzbek women.

A review of the literature shows that over the last several decades women's perspectives have attracted much attention as a result of the influence of feminism on traditional research and on the lives of women and their experience of their life. This study will attempt to draw on this literature to develop an integrated framework for analysing health, gender, and social patterns of health.

Chapter 2
Historical Background

2.1. Introduction: General Background

This chapter provides Western readers with a general overview of the historical, political and cultural situation of the country in order to reveal the local peculiarities, which can assist in a full understanding of the contemporary Uzbek social conditions and consequently appreciate setting of Uzbek women and their perception of their status and the health.

Uzbekistan is a landlocked country. In the North and West it borders Kazakhstan, in the East - Kyrgyzstan and Tajikistan, and Turkmenistan and Afghanistan in the South. It is the most populous of the Central Asian Republics. It has an estimated population of 24.1 million inhabitants (UNDP, 1999). The population is divided into different ethnic groups. Eighty per cent of the population are ethnic Uzbeks (Ilhamov, Jakubowski, Hajioff, 2002). Other ethnic groups on the territory include, Tajiks, Kazakhs, Tatars, and Karakalpaks (Uzbekistan, http://lcweb2.loc.gov/cgi-bi/query/r?frd/cstdy, 1996). The majority of the population (88 %) is Muslim. Other religious affiliations are Russian Orthodox, Baptist (i.e. Evangelical Christians), Korean Protestants, etc (UNDP, 1999). The population of Uzbekistan is exceedingly young. In the 1990s 46 per cent of inhabitants were under 18 years and only 4.2 per cent were 65 years or older (Ilkhamov, Jakubowski, Hajioff, 2002:211).

Uzbekistan's most productive heavy industries are the extraction of natural gas and oil, coal mining, machine building, and chemical and electrical power industries. Predominant light industries are the primary processing of cotton, wool and silk for fabric. The food processing industry specialises in the production of dried apricots, raisins, and peaches. In agriculture cotton remains the most important crop, requiring heavy irrigation. Other crops include wheat, oats, corn, barley, rice fruits and vegetables.

Uzbekistan has a presidential system of government, with separate executive, legislative and judicial bodies. The President has the power to appoint the government

and dissolve the legislature. The People's Democratic Party (the successor to the Communist Party) dominates the legislature and government. (see Ilkhamov, Jakubowski and Hajioff, 2002).

As was mentioned above, the past history and historical sequence of events in Uzbekistan are highly important and have to be carefully evaluated in order to understand the current development of the country. Shirin Akiner (1998) stresses that the pre-Soviet background is essential in understanding the present day situation in Central Asia, because even the seventy years of Soviet rule did not eradicate completely deeply rooted traditional political structures. Looking at the early history one can trace the continuities of the traditions, which were preserved during the Soviet period, despite the attempts to eradicate the old heritage.

2.1.1. Early History

The history of Uzbekistan takes its roots from the ancient territory of Turkestan. The territory which is called today Central Asia encompasses the areas of Turkmenistan, Uzbekistan, Tajikistan, Kyrgyzstan and Southern Kazakhstan. Throughout its history Central Asia had been invaded by various groups of peoples: Greeks, Arabs, Turk and Mongols. Arab invaders introduced Islam in the seventh century. At that time the main east – west trade route, the Silk Road, from Europe to Asian countries run through Central Asia. Thus the country was open to the different cultural influences from China, India, and the Islamic World. However, after the sixteenth century, a new water route to Asia was discovered. As a result, trade along the silk route decreased and the country was left in isolation, which led to the decline of economic and political prosperity.

Before the Russian annexation of the Central Asia territories in the mid-nineteenth century, the region was a part of the Muslim civilisation. The remoteness of the region from Western influence and the severance of contacts with other Asian countries like China and India meant that Islam became very deeply rooted in the life of the indigenous population. Legitimacy was based on religion and the customary law of Islam. The *Adat* and the *Shariat* ordered the life of the Central Asian population. Nevertheless, many practised a religion that was a mixture of Islam and different pre-Islamic beliefs (Bennigsen, 1971).

Central Asia remained firmly within the central Islamic world until at least the nineteenth century. However, there was another ruling ideology, which coexisted

alongside Islamic Law and was in competition with it – a strong dynastic tradition. This tradition and the system of government, society and legitimacy were introduced by Mongols in thirteenth century and remained dominant until nineteenth century (Voll, 1994).

A clearly defined national consciousness and the consolidation of the nation-state were not present in Central Asia before the beginning of the twentieth century. Presumably, the only form of social identity was tribal and clan organisations, ethnic identity (Turk or Persian) and religion (Islam) (Dannreuther, 1994; Manz, 1994). Gleason argues that in Central Asia, nations, and thus nationalism, did not exist before the revolution. "The political institutions that existed were subordinated to the Khanates rather than to institutions of a popular-based republic" (Gleason, 1997:572).

The social structure of Central Asian society constituted a complex hierarchical pyramid. At the base of that pyramid lays the patriarchal family, which was linked horizontally and vertically with the larger families: clans and tribes. Each stage of the pyramid represented a smaller pyramid in itself, with the head of a family, or the chieftain of the tribe. At the apex of the whole structure was the supreme ruler, the Khan (Akiner, 1998). The society at that time was governed by a strong despotic government that owned the land and water resources. Collective rural renters were obliged to pay taxes and be responsible for their part of irrigation system (Yalcin, 2002:140). The management of water was of fundamental importance for agriculture in Central Asia. There was no private ownership of land or water resources and any kind of individual farming was impossible, because artificial irrigation demanded the utilisation of a collective workforce. Yalcin (2002) argues that due to several specific features such as the 'government as a chief irrigator' and landlord; 'political and economic dependence of individuals from government'; and the 'impossibility of individual farming activities outside the framework of community' the conditions for the development of 'free ownership and politically and economically independent individuals' were not present (pp. 140-141). The structure of 'regimentation and centralization required by the nature of the irrigative oasis society produced an effect on the structure of power' (Gleason, 1997:585). The concentration of large amounts of land in the hands of few landlords (*bay*) determined the presence of a feudal form of exploitation, and led to the spread of patriarchal and communal life. These factors are very important for the analysis of the development of the culture of democratic authority in contemporary Uzbekistan.

At the end of the nineteenth century, the country consisted of three coherent political entities: the Kokand, Khiva and Bukhara Khanates (Biergerson, 2002; Akiner, 1994). The khanates inherited elements of the Iranian, Turkic and Arabic civilizations. Their population were mostly Uzbek, but also encompassed considerable numbers of Tajiks, Turkmen and Kyrgyz (Uzbekistan Review 2003). The power in each khanates was 'controlled by a single leader who acquired the support of the key families and clan leaders' (Kangas, 1995:273). The distinctive features of the khanates were feudalism, survival of patriarchy, constant wars and civil conflicts, which led to separatism and ruin (Sharapova, 1997:29). The Uzbek people were not fully developed and consolidated as a nation before the Soviet Socialist Revolution in 1917.

2.1.2. Russian Tsarist Rule

Between 1865 and 1876 the Russian Empire penetrated the territories of Central Asia in competition with the British Empire. By the end of the nineteenth century, the khanates of Bukhara and Khiva had become vassal states of the Russian Empire. The territory of the Kokand khanate was incorporated into Russian Turkestan under the administration of a Russian Governor General (Uzbekistan Review, 2003). Tsarist Russia did not interfere with the political structures of the Khanates. However, the Russian army put an end to the internecine feuds by force, and changed the situation in line with its own interests because without peace the development of the region was impossible (Sharapova, 1997:29). The Russian authorities supported traditional leaders and allowed the former local judicial and political institutions to continue their traditional work. The Russian administration maintained the previous structure of administration and education. The indigenous people were reluctant to attend Russian schools. For a long time the local and the Russian hierarchies coexisted with very loose ties. The Russian military and civil populations were concentrated mainly in urban centres, and there was little interaction between the Russian settlers and the indigenous population (C. d'Encausse, 1967). That was partially due to the fact that the conservative Islamic rulers of the Khanates had a very hostile attitude to any form of modernisation. Even the Islamic reform movement "*Jadidism*" which was very popular in other Muslim parts of the Russian Empire (Azerbaijan, Tatarstan), had no significant

impact and was very slow to spread in Central Asia.[1] *Jadids* were the representatives of the Turkestan educated strata. Their goal was the adaptation of Islamic practices to modern conditions with the help of modern education (Yalcin, 2002, C.d'Encausse, 1967, Wheeler, 1966, Hiro, 1994, Rywkin, 1990).

Russian domination had a significant impact on the economy of Central Asia. It resulted in a huge growth of cotton production. As a result of the American Civil War, Russia was cut off from the foreign cotton supply. Therefore, Central Asia became the main territory for cotton production in the Tsarist Empire. In time this led to the destruction of the traditional agricultural balances and damaged the irrigation system. That was the beginning of the environmental disaster, which reached its culmination a century later, when the Aral Sea dried out almost completely.

The integration of Central Asia into the Russian empire led to establishment of industrial, trading and financial infrastructures. The first commercial banks were opened in Koqand and Bukhara, the first industrial enterprises had emerged, even though Turkestan's entrepreneurs lacked experience and worked under the control of Russian capital (Sharapova, 1997:28). That was the beginning of the social transformation of Turkestan, and led to the development of private enterprises on its territory.

2.1.3. The Soviet Period

Soviet rule was established in Central Asia in 1918-1920. The Muslim part of the population was reluctant to take part in the events of Bolshevik revolution. The Bolshevik attack on religion, society and culture was challenged by violent resistance from the indigenous population (such as the Basmachi Rebellion) (see Critchlow, 1991). However, the resistance was suppressed and in 1924 Uzbekistan came into being as one of the Soviet Socialist Republics. In contrast to Russian colonial policy, the Soviets made 'a significant conscious attempt to develop industry in the region' (Melvin, 2000:66). The industrial sector included the manufacture of agricultural and textile machinery, chemicals, metallurgy and aircraft construction. However, Soviet economic activity in Uzbekistan was focused mainly on the production of cotton. As elsewhere in

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[1] (*Jadids* propagated the ideas of unification of Muslims of the Russian Empire. These ideas surely were in contradiction with Russian imperial goals. Their objectives were to isolate different areas of the country from one another, implementing the rule "divide and rule". Their policy was to preserve social and cultural differences between different regions in order to hamper the unification of the Muslims (Bennigsen, 1971).)

the Soviet Union there was a distortion of the economic structure with the priority on heavy industry; as a result the service sector in the country 'remained almost completely underdeveloped' (Melvin, 2000:69). Uzbekistan provided the Soviet Union with cotton and minerals, but it was not self-sufficient in food and manufactured goods and therefore became dependent on Russia 'upon imports of basic foodstuffs' and 'clothing made from the very cotton in Central Asia' (Biergerson, 2002:132).

As far as religion is concerned, after the revolution the Soviet leaders, not unlike the Tsarist authorities, appreciated and feared the strength of the unifying movement among Muslims. Therefore, their policy was firstly to divide the Muslim community and secondly to draw different Muslim groups closer to the Russians. This process was called '*sblizhenie natsyi*' – rapprochement of nations. There was never any question of encouraging the rapprochement between Muslim groups. What was essential was the integration with the Russian nation – the 'elder brother' (Bennigsen, 1971).

In order to implement this policy new artificial national units had been created during the first years of the Soviet regime. 'The modern borders of the Central Asian states are totally artificial in that they represent neither the boundaries of historical polities, nor the national, ethnic, or linguistic boundaries' (Biergerson, 2002:136). A 'nation' as a large group of people that shares a common language, territory, and psychological and historical experience, was not clearly defined in Central Asia before Soviet revolution. 'Uzbekistan came into being as a "state" before it existed as a nation' (Gleason, 1993:334). The Soviets created new ethnic groups and identities.

One of the goals of the Soviet power was to cut the Central Asian Muslims off from the influence of the Islamic ideas from abroad. The first step towards achieving that was the introduction of the Cyrillic alphabet (Rywkin, 1990; Akiner, 1998; Wheeler, 1966). In that way the links with the outside Muslim world were cut. However, despite Soviet endeavours to eradicate all the traditional political and social structures of the Central Asian society, some elements survived and even revived. Dannreuther (1994:13) states that "as the new ethno-nationalist categories had little meaning for the Central Asian peoples, they reverted to the more deeply regional, clan and tribal identities."

In fact, the new artificial states had become the reality, at least from a purely administrative point of view. Now each of the republics, which were formed on a political basis, required a set of 'national' characteristics. Soviet Russia established the new socialist order in the Central Asian Republics and granted them federal rights

within the Soviet system of government (Gleason, 1993). Each of the Republics had their national symbols, constitution, government and Communist parties, 'a wide range of political and social institutions for the titular nationalities including their own universities, academics of science, and so forth' had been established (Biergerson, 2002:8). However, these 'national' identities "were in turn developed in tandem with and as part of the over-arching Soviet identity" (Akiner, 1998:12). The Uzbek Soviet Socialist Republic was created out of feudalistic societies, which were economically and socially backward relative to the European parts of the Soviet Union (Pomfret, 1999:2) and there was little experience of any form of democratic political culture. The transformation from the feudal society to a more egalitarian society started through improvements in education and the health system, significant endeavours were made on the path to eradicate gender discrimination and inequality.

During the Stalin period (1924-53) the objective of the government was to destroy the political and cultural elites in the country. As Diuk and Karatyncky (1993:188) state "in Uzbekistan, there is no old intelligentsia. During Stalin rule, anyone who could remember how to read the Arabic script was sent to prison, and usually never heard of again." "From 1930 to 1938 seven successive purges destroyed almost all the fragile local Communist Party cadres in all Central Asian Republics" (Rywkin, 1990:108). In their place the new Soviet elite was brought into being. The Party elite was formed out of native cadres, the so-called 'designated workers' (*nomenklaturanye rabotniki*), whose names were on lists specially kept by district and regional party committees to supply a pool of reliable party members qualified for future managerial openings (p.109). Devoted to Soviet power political and cultural statesmen implemented policies dictated by Moscow. A certain agreement existed between the local officials and their Moscow patrons that 'natives would rule, but they would do so in accordance with Moscow's designs' (Gleason, 1997:576). Khazanov (1994) argued that in a complete absence of civil society in Central Asia the new elite inevitably used their power to surround themselves with from their own milieu. They were people whom they could trust and with whom they were brought up and had lived (p.149). Thus the process of clan and tribal consolidation continued and became stronger. The ruling elite accumulated power by the promotion of loyal kinsmen. As a result, the corruption became so widespread that the population became used to it and considered it normal. Manz (1994) emphasises the parallels between the Turko-Mongol society with its dual ideologies and that of Russia with its double standards.

Many scholars claim that in Central Asia during the Soviet period the earlier traditions - political, cultural and religious- have been preserved and even continue to flourish. While this is undeniable, there is no doubt that the Russian-Soviet influence was very strong. As Allwort (1994) asserts, the depth of Russian influence on language, culture and some socio-economic patterns has been profound. Akiner (2002:15) also admits that:

> "Every public and many private areas of human activity were affected, ranging from education to entertainment, language to dress, and patterns of employment to patterns of marriage."

Dannreuther (1994:9) supports this view stating that "Russia and Soviet rule, for all its faults did introduce a modernity, industrialisation and rapid social change to Central Asia." Many reforms imposed by the Russians and then by the Soviets have radically changed the essence of Uzbek society. Although, many of the changes were necessary and progressive, some of them were enforced brutally, without taking into consideration the cultural and traditional context of the country.[2]

The analysis of the socio-economic and political changes below will explain the influence of the pre-Russian and Russian past on the development of contemporary Uzbek society. One of the strongest ideas among the Soviet population was a belief that the 'government was the core of social life' and thus autocracy was 'fundamentally important in the Social consciousness' (Yalcin, 2002:139). The economic basis of the socialist system – the public ownership of the means of production – gave rise to certain psychological stereotypes among population. State control system did not provide a basis for individual freedom or private ownership. There was no possibility to develop a democratic legal and political culture. This fact complicates the establishment of democracy in contemporary Uzbekistan.

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[2] Consider for example, *Khudzhum* – women's liberation, when women were forced to abandon their veils, or the process of the elimination of nations during the Stalin period. According to the Marxist-Leninist theory, nations were the product of capitalist relations, and were supposed to disappear with the increase of class-consciousness of the Soviet people.

2.1.4. Socio-Economic and Political Changes in the Independent Uzbekistan

The independent Uzbekistan emerged suddenly in 1991 after more than sixty years within a highly structured and in many ways protective, political and economic system. As Diuk and Karatynsky (1993:178) argue "political independence was thrust upon the Central Asian states, who had neither asked nor struggled for it." After becoming independent the authorities of Uzbekistan's authorities proclaimed that the country would build a democratic state based on the rule of law. However, Western observers, independent researchers and journalists are prone to assert the notion that today Uzbekistan is an authoritarian state, where all power is concentrated in the hands of the President and his associates. Moreover, there is practically no separation of powers in the republic, no independent parliament and judicial system, and no independent media.

With the collapse of the Soviet Union Uzbekistan faced serious economic and political challenges. The development of the Uzbek economy had been determined by the Soviet state system based on central planning and budgetary allocations from the centre, in order to meet the needs of the whole Union. The breakdown of central planning from the centre, a significant decline in productivity, the loss of reliable inter-republican trade, as well as the disappearance of the budgetary subsidies on which Uzbek economy relied and from which it benefited considerably for 70 years, all these changes have led to a drastic deterioration of the country's economy (Hiro, 1995; Scpechler, 2002). Thus, after the break-up of the Soviet economic ties, Uzbekistan was deprived of the former Soviet markets and had difficulty to maintain access to global markets. The geographical isolation made it difficult for Uzbekistan to find trading partners for its cotton, gold and other natural resources, despite continual efforts to expand exports and foreign investments.

Uzbekistan possesses an abundant potential of natural resources (Yalcin, 2002:179). However, since the end of the nineteenth century when the Russian empire penetrated Uzbek territories, cotton became and still remains the dominant agricultural product in the Republic (Melvin, 2000:61).

Traditionally a raw materials supplier for the rest of the Soviet Union, Uzbekistan's economy was highly integrated into the all-Soviet economic system. After the disintegration of the Union the economy became inefficient. The Uzbek government had run into deficit (Gleason, 1993:353). There was a fall in real GDP of 15% between 1991 and 1994 (Melvin, 2000:70; Griffin, 1996:21). The annual population growth

significantly increases the strain on employment (UNDP, 1998, 1999). Economic reforms were initiated based on a very conservative approach, avoiding drastic changes. At the beginning pushed by Russia's price liberalisation the government pledged its so-called commitment to market economy. However, the Uzbek government has 'resisted such important components of the reform process as privatisation and the elimination of state orders' (Dawisha and Parrot, 1994:87), 'trying to protect uncompetitive domestic enterprises so as to not worsen inflation and unemployment' (Biergerson, 2002:127). As a result, the old Soviet methods of economic coercion have been preserved.

Despite small steps on the way to economical liberalisation and privatisation in Uzbekistan since independence, the economy has continued to be heavily distorted by state intervention. The IMF was critical of the way that economic policy was developed in Uzbekistan. It questioned the independence of the Central Bank of Uzbekistan and called on the President to reduce 'administrative intervention' in the economy (Melvin 2000:71). "The government" - argues Neil Melvin (2000:85), was "almost obsessive in its desire to control the country and the economy..."

Uzbekistan has suffered from a serious and steady economic decline since the Soviet system collapsed. Despite attempts to move from the centrally planned economy to a market-based economy falling prices for the country's main export goods like cotton, gold, metals, a high level of inflation, due to an overvalued exchange rate had a devastating and distorting effect on the economy.

Most part of the population, industrial, agrarian and public sector workers as well as intelligentsia were affected significantly during the transition. People's material well-being, status and security have been drastically reduced. Akiner (1997:22) argues that:

> "academics and other professional in arts and sciences, formally a highly privileged elite, have also suffered serious material hardship, their salaries not only lagging far behind inflation rates, but also frequently not being paid for months on end."

Slow progress in market reforms was justified for fear of unrest among the population. Prices for basic foodstuff were capped and subsidies to certain sectors were doubled in an effort to soften the blow (Melvin, 2000:71-72). The government tried to hold as much of the old system as possible. However, this approach has restrained movement towards democratic reform. Many authors (Akiner, 2002; Melvin, 2000; Pomfret, 1999) consider Uzbekistan the least liberated among the post-Communist states and admit that the transformation from totalitarianism to a presidential democracy

would be a very arduous process for the country. "Uzbekistan", states Pomfret (1999:2), "has been distinguished among the economies in transitions from central planning by its gradual economic reform strategy and authoritarian political system." According to OSCE Report 'the ideas and principles of human rights including freedom of expression, declared in the country's Constitution, are seldom utilised' and in most cases for decorative purposes (OSCE, 2002:120).

Thus, it seems there are no significant changes in the political sphere. The political arrangements remain highly centralised. Many authors emphasise that the power in Uzbekistan is still in the hands of the old Communist elite, although it operates under new names (Akiner, 1998; Fierman, 1997; Dawisha and Parrot, 1994; Biergerson, 2002). By evaluating the recent political changes the authors contend that despite the fact that all post-Communist countries have chosen the path of democratic reforms, some of them, Uzbekistan in particular, have been developing along authoritarian lines. Today's president Islam Karimov came to power before the collapse of the Soviet Union, as he was 'Soviet apparatchik' (Cohen, 2002) and established himself as a powerful leader. The Soviet-era bureaucrats were trained in such a tradition, so that 'they are neither champions of "democracy" nor proponents of free market capitalism free of government direction and intervention' states Biergerson (2002:127). Hiro (1995) argues that the President's strategy is to establish an authoritarian democracy, because he warns of the danger of accelerated economic reforms and a rapid transition to democracy. Important preconditions for democratic rule such as the existence of a system of strong opposition or 'a solidly entrenched system of private property or a widespread public commitment to observe the laws adopted by the national legislation' have been missing in the country's development (Dawisha and Parrot, 1994:157). According to foreign observers, the Uzbek government declined to register truly independent opposition parties, nor did it allow members of those parties to run for president (Uzbekistan Review, 2003:17). Yalcin (2002) argues that while the Constitution of Uzbekistan, adopted in 1992, declares 'priorities of personal economic, political and social freedom and rights of citizens' and basic for the diversity of political institutions, ideologies and opinions', in reality the development of governance evolves in the opposite direction. Political pluralism is associated with destabilisation, 'street democracy' or anarchy and the opposition is oppressed under the guise of 'maintaining stability' in a region threatened by instability.

Although there are a number of political parties such as *Adolat* (Justice), *Vatan Taraqqiyoti* (Progress of the Fatherland), *Khalk Democratic Partijasi* (People's Democratic Party), *Fidokorlar* (Self-Sacrifice), *Milli Tiklanish* (National Renaissance) none of them has any significant function in the country, except the successor to the Communist Party, which was painlessly transformed into the People's Democratic Party, and which 'dominates legislation and government' (Melvin, 2000). The opposition parties like *Erk* (Liberty), *Birlik* (Unity) and Islamic Renaissance have been banned and their leaders were forced to emigrate to Russia, Saudi Arabia and United States. These events illustrate the fact that the basic elements of a civil society and secular opposition were ruthlessly suppressed. The Uzbek government also imposes a strict censorship over the press and mass media. Following the practice of Soviet times, the Uzbek authorities prohibit any meaningful discussion of domestic problems and continue to use media as a propaganda tool (OSCE, 2002:121-122). It should be noted that due to the lack of technical and economic resources and professional experience which could help to express free opinions and criticise the system, the professional standards of Uzbekistan's daily newspapers, the national and local television and radio stations remain very low.

The constitutional restrictions on the presidential rule have also been gradually changed. (According to the Constitution, a president can hold office for no more than two terms.) In 1991 Karimov was elected President of the Republic for five years. In 1995 a referendum was held on extending Karimov's term from1997 to 2000. In 2000 Karimov was re-elected to another five year period. In 2002 the government called for a nationwide referendum to extend the term of the president for another five years. As a result Karimov will remain in the office until December 2007 (Uzbekistan Review, 2003).

All these measures were justified by the growing 'threat' of Islamic fundamentalism. Fundamentalism[3] or Ismamisim in Uzbekistan is known under the name of Wahabbi movement. Some authors like Hiro (1995:186) argue "that it was in Karimov's interests to exaggerate the threat of fundamentalism in his republic in order

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[3] 'Fundamentalism' is a broad and in some ways misleading term – variously denoting eighteenth century Wahhabism, Islamic opposition in Saudi Arabia; the Muslim Brotherhoods in Egypt and Syria; Iranian political concepts such as Khomeini's doctrine of *velayat-e faqih* (Guardianship of the Jurists) and of course the Al Q'eada network. Though claiming to appeal to an 'original' Islam these movements are eclectic and post-traditional in many respects. For more on this see Ray (1999).

to encourage American diplomats to conclude that the only alternative to his government was Islamist."

Islam plays a very ambivalent role in the country. 'On the one hand, there is a general consensus that the faith is an integral part of the national heritage; on the other, here is widespread fear of the rise of Islamic fundamentalism' (Akiner, 2002:29). During the first years of independence the Uzbek government provided substantial support for the promotion of Islam, although in a moderate way. In order to implement their political strategy the Uzbek government endeavoured to build up its legitimacy on the basis of Islamic traditions. President Karimov and other officials made a pilgrimage to Mecca, the official celebration of Muslim holidays were proclaimed, there was an increase in the publication of religious literature, Uzbekistan obtained membership in the Islamic Conference Organization, an international body that admits only Muslim countries (Dawisha and Parrott, 1994:113). 'President Karimov took his Oath of Office on both the Qur'an and the Constitution to underline the point' (Yalcin, 2002:100). 'The number of mosques has increased from 80 at independence to over 5000 by 1997' (Melvin, 2000:52). With the help of the press and broadcast media public opinion was directed to accept Islamic norms in society. The ideas and principles of religion are introduced and maintained by the mass media, although under strict government control. Thus, of the 165 registered magazines only one is an Islamic magazine, "*Hidoyat*". Out of the 557 registered newspapers two can be described as 'religious'- "*Islom Nuri*" (Islamic newspaper) and the Orthodox newspaper "Slovo Zhizni".

To some extent, Islam was supposed to fill the spiritual vacuum that emerged when traditional Marxist-Leninist values were undermined and eventually rejected. However, the intensifying activities of Islamic groups in Uzbekistan, and events in neighbouring Tajikistan, and the 'fear that independent movement may lead to the rise of extremist opposition (Yalcin, 2002:97), have caused the authorities to change their policy and made them adopt a rather coercive approach to any kind of Islamic belief beyond the officially approved religion that they felt they would be able to control. As Dannreuther (1994:33) puts it "Karimov has subsequently attempted to ensure that the Islamic life of the country is carefully controlled and directed by the official and state-sponsored Muslim hierarchy, the "*Muftiate*". The republic was identified as secular state and has 'steadfastly opposed the political aspect of Islam' (Gleason, 1997:590).

Authors like Akiner (2000), Melvin (2000), and Spechler (2002), emphasise the authoritarian nature of the regime in Uzbekistan. They argue that all the economic and

political problems, especially issues with fundamentalism, have been caused by authoritarianism in Uzbekistan.

Gleason (1997:585) argues that the form of authoritarianism in Uzbekistan is not a continuation of the communist totalitarianism, but takes its roots from the traditions of ancient settled regions in Central Asia – 'traditions of hierarchy and authoritarianism'. A traditional societal structure in the region was based on kinship ties. This culture of authority is distinctive not only from Western democratic tradition, but also from the nomadic tribal traditions of the Kazakh and Kyrgyz. He also emphasises the importance of the ideas of respect *(hurmat)* for Uzbeks. The respect and subordination originates in the family, then transforms to clan and tribal subordination and eventually personalises to loyalty to the President of the country. This pattern can be clearly seen in the forms of hierarchical systems of ancient Khanates. 'The authority personalised and personal loyalties are deeply rooted' (Gleason, 1997:586) in the consciousness of Uzbek people. Thus he argues that "unquestioning respect for elders, deference to authority, and the perceived 'impoliteness' of public criticism render democracy impossible in Uzbekistan (Gleason, 1997: 352). Among the obstacles for a successful transition could be the fact that the political culture of the society was strongly influenced by the Pre-Soviet traditional loyalty to khans and the subsequent Soviet strict state control and belief that the Party should provide for most of the societal requirements. Moreover, the majority of the Soviet population had no any expectation of their 'capacity to influence decisions' despite the 'general suffrage' (Akiner 1998:19).

The sudden demise of the Soviet system put Uzbekistan in an extremely complex social, political and economic situation. The priority of the government was to avoid radical changes in order to preserve the stability of the country. According to Craumer (1998:4) the slow progress in the movement towards a market economy has cushioned the economic collapse caused by the disruption of Soviet system. The authority of Uzbekistan managed to maintained stability so far but at the expense of democratisation. It is generally recognised that in every country the economy is significantly interconnected with politics. Explaining Uzbekistan's meagre, half-hearted attempts to develop democratic political norms and practices, Melvin (2000:86) makes the assumption that 'economic policies in Uzbekistan are often intent to prevent individuals building up economic base that would permit a political challenge to President. Therefore, economic development will suffer from political mistakes and vice versa. It could be argued that corruption, tribalism and organised crime also prevent any

endeavours in Uzbekistan to build a democratic society. Given this situation and the fragile social structure in the country, the conditions for a transition from a totalitarian state to a democracy, are very far from being satisfied for the time being. The formal declaration that the country has chosen the democratic path, does not necessarily mean that the country really evolves towards democracy. It could equally 'fall back into authoritarianism' (Dawisha 1997). It must be mentioned also that Uzbekistan was one of the poorest among the Soviet republics (Biergerson, 2002) and 'had a low-level per capita income (Yalcin, 2003:144). Environmental disaster, due to the shrivelled Aral Sea, had also a profound impact on the economy. After the collapse of the Soviet Union the economy of Uzbekistan faced such difficulties as 'lack of business expertise', the difficulty in 'maintaining access' to world markets, a ruined infrastructure, a currency crisis, a high level of inflation, spiralling unemployment, and the inability to 'substitute for the wide range of commodities and manufactured goods' (Gleason, 1993:349).

Moreover, there was not a tradition of democracy, citizens lacked the experience of participation in democratic activity, such as multi-party competition, or parlamentarism, whereas Uzbekistan's political leaders were primarily concerned to maintain stability and fill the 'power vacuum created by the fall of the Soviet State' (Kangas, 1995:271) by means of the old command system of management. One important positive feature is that today Uzbek students from all spheres are encouraged by the government to obtain education abroad. That will help the young generation to gain experience essential to form the basis of the knowledge required for building a modern democratic state.

2.1.5. Summary

From the ancient times societal structures of local Central Asian states were based traditionally on kinship ties and its political organization was built on the basis that power was exercised in ways that were comprehensible to ordinary people. The state was ordered by the same rules as private life. Domestic discipline served as a pattern for public and state discipline. As in private life, where the head of the family was the master in whom all power was vested, at the state level the population saw the head of state as its own father, and citizens were fully obedient and subordinate to him. In such a conception of the unity of the power, the power of the individual ruler and the power of the state were considered as inseparable. This conception is still alive, and represents a peculiar aspect of the political culture of the Uzbek population. The entire system of state management, traditions and conceptions, the ability to withdraw inside the

community, led to a specific type of political culture, which could be characterised as a concentration of the population on their own origins, their own community, their own family. The collective unity of the *Mahalla* which has been preserved for several centuries could serve as an illustration for such conceptions. The Uzbek people have been favourably disposed to the collective life in the *Mahalla* for centuries. There the way of conducting common activities turned into traditions and rules, as people took part in social life by means of unification into the *Mahalla*. However, the population did not challenge the structures of authority. The structure of the state and society that could tie and bind people for the common good had not developed in people's consciousness. Although with the Russian intervention social stratification had occurred, and a new very small strata of the population that strived for a new life began to emerge. However, the Soviet revolution with its collectivisation and abolition of private ownership of the means of production led to the creation of new psychological relations among the population. During the Soviet period the church (religion) was separated from the state, women gained equal rights, illiteracy was liquidated, a comprehensive health care system was introduced. During the Soviet period industry and agriculture were developed. That led to emergence of a working class and collective farmers. Although it must be noticed that the working class in Uzbekistan predominantly consisted of non-indigenous people (see Lubin, 1998). The political and cultural level of the population was raised. However, the political participation of population in the management of the state was very low, due to the authoritarian power of Communist ideology. Communist leaders made decisions on behalf of the whole Soviet population. People took for granted Soviet achievements, but were passive in the political arena. No nationalist movement or viable political opposition emerged, and the unique indigenous culture of the region that goes back to ancient times endured (Biergerson, 2002:134).

When the country obtained independence, people's consciousness was still occupied with ideologies inherited from the past. New Uzbek political leaders decided to embark on a transition from the Soviet regime to a market economy by avoiding radical changes, using the same approach as previous leaders. In other words, they believe they are in a position to decide what is best for the country and its population. This could be due to the fact that most of the new political leaders in the country started their political careers as Communist leaders. Given the lack of democratic culture the general public remains silent concerning policy issues. The notion that it is the government's responsibility to provide for the public would be difficult to eradicate.

The process of the formation of new economic, political and cultural relations will take time. However, people continue to live in the contemporary society with its own peculiarities. Every day they must face the reality and survive in any conditions, be it authoritarianism or democracy.

2.2. Health Care Reform

This section is concerned with the health care reform process in Uzbekistan. Radical changes in Uzbek economy demanded urgent and substantial reform of the health sector, because Soviet social health programmes were no longer effective due to the sharp economic decline. An analysis of developments in health care system is required to understand fully the context in which people find treatment and cure. An insight into reforms is important because this process will affect the health behaviour of women who are the primary users of the health service. It seems essential to provide some information on developments, structure and work of the Uzbek health system, because it has an immediate relation to my research, has its own peculiarities and not very well-known worldwide. First of all health services in the Soviet period are scrutinized and compared with the newly introduced reforms after independence.

In ancient times health care in Central Asia was delivered through a *tabib*, a self-trained healer who provided basic health services to the people. The most famous scientist and *tabib* in 15th century Central Asia was *Abu Ali inb Sina* (Avicenna) who contributed significantly to medical science. His medical works were translated and published in Uzbekistan in 1989.

After the Russian colonization at the end of eighteenth century the first hospitals and pharmacies were introduced in Central Asia. After the Soviet Socialist Revolution all medical institutions and pharmacies were nationalised and a highly centralised health system was established. For over seventy years of Soviet Rule the health care system in Uzbekistan was organised, planned, and managed centrally, services were financed by public revenue, with 'budget allocations based on norms developed by the Ministry of Health in Moscow' (Hajioff, 2001). 'The state became a provider of all health services' (Field, 2002).

2.2.1. The Soviet Period

The Soviet system provided a centrally planned, state-financed and professionally supervised health care system. The Soviet health system provided accessible health care

to all strata of population free of charge. However, it was not always of high quality. The quality, as Field (2002:71) argues was postponed to the distant future of exult communism and 'social abundance'.

The Soviet health system put more emphasis on specialised care. It was divided into general clinical and industrial medicine, maternity and child care, and public health. There were industrial health centres (for workers at the enterprises), general polyclinics (for certain age groups), sanitary-epidemiological stations and public health stations (for sanitary health protection and control of infections). The police, railroad, university employees, and high-level government officials, KGB, military services and war veterans all had their own clinics and hospitals (Lassey, 1997:274). The enterprises invested more money in technologically advanced equipment and provided better facilities for the physicians in order to attract workers. Therefore, the services there were of a higher quality. It is worth mentioning that there existed a Fourth Department in the health service for privileged members of the party and government elite. These closed hospitals and clinics were subsidised by the government and were equipped with the latest medical facilities.

All citizens of the Union were required to be registered with a polyclinic – a basic primary health care delivery unit, in a local residential area. The services in polyclinics included diagnostic examinations, surgery, ophthalmology, maternity, obstetrics and neurological care. Special paediatric clinics served children, where regular examinations and immunisations were provided. This practice led to the development of a highly specialised medical system based on a vertical management structure. The local polyclinics also provided home health services for non-emergency patients, especially the elderly, the disabled and newly-born children.

The system of public health was mainly directed towards the development of hospital services and primary health care with the emphasis on curative rather than preventive techniques. On average twenty five per cent of the population received that kind of hospital treatment every year (Medic, 1990:63). Primary health care was insufficiently used despite the fact that such services were capable of satisfying many of the requirements of the population. According to the information gathered by the Soviet system of regular public polls, only ten per cent of rural population estimated Soviet health care as positive. Furthermore, forty one per cent pointed out the very low level of qualifications of medical personnel, seventy-four per cent of respondents complained about heartless, careless, and rude attitudes from health professionals, twenty-two per

cent mentioned the violation of professional duty and ethics (Medicina I Zdravoohranenie, 1990:44-45).

The main problems of the Soviet health system were poor equipment in hospitals and clinics, a lack of discipline as well as the general proliferation of infections due to the fact that no disposable medical equipment was in use. Such items as syringes, needles and gloves as well as all surgical instruments were sterilised and reused several times. Despite the fact that the health care system was free, it was a general practice to make small presents of money to the medical staff, usually for home visits or after an operation or for speeding up the waiting period for medical procedures. Physicians also took bribes for the medical certificate of illness needed by individuals who stayed away from work.. However, Savas, Gedic and Craig (2002) criticised the Soviet system for the fact that the priority of the Soviet health system were quantity, rather than quality. There were a large number of medical professionals and high hospital capacities, for example. "The role of hospitals was over-emphasised and primary care was used inefficiently" (p.81).

Despite all the criticism of the Soviet health system it established a comprehensive system which had its own advantages, as can be seen from the indicators of the health of the population in Uzbekistan. Life expectancy was fairly stable at around sixty-eight years for men and seventy-three for women (ABD, 2002). Health care during Soviet period was widely accessible to all strata of the population, both in rural and urban areas. It was comprehensive, universal, free, provided by the state (George and Manning, 1980; Littlejohn, 1984). There were large numbers of regional, district, rural hospitals and small local medical centres. The number of doctors and nurses was high enough to meet the needs of the population. The whole population had regular screenings and check-ups. The health services also provided the population with sanatoria and resorts, of which 70 per cent were paid for by trade unions and 30 per cent by the workers themselves. Enormous investments were granted for medical research.

Socio-economic changes in Uzbekistan after independence had a profound influence on all spheres of state structures, including medicine and public health. Inherited from the Soviet times the system has little chance to survive in the new economic conditions due to the lack of financial resources, and requires a deep and thorough transformation in order to satisfy public requirements. The transition to a market economy has demanded a new approach to the economics of health care.

2.2.2. Health Care in Transition

The health care system in Uzbekistan has partly preserved the Soviet heritage and still remains a state system financed from the state budget with allocations distributed from above. The government at all levels owns and controls medical institutions and medical equipment, although the process of privatisation has started recently.

The process of transition has reduced the financial resources of the state and therefore public spending due to significant falls in the level of national income. Reductions in the state budget have led to cuts in health care spending. The Ministry of Health is the major player in organizing, planning and managing the health care system in Uzbekistan (Hajiof, 2001:13).

In 1991-1992 the Health Ministry together with the Ministry of Finance of the Republic of Uzbekistan unveiled a plan to reform the health care system and change the policy on the financing of health protection, so that it would correspond with the demands of the new market economy, taking into consideration the specific demographic, cultural and historical features in Uzbekistan. Health spending as a share of national income fell by about one fifth between 1992 and 1996; that is from 4.6 per cent of GDP to 3.7 percent (ABD, 2001). 'The volume of budget allocations in favour of in-patient services has now reduced from 80 per cent to 60 per cent' (Population Health, 1996:8). At the same time changes were made in order to obtain further financial resources for health care and the main mechanism for achieving this has been the development of paid services (Ibid).

The situation in the health care system has implications for women, who typically have higher demands for health care and who generally have day-to-day responsibility for their children's health (ABD Report, 2001). Despite the incipient changes in the way health care is financed, maternity and child health remains one of the priorities for health care in Uzbekistan (Hajiof, 2001:35). However, the new policy seems follow more closely international patterns of health care. The specialised agencies of the United Nations such as UNICEF, WHO, began to play an active role in the process of international medical co-operation in Uzbekistan (Population Health, 1996).

The government has initiated a series of first steps in restructuring the health sector, moving away from the Soviet model to a model based on more cost effective primary and outpatient care. The reform includes the rationalisation and restructuring of the health delivery system in urban areas and the development of an appropriate mix or public and private provision of care.

In order to distribute the resources evenly the financial resources have been shifted towards new priorities such as primary and preventive health care. The focus on local and especially on rural health care centres has increased. The restructuring of the system and medical institutions has been designed to achieve the partial privatisation of medical institutions. A network of self-financing medical establishments such as medical cooperatives, private practices and joint ventures has emerged. In relation to this the government put the emphasis on the development of the national pharmaceutical and medical industry responsible for meeting the country's drug and medical equipment requirements. The privatisation of pharmacies and other facilities, such as drugstores and medical clinics was introduced. In 1996 62.4 per cent of drugstores were privatised. However, due to violations of the rules governing the sale of medicines by unprofessional pharmacists of 2,478 drugstores twenty-three had their licence to sell revoked, fifty-one were fined and seventy were closed (Rahmatullaev and Isaeva, 1996:19). In order to achieve self-sufficiency with regard to the pharmaceutical needs of the country priority has been given to joint ventures in the pharmaceutical and medical industries (ibid, p.18).

Shortage of antibiotics and anaesthetics was a chronic problem in Soviet period. Only seventy-five per cent of required medication was available due to inefficient and poorly managed production (Lassey, 1997:276). Today the drugs are available in commercial drugstores but for a very high price. The reason for this is the fact that pharmaceutical services depend primarily on imported medicines, but the shortage of foreign exchange constrains imports. As a result, the drugs become less available to lower strata of the population.

According to the Human Development Report (1999:19) in 1998 fifty-nine private hospitals and 15000 hospital beds were operating on a self-financing basis, and approximately 3.000 doctors were licensed for private practice In 1992 the share of private services was 0.1 per cent and in 1995 it was 5 per cent of state budget (Melnikulov, 1997:25).

The government also intended to reorganise primary medical care in order to introduce a system of general practitioners. Professor Fazylov (2000) argues that Soviet medicine was oriented mainly towards highly specialised health care. Therefore, medical professionals trained under the Soviet system would find it difficult to reorganise their work to meet new requirements. He states 'that today in the Republic there is no specific plan on how to organize the work of general practitioner, which

could reflect the main features of his activity' (p. 117). The Tashkent Medical Institute carried out a survey among the medical professionals. Doctors were asked their opinion concerning the relative advantages of a general practitioner compared with practice of a therapeutist in a district clinic.

Another step in the reorganization of the health care system involved the liquidation of thousands of hospital beds that were not used effectively. Sidikov (1997) argues that although it was designed to increase the efficiency of health care, the decrease in the number of hospital beds was 'actually only an administrative step' (p. 9). The reduction in the number of hospital beds did not mean a decrease in the funding for hospitals, on the contrary, it was supposed to release financial resources at the expense of saving. This process resulted in the restriction of resources to the hospitals giving preference to the outpatient care. The increase in the number of therapeutic outpatient clinics and the decrease in the number of hospitals were supposed to achieve qualitative changes in medical services.

According to the Ministry of Health (Population Health, 1996) outpatient care has much greater capacities for preventive measures and the rehabilitation of the health of patients. The network of effective outpatient institutions has included day-care centres, rural district hospitals, homecare centres and centres of ambulatory surgery. The reorganisation of the system with an emphasis on primary health care had its consequences. Today twenty five per cent of patients get treatment in day-care centres, centres of outpatient surgery or in polyclinics (Turtaev, 1997:13). Thus, patients suffering from milder cases of diseases tend to be treated in day clinics or at home, only patients with severe illnesses receive hospital care. The average duration of a patient's stay in hospital has been reduced from 18.5 days in 1990 (Medik, 1990:63) to 14.3 days in 1994 (Human Development Report (1999).

The level of incidence of illness and mortality in the population of Uzbekistan related to infectious diseases, typical for undeveloped countries, as well as diseases that occur frequently in the most European and Asian developed countries in transition. The level of mortality due to cardio-vascular disease had been increasing during the 1990s, which was explained as the result of psychological stress associated with the hardships of the transition period (World Bank, 2003, p. 84). Although according to the Human Development Report (1999), Uzbekistan has managed to improve all of the basic health indicators (p.13), the high rate of infectious disease continues to prevail. The main infectious diseases affecting the population are acute intestinal infections and viral

hepatitis. The problem of clean water supply in Uzbekistan, especially in rural areas remains the major cause of the spread infectious diseases (Melnikulov, 1997). Tuberculosis and sexually transmitted diseases are also becoming a pressing problem. The number of deaths attributable to tuberculosis has increased since 1991 from 5.2 to 8.6 per 100,000 (Population Health, 1996:36-37). The number of cases of this kind of disease is increasing mostly in the urbanised areas of the country and increases problems of social well-being of the society. The high incidence of some infectious diseases, like tuberculosis and hepatitis, reflects the decay of medical and social institutions, as well as low levels of income in the population, poor sanitary conditions and inadequate access to clean water. In other words, social policy such as housing, income maintenance, education and environment should be taken into consideration in order to improve the health status of population.

Every citizen of Uzbekistan has the right to receive key medical services free of charge. Such services include emergency and first aid, primary care and disease prevention, especially in rural areas, including immunisation and vaccination against infectious diseases.

Relatively decent medical services, which are free of charge, are available to both urban and rural population. However, the budgetary funds allocated to public health care during the transition period were reduced radically. There is growing evidence according to McKee, Healy and Falkingham (2002:6) that access to 'free' health care had become less affordable for poor people. Due to the budget cuts there is a widespread practice of 'official charges and under-the-table payments'. Ensor (2004) states that there is a considerable evidence that unofficial payments are deeply embedded in the markets for health care in transition countries. The very low salaries of medical personnel combined with a generally low morale in the health sector have made the practice of charging patients almost universal (Falkingham, 2004). Due to financial shortcomings new mechanisms for health care management in Uzbekistan do not ensure and guarantee every citizen adequate medical assistance. Socially vulnerable categories of patients retain the right to obtain free medical care, which means waiting in long lines, sometimes facing refusal of treatment on the ground of lack of medical supplies and being forced to eventually give gifts and tips to doctors and nurses. The problem is exacerbated by the fact that informal fees charged by medical professionals for allegedly free health care services have increased. Consequently even the poorest in society, who are entitled to free health services, have to pay more. Moreover, a great

deal of financial capital by-passes the medical establishment and consequently does not make contributions and investments in health care system (World Bank, 2003:96).

The practice of official and unofficial payments deters people from seeking medical assistance. According to Cashin (2001) 45 per cent of the population in Fergana used self-treatment with over-the-counter medicines before they turned to professional medical help. The results of the survey showed that people with a low level of income turned to the medical help rarely compared with people with a higher level of income (Cashin, 2001). Many categories of population, especially poor suffer from the negative impact of the demands for informal payments and the corruption particularly in the health system. According to the ABD report 'the real cost of health care has risen due to increase in formal fees charged by medical practitioners, nurses and for medication all of which are ostensibly free' (ABD, 2002). In order to continue to expand the quality of health care services and to ease the burden on the state budget the Government of Uzbekistan is encouraging the development of fee-based medical services (Sidikov, 1996). Health care institutions can now charge for services. Payments include fee for hospital food and drugs and official co-payments. Patients are often given a list of medicines and medical supplies to bring with them to hospitals.

The health care reform also includes changes in medical training. Today there is an imbalance in the medical personnel. There is an excess of medical staff in hospitals and a shortage of qualified people in outpatient departments. The ratio of medical personnel per head in the cities is much higher than in rural areas, despite the fact that the Soviet Ministry of Health motivated doctors to work in rural areas by providing considerable material incentives, such as up to three times the urban salaries after ten years, plus the opportunity to buy a car, and free accommodation (George and Manning, 1980:111). Moreover, there is a redundancy of doctors and lack of hospital nurses, midwifes and medical personnel in small rural medical centres. Institutions of advanced training have been established in the country in order to provide well-qualified doctors. The emphasis has been made on training medical assistants and paramedics instead of doctors. The admission to higher educational institutions has decreased significantly compared with an increase of admission to secondary medical educational establishments. These steps have been taken to increase the number and provide better use of nurses, and to introduce a new practice - general practitioners. Thus, reforms aim to emphasise and increase the role of mid-level medical staff and take the pressure off the doctors. Turtaev (1997) states that today the policy of the Health Ministry is to cut

the number of managers in the administrative health centres. During the last three years the number of managers in public health has decreased by thirty-four per cent, and the ratio of managers to doctors has changed from 1:16 to 1:28 (p.13).

As has been mentioned above, the economy of today's Uzbekistan is characterised by a high rate of inflation, a decline in production and a reduction in social expenditures. Such basic models of health care organisation and financing as a system of private health care, financed mainly by personal funds and private insurance, or a system of state-financed insurance paid for through obligatory taxation would be very difficult to introduce under contemporary conditions. Uzbekistan's health care system requires an adjustment to respond to new market conditions.

Considering that the health care system in Uzbekistan has been provided free of charge for many years on the one hand and the pressure on the health budget today on the other, it becomes evident that a shift to an effective health care system is not an easy task. It is true that too many hospitals have outdated equipment, there is a shortage of medicine and qualified doctors. Many medical facilities are located in unsuitable buildings. The outbreaks of such infectious diseases as hepatitis, diphtheria, and tuberculosis have become more frequent because of a lack of vaccines and the high cost of medicine. Many highly trained professionals have left their jobs due to the very low wages in medical system. The average monthly salary of a physician working for the state is 7000-9000 som (about US $ 60-80) (Hajiof, 2001:55). Low wages do not stimulate productivity or creative labour and lead to a deterioration in the quality of services. Moreover, physicians and nurses have to generate extra income, in some cases through informal payments made by the patients given the low level of the state salaries.

Preserving the achievements of an efficient and modern health system have been given priority according to Ministry of Health (Population Health, 1996). However, due to the reduction in resources allocated to health care it is impossible to sustain a high level of investment in health like during the Soviet period. Endeavours have been made to reduce the excessive capacity in the hospital system, to introduce general practitioners into the health services, to find new sources of revenue through privatisation, and enhance the training of health professionals. Thus, health care reform has been inevitable; however, improvements can be achieved only with the help of political support and financial resources.

To conclude: the changed economic conditions undermined the state's capacity to maintain health care at previous levels. The political and economic transformation of

the state has resulted in the reduction of existing health care resources. That reduction in turn, has made women more responsible for their own health and women's endeavours to maintain their own good health and that of their family members has become more difficult. Limited public funds in the health sector increase women's traditional responsibilities as health providers to their families. In actual fact it necessitates women to substitute for the lack in primary health care and provide basic health care. However, despite major problems in the health system, the health protection of women and children has been given substantial consideration. Charity foundations financed from the state budget and sponsored by international organisations like 'Soglom Avlod Uchun', 'Kamalot', 'Mahalla', have been established and aim at improving women's health (See UNDP Report, 1999:64; Kandiyoti, 1999)

2.3. The Islamic Factor and Social Status of Women

2.3.1. The Impact of Islam on the Life of Uzbek Women

Islam played an enormous role in the history and culture of Uzbekistan. Islam was not only the main religion in Central Asia since the seventh century, but also determined the way of life and was profoundly rooted in Uzbek society. As Rywkin (1990:89) states: 'Islam is not only a religion but also a part of personal identity: one cannot simply call oneself Uzbek or Tajik, at the same time, reject Islam." Islam serves an important social function: it serves to unify people around the community. Even people who are not practicing Islam in Central Asia identify themselves as Muslims (Biergerson, 2002:135). Understanding the status of women in contemporary Uzbekistan is impossible without realising the impact of Islam on the lives of ordinary women.

Although Uzbekistan was officially secular during the years of Communist rule, domestic life, traditions and customs, the way that people perceived their health, hygiene etc., evolved under the influence of Islamic norms. Islamic beliefs and observances were deeply woven into fabric of everyday life, making it more difficult for anti-religious propaganda to root them out (Dawisha and Parrott, 1994:112). Therefore, before looking into the patterns of domestic and family life of Uzbek women, a brief examination of development of Islamic factor in Uzbekistan would be appropriate.

The social status of women in pre-Soviet times was guided by the *Shariat*, based on the segregation of sexes and the isolation of women from social life. Women had to appear outdoors covered from head to toe in a black coat with a net in front of the face

(paranja). Even at home women were allowed to stay only in '*ichkary*'- segregated rooms, closed to everybody, except close relatives. The minimum age at which a girl could be given in marriage was 9 years old. Polygamy was widely practised. However, there were some facilities for the education of girls. "For the most part, these took form of elementary religious schools run by the wives of local 'mullahs' (religious functionary)." "In the middle and upper class circles women received a fuller education; a few became accomplished literary figures in their own rights" (Akiner, 1997:266). In general, the role of women was defined through family relationships and child bearing was their main function.

Soviet policy was directed towards ideological and cultural change in Central Asia. 'The Soviet Union was the only empire that declared anti-religious ideology as the primary foundation of its world view.' (Pahlevan, 1998:81) Modernisation of this region was implemented by forceful methods against the existing patriarchal and theocratic society. In 1927-28 the political campaign on "unveiling' women, "*Khudzhum*", liberated women and changed their image as weak and dependent.

Such attacks on Islam and campaigns to change the traditional position of women were designed firstly to 'facilitate greater modernization' in Central Asia and secondly to 'destroy the pre-Soviet political culture' (Kangas, 1995:274) 'The religion was replaced by Marxist ideology and the Church by the Communist Party' (Pahlevan, 1998:81).

Women obtained access to education and opportunity for employment outside their homes. However, traditional society did not recognise the achievement of liberation of women. The 'unveiling' campaign was accompanied by cruelty. Women were forced to take off their veils and burn them publicly. Their own relatives killed many women for violation of honour of their families. The organisers of the campaign suffered from terrorist acts and suppression. Thus, contrary to tsarist policy, which allowed the people to worship and educate their children in the aged-old traditions, "the Bolsheviks began to systematically wipe out the old faith and to indoctrinate the people into a new way of life, with an aim toward clearing Soviet Central Asia of its indigenous religion, history, literature, and culture" (Diuk and Karatnycky, 1993:177).

The Soviet government believed that they were obliged to protect women from barbaric practices and to liberate them. The Soviet authorities supported and encouraged women who wished to study and pursue their professional career. As a result of Soviet policy, the number of women represented in the administrative institutions in

Uzbekistan grew considerably, including rural areas (Allworth, 1990). However, the deep influence of religious traditions had great power in the society. The process of emancipation inspired from above was not able to involve women from all categories and groups of the society and make the process irreversible. "It was impossible to eradicate overnight something that had for centuries been the very essence of life. Quite apart from the role that religion had played in shaping the culture and history of Central Asia, almost every custom and tradition had its roots in Islam." (Akiner, 1990:338) Despite the fact that religion in the Soviet Union was replaced by Marxist ideology, that ideology was never 'able to become the spiritual way of thinking of the ordinary people' (Pahlevan, 1998:81-82); it was not able to become a real challenge to Islam. Of course, it would be wrong to ignore the influence of the atheistic ideology on people's attitude to religion.

This policy greatly distorted the understanding of Islam among the population of Uzbekistan. However, despite endeavours to uproot the Islamic faith among the Uzbek population, Islam provided cultural and spiritual nourishment for the indigenous population (Diuk and Karatnycky, 1993:179). With independence the process of national revival encouraged the revival of Islam and the *Shariat*. However, the 'revival' of Islam was thought of in traditional and cultural terms. Shirin Akiner (2002) argues that the Uzbek population has a limited and distorted knowledge of the principal tenets of Islamic faith. Rywkin (1990:89) also states that of the five pillars of Islam, five time daily prayers, pilgrimage, almsgiving, Ramadan fasting and the affirmation of faith, only the last is universally observed The most frequently observed practices are circumcision, marriage and burial rituals and the dietary prohibition against pork. However, after the end of era of official atheism, the interest in Islam and religious teaching has been growing. New mosques and religious schools have been built, restored and reopened. However, as in the Soviet period, due to threat of upheavals and instability caused by growing Islamic influence 'stringent measures to monitor and control Muslim institutions have also been introduced' (Akiner, 2002).

Tahtakhojaeva (2000) argues that there is a danger of the radicalisation of the process of revival of Islam in the form of fundamentalism. There are all kinds of preconditions for fundamentalism to gain power in the country - a spiritual vacuum, as a consequence of withdrawal from the communist ideology, a sharp decrease in living standards, a high level of religiousness, the rapid growth of religious organisations in the context of a low level of religious knowledge among population, as well as

undeveloped social organizations, which were created by the state and are therefore considered unreliable. However, she emphasises several factors that could inhibit the growth of fundamentalism, for instance, adherence to the Soviet way of life, especially among the citizens in urban areas, and the existence of civil political organizations. She states that the fundamentalist movement in other Central Asian republics gives rise to mistrust amongst the majority of educated women, who are worried about their future, their rights in society and in the family.

The principal impact of the revival of Islam is on the life of women. Uzbek women, who once had been emancipated and liberated, today have to face the challenge to their rights once again. What would the revival of Islam mean for women who already tasted the emancipation? Will it relegate women to a secondary role in the family and society again?

One cannot claim that women in the Soviet times gained total liberation from all forms of inequality. Moreover, women had to make many sacrifices. They had to give up many positive and negative traditions and instead had to accept a more Westernised style of living. In some respect, the emancipation was introduced in Uzbekistan without any reference to what women wanted for themselves. They were forced to jump from an archaic feudal system to a socialist structure, without any preparation. Probably, they were not ready at that time for such a radical change. And for the first generation of women these changes turned into tragedy.

Today under the Islamic banner, the propaganda in favour of early marriages, polygamy and the submissive position of women has started. In the mass media the subjects 'Where is the Place of Women Today?', 'Islam and Woman', 'Muslim Woman' were raised. The writers and politicians argue that socialism deprived women of their natural and essential role of motherhood. However, the exaltation of motherhood, the role of housewives and women's economic dependence on their husbands could easily turn into a glorification of polygamy.

Some politicians have proposed polygamy as a solution for women living in poverty, for widows with children, and as a way to fight prostitution. Voices have been raised for the abolition of coeducational schools, for throwing away Western clothes and eschewing modern hair fashion for women and men and even the removal of male doctors from gynaecological clinics (Fierman, 1991; Hiro, 1994). There is a group of intellectuals that promotes the idea that "women should reject the opportunity to

participate in public life and seek a subordinate position within the family and society more generally" in the mass media (ABD Report, 2001).

Today Islam, after seventy years of purely traditional and cultural forms has acquired more power, which is aimed first of all at the most vulnerable stratum of the population – women. Once again in the history of the country it is women who have to cover their faces, who have to retreat to domestic lives and abandon their work outside their homes. In other words, they are called upon to give up all their achievements and thus to demonstrate that Islam is working in the country. Would it not be another tragedy for the new generation of girls and women?

It can be argued that it would be harder for women to cope with the clash between the modern way of life and old Islamic norms. Here I would take issue with Marta Olcott (1991) with her statement that Islam "may make the lives of contemporary Central Asian women easier" and "it is hard to imagine that it can make their lives any harder" (p. 251). Probably women in the Soviet period had a lot of hardships struggling with the double burden of career and domestic responsibilities. However, they already unveiled their faces, they are more independent from religious backwardness, and they gained opportunities for education and work. Therefore, I would argue that women must strongly hold on to what they gained during the Soviet period, and try to take advantage from the past social achievements. As Anara Tabyshalieva (1999:51) states:

> "Greatly improved healthcare meant that, for the first time, women made up more than 50 per cent of the population. The literacy rate among women was almost 100 per cent, and majority of doctors, chemists, and biologists in Central Asia were women – feature unusual even in developed countries. The high level of women's employment was proclaimed as a supreme achievement of 'Developed Socialism."

Despite the general criticism of women's status in Uzbekistan (Rosenberg, 1989; Olcott, 1991), the majority of women are quite happy to be part of a society that inherited a mixture of Islamic and modern culture. It is not that they perceive the situation as ideal, and they are aware of the shortcomings of their status, however, they probably would gain less if they turn back to their Islamic past, abandoning all their achievements.

The revival of Islam has also had an impact on women's health. If during the Soviet period religious healing was prohibited, today hundreds of religious healing practitioners have started their own business. The problem is that due to the general

deterioration of economy, health care provision is also less effective then it was in Soviet period. Moreover, the provision of health care services has become very expensive. In order to obtain further financing payments for health services have been introduced. At present over 15,000 beds are completely self-financing and paid services for out-patient departments are also emerging (Population Health, 1990:8). Instead of going to the clinic or hospitals women can choose to turn to mullahs. It is supposed that they possess the 'supernatural power of healing'. The treatment usually consists of reading aloud verses from the Qur'an. Although, there are queues and treatment is not cheap, women tend to go to mullahs before they go to the clinic or do both. (The reasons why some women prefer such treatment will be examined at greater length in subsequent chapters). However, it is obvious that such treatment can be very harmful for women's lives.

Islam is a rich element of the Uzbek traditional cultural heritage, deeply rooted in all spheres of private lives. Islam could be a means to fill in the ideological vacuum, which emerged after the loss of communist ideology. However, it is obvious that politicians in their struggle for power could use Islam as a weapon, and women would be the first to suffer the consequences.

2.3.2. Patterns of Domestic Life in Uzbekistan

During the seventy years of communist rule in Uzbekistan the institution of the family was one of the strongest pillars of the nation from which the Uzbek population derived their national spirit. It was the family structure and family relations that preserved the cultural heritage. In this way there existed a kind of passive resistance to the Soviet policy of elimination of differences between the nations. As Kandiyoti (1996:145) puts it, "the attempted cultural hegemony of the Soviet system over the local population resulted in patterns of resistance which valorised local customs in more self-conscious ways."

Families in Uzbekistan constitute large extended groups encompassing two to three generations. All members of the family are subordinated to the interest of the whole with a male member as head. There is a strong gender and age hierarchy in the patriarchal families. Newly married couples live with their parents. Most of these families are financially dependent on the parents at least until they complete their education. The average age for starting a family in Uzbekistan is 17-18 for girls and 20-22 for boys. The youngest members of the family have the lowest status, because of their dependence. The cohabitation of two or three generations under one roof often

leads to conflicts. However, such families also provide a support network not only financially but by looking after babies, so that young couple are able to complete their education.

Women gain their authority in the family gradually, by giving birth to the children and when they become mothers-in-law. The position of the new wife in the family is usually very low. However, after becoming a mother, she acquires a formal and very honoured position, and she has strong control over and influence on her children. Thus a status of woman remains 'associated with her high level of fertility' (Kandiyoti, 1996:144). As Olcott (1991) highlights 'the main task of Central Asian women's is child bearing and child rearing'.

Ata-Mirzaev (1982) in his research tried to analyse why women of indigenous nationalities in Uzbekistan displayed such an unconscious orientation towards large families. However, it should be noted, that in contrast to rural patterns there existed a small stratum of families in the urban intelligentsia that were fairly emancipated from traditional clan bond, and were more influenced by European standards and therefore, were more vulnerable to change. The Uzbek intelligentsia was much more open to modern influences. The patterns of such families changed rapidly and the relationships between wives and husbands gradually became closer to equality. Ata-Mirzaev's (1982) survey discovered that there was no correlation between levels of education and the number of children in the families in Uzbekistan. He claimed that having many children for Uzbek women was the basis and guarantee of family stability. He states that:

> "Among the indigenous people divorce is exceptional, especially if they have large families. Moreover, the main reason for divorce is usually the infertility of one of the spouses" (p. 245).

He cited another argument in favour of large families based on the fact that the burden of a household was considerably reduced for the women by the help from her numerous children. Young children are brought up with a strong sense of respect and courtesy for elder members of the family as well as obedience and conformity. There is still a preference for boys in the family, because boys are regarded as a support for the parents in their older age, whereas a girl usually has to leave the family at a very young age and serve the family of her husband.

A common practice in Uzbek families both urban and rural is to live under same roof with the parents. In part this is due to the lack of housing. Apartments were

distributed free to the population; however, they had to spend years waiting for their turn.

Arranged marriages are also common. It is considered to be very important that a girl is a virgin until marriage. Usually a girl has to live in the house of her husband's parent. The cases when man live with his wife's parents are very rare. In traditional Uzbek families a young bride must serve all the members of her new family. Rosenberg (1989:50) states:

> "In many Central Asian families, particularly in rural areas, a woman who has barely finished giving birth to her child is expected to get out of bed and tend to the farm animals, the garden and the kitchen stove. She must also endure sleepless nights by the cradle and the endless chore of washing clothes, usually by hand. She must please her husband, her mother-in-law and all her other relatives by fixing meals and catering to their whims... If a woman has come to her new husband without dowry, she is often persecuted by her mother-in-law."

In order to be able to integrate into another family girls usually receive quite a good training at their own homes.

In sum, there were relatively few changes in composition of Uzbek family despite seventy years of Soviet rule, and family relations 'remain the most conservative areas of society' (Akiner, 1997:276) in Uzbekistan today.

Chapter 3
Research Methods

3.1. Theoretical Framework

This section explains the research design for the empirical investigation of women's health in Uzbekistan. The method of unstructured in-depth interviews was used to study women's health. Health behaviour was assessed by means of analyses of women's full life stories on their own health, and those of their family members. There is practically no secondary literature on the experience of Uzbek middle-age urban women, their health status and their health behaviour, how they define and rate their own health and their everyday life experiences. The research for the thesis therefore required a methodology appropriate for an exploratory study and theorisation of a relatively un-researched field. In other words, what was required was not only an empirical investigation but also an understanding of the construction of the social phenomenon.

Therefore, a model of social research that utilised a detailed analysis of social events and was grounded in the research process itself, was chosen as most appropriate for purposes of this study. The Grounded Theory approach provided a framework for analysing face-to-face interviews with women and observations of women's lifestyles as well as the situation in hospitals and clinics. The work based on this theory was concerned particularly with empirical research and the theory is generated gradually from empirical data. The main advantage of using this approach is that while collecting the data that might be relevant to the group of the population being studied, it is also possible at the same time, to frame and reframe the research questions, the sample selection, the analysis and consequently interpret and clarify the theory, which in turn 'maximises the likelihood of gathering data rich in detail' (Crabtree and Miller, 1992:232). As Glaser and Strauss (1967:36)) state:

> "The constant comparing of many groups draws the sociologist's attention to their many similarities and differences. Considering these leads him to generate abstract categories and their properties, which, since they emerge

> from the data, will clearly be important to a theory explaining the kind of behaviour under observation."

The crucial point in this theory is that the research is not guided, but is directed by what is discovered during the data collection. Moreover, Glaser and Strauss (1967:38) argue, that "one strategy for bringing the generation of theory to greater importance is to work in non-traditional areas where there is little or no technical literature." This perfectly applies to this study.

The initial idea to research Uzbek women was based on an assumption that after independence the health of women has significantly deteriorated. Following the principles of the grounded theory, it was essential to avoid the assumption that this was experienced by most of the women in general. As Glaser and Strauss (1967:45) argue that it was central to explore the true conditions without bias, that is without imposing a preconceived theoretical framework, which will enable women under investigation study to define their own experience and problems in an explanatory framework without external prejudice.

Another strong point in favour of grounded theory is that it makes it possible "to shift focus as the data collection progresses – as long as the process does not become disorganised and lose its rigour" (Bowling, 1997). Thus the questions could be redesigned during the process as new facts emerge which need to be explored.

However, this theory has its own deficiencies. My main concern about using this theory is that its development requires a great deal of data. Therefore, the basic requirement for using 'grounded theory' is to collect as much information as possible by means of interviews and documentary analysis. Another point is that the 'grounded theory' has been criticised for its failure to acknowledge implicit theories, which guide work at an early stage. "Used unintelligently, it can also degenerate into a fairly empty building of categories or into a mere smokescreen used to legitimise purely empiricist research" (Silverman, 2000: 253).

The data was collected and sifted by repeated readings through interviews and field notes in order to identify components and details relevant to the research questions. That helped to locate patterns and link them to describe a phenomenon under study and then elaborate a coherent theory for their explanation. In the course of the research process a theory of women's hardship and gender injustice emerged, identifying the most important patterns within a particular cultural setting. By means of comparison I looked at the process of development and change in Uzbek society, in order to

understand how the women's rate of ill-health, their health attitude and health behaviour related to some social facts and social interactions constructed by historically produced order.

3.2. Unstructured Interviews: Methods and Their Limitations

In order to address the research questions a methodology was employed based on unstructured in-depth interviews, observation and document analysis. This methodology could be flexible and consider the views and opinions of ordinary people from their own perspective. I decided that interviewing would generate a richer body of data than that produced by other survey methods, because it includes the 'free interaction between the researcher and interviewee' (Reinharz, 1992:18). In the course of unstructured interviews there is a greater possibility to obtain information which can be lost in structured pre-coded questions, and can 'open up understandings that are ignored or avoided in non-qualitative approaches to research (Murray and Chamberlain, 2000). Reinharz (1992:19) argues that unstructured interview research 'produces non standardized information that allows researchers to make full use of differences among people.'

My intention was firstly to define the health related quality of life of Uzbek women, by evaluating all spheres of their lives as a whole, their personal health behaviour, family, religion and their subjective evaluation of these circumstances. Secondly, the research was designed to look for a relationship between these factors, women's health behaviour and coping strategies and their adaptation to the post-communist changes in society. In-depth unstructured interviews allowed the development of a thorough understanding of women's own perspective on the events of past and present more than a survey method and structured interviews would have done. The main focus in the interviews was to explore the meanings and practices of health of all kinds during women's lives, paying attention to the ambiguities and complexities of their lives during transition. By looking at the everyday lives of women it was attempted to draw out the connections between the circumstances in which women live and their experience of ill-health and well-being. "Although it surely is important to explore what makes women sick, it is equally crucial to acknowledge women's optimal health and well-being." (Stanton and Gallant, 1995:570).

I created a simple research design to start collecting accurate information. Although I defined and noted standardised and key questions, topics and issues that

needed to be covered during the interviews, questions were not asked in a particular order. Thus, I conducted the interviews with a list of questions and topics for a discussion, which was intended principally as an aid rather than a formal interview schedule. The actual questions asked were determined by what was appropriate to collecting information from each individual woman. This was because some women were open from the very beginning of the interviews and eager to give information while others were less prepared to share their opinions, especially on controversial topics. I conducted interviews as an informal conversation, giving women the opportunity to expand and talk at length on aspects of their own experience. The important principle of unstructured, in-depth interviews is that women should be allowed to speak for themselves with a minimum of guidance. That would enable interviewees to select what they see as relevant about their lives.

I also decided that single interviews could be too formal to gain full information from the women I was going to interview. It would be very difficult to establish trust and confidential connections with respondents at the first meeting. I hoped that by meeting women more than once I could build up a relationship of trust so that the chances of validity would increase at each interview. As Reinharz (199:37) argues:

> "Multiple interviews are likely to be more accurate than single interviews because of the opportunity to ask additional questions and get corrective feedback on previously obtained information."

This method of extracting information can produce more valuable data because it enables the development of a much deeper understanding of the information women provide. To overcome the problem of validity I decided to meet women more than once to obtain as full a story as possible and to dig as deep as possible into their life stories. I decided to use second subsequent interviews to fill in gaps, to monitor changes, get additional information and obtain a full picture of lives of women I studied. Moreover, when I met women for the second interview I noticed that they were much more prepared to talk and discuss the issues. It seemed that they had thought about the topics we discussed previously because it had begun to trouble them. Their thoughts and ideas were more organised. Not only did they tell their stories, but also they tried to find the answers and provide some explanations about their own behaviour and about the situation in Uzbekistan.

The process of 'constant comparison' was used during data analysis. That method enabled me to identify categories and analyse them while a comparison was made as the interviews continued, and more data was collected. Throughout that process literature that had been collected prior to field work was used to compare the existing evidence and the concepts emerging from the interviews.

As I rejected the method of quantitative techniques I reduced the sample of respondents to a maximum of 20 women. It was clear that fieldwork would be extremely time-consuming, which severely restricted the number of interviews it was possible to conduct. However, I decided that with sufficient depth and detail, the research would be meaningful even with a small number of respondents. As Zyzanski, McWhinney, Blake, Crabtree and Miller (1992:233) put it, 'sample size is not the determinant of research significance; the major concern is with information richness' Miles (1991:59) in turn argues that large-scale surveys provide rather generalised information about patterns of the behaviour of individuals, whereas 'the subject meanings and interpretations given by individuals to the events in their lives and to the actions they take, tend to be left unexplored'.

The main criticism of this method could be that analysis based on a small sampling group will undermine the attempt to draw general conclusions and could not be used to reveal the major issues of a broader social environment. In my defence I would argue that generalisation is not the main purpose of this research, but the identification of the factors that would not emerge from large scale research. The findings I aimed to provide would give 'rich insights in order to understand social phenomena rather than statistical information' (Bowling 1997:338). In support of this approach Stanton and Gallant (1995:574) emphasise that the 'selection of individual as the unit of analysis has been most typical in women's health research'. Furthermore, in order to develop the argument in favour of small-scale research it can be argued that intensive in-depth interviewing could provide the depth of analysis, and permit to conduct the research not on the basis of an horizontal large-scale survey, but to reveal important findings through the vertical axis of collecting data. As Patton (2002:244) states: "In-depth information from a small number of people can be very valuable, especially if the cases are information rich"; "information rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research..." (p.46). I would argue that it is not generalisation that is important but the identification of the phenomena of women's life, in the process of dealing with the

demands they face every day. The emphasis should be on providing the access to women's experiences of life with the means of in-depth interviews in order to avoid the stereotype that try to fit all women in. Of course 'considering the larger contextual picture is important' (Stanton and Gallant, 1995:574) and an understanding of women's experiences in relation to that of other women living similar lives (Delphy, 1997:174) is crucial to the findings of my research. However, there is no one simple solution to benefit all women, because each woman experiences a complex variety of social and psychological processes depending on the way they live. Therefore, in the case of a small sample study, generalisation could be incomplete. Instead the aims of the research would be better served by methods 'to collect, categorise and examine the multitude' of voices (Reinharz, 1992:4).

There are some other problems related to the research methodology. One of the problems could be the interpretation of data. The respondents' stated opinions, attitudes and beliefs may differ from their actual behaviour and beliefs. Therefore, the possibility of a discrepancy between the real experience of the persons interviewed and how they express themselves must be taken into account when evaluating the meaning. Another problem that could emerge is a bias, which I also tried to protect my research from, by presenting facts as objectively as possible. However, Pratt and Loiziz (1992:34) make the following point on this subject:

> "In principle, all researchers should try to be objective as possible in the way they carry out the research, that is, they should seek for precision and accuracy, and to control bias. But if they are wise, they will never suppose that they have completely succeeded, and they will remain open, right down to the last stages of their research, to the possibility of their having made interpretive errors of all kinds."

In addition to other possible criticisms of my research I would argue that on the one hand, the fact that I am from the same society could play a positive role in my investigation, because I am familiar with the traditions, language, and cultural organisation of Uzbek society. 'Feminist researchers argue that studies of women in a particular country should be done by women of that country' because 'even an empathic outsider cannot know women the way women know themselves' (Reinharz, 1992:260), and cannot know the context and environment that surround and influence women's existence to the same extent as a person who was brought up in the same society. On the other hand, being a member of the same society could create the problems as well as advantages because difficulties could occur in the perception of contradictions in one's

own society. As Martin (1987:11) puts it 'the problem was how to find a vantage point from which to see the water I had lived in all my life'. Therefore, one must be careful about bias that could be brought to the study when differentiating one's own opinion or too closely associating with the respondents.

The difficulties with the translations emerged when referring to medical terminology, for which I used a special medical dictionary. Words that do not have an English translation are italicised and their definition is explained in the footnotes. For example *paranja, beshik, qusimunchoq*,ect.

3.3. Participant Observation

Observation of behaviour, actions and interactions is a useful method, which can help to understand complex situations more fully. In order to understand the experiences of family health practices one must actively enter the world of residency as a participant observer (Crabtree and Miller, 1992:21). Another important point regarding the process of observation is that "observation does not depend on people being willing to be interviewed or the existence of accurate and complete documents (Bowling, 1997:317).

During my stay in Uzbekistan I visited state clinics and scrutinised the order and rules in the clinics, which have already adopted Health Reform and clinics, which still operate the old system. There I conducted informal interviews, because people were eager to share information in the form of explanatory conversation while queuing to see the doctor. According to May (1997) researchers must become part of the environment for only then can they understand the actions of people who occupy and produce culture.

I do not consider observation as a complete research method by itself. Nevertheless, as a part of the research it provides a unique opportunity to enhance the information available from other sources. Thus by listening and looking at how people act within their social environment one could gather information on the continual ongoing social process. Observations in clinics, homes and markets were helpful in providing the opportunity to check the validity of formal interview responses. The important advantage of this approach is that the data collected will not be limited to what the interviewees said. My own observations and experiences were useful source for the analysis.

3.4. Secondary Data Analysis

Documentary research alongside other methods has been used to yield valuable information on the dynamics of social life and the societal transformation of Uzbekistan during the last decade. This method 'could allow comparisons to be made between the observer's interpretations of events and those recorded in documents relating to those events' (May, 1997: 157). The documentary search was also required to identify relevant empirical studies on the impact of transition on women's health conducted in Uzbekistan. In addition to published studies, unpublished documents have been located through contacts with researchers active in the relevant areas.

To find related papers and reports, additional sources provided by various institutions and organisations have been used. In addition to English-language sources I also consulted *Sovetskaya Medicina, Informacionnyi Bulletin Associacii Vrachey Uzbekistana* and other Russian-language publications. During the course of primary data collection a wide variety of documentary sources has been gathered, among them UNDP Human Development Reports, ABD Consultative Papers, governmental sources, journals and magazines etc. Articles from local magazines and newspapers and a great deal of statistical data related to women's status and women's health, in particular, have been examined to obtain the latest information on problems of Uzbek women and the situation in the health system. Although these data could seem inconsistent and unreliable, they proved to be helpful and provided a broader picture on the problems under study. As Ann Bowling (1997:372) puts it, "no document can be regarded as a completely accurate reproduction of the phenomenon of interest, but, within limitations and taking their social context and process of construction into account, they can be valuable sources of data about society." Thus it was considered that using a variety of methods would be more useful and permit to 'link past and present and correlate 'individual behaviour with social frameworks' (Reinharz, 1992:197).

3.5. Selecting a Sample Group

There are a lot of contradictions in defining social class and income status in Uzbekistan today due to the peculiar social changes in the country during transition. The definition of class position in Uzbekistan today is a very complex matter. The universal index for classifying class position - occupation (Delphy, 1981:117) - cannot be applied to women who do not have paid employment. Most of the respondents in this study were housewives. Taking women's marital status as classification was also

inappropriate, as "the fact that a woman is comparable to her husband from the point of view of economic independence distances her from him in sociological terms. Putting a non-employed woman into her husband's social class does not just obscure this fact, it completely reverses its meaning" (Delphy, 1981:123). According to Lillie-Blanton, Bowie and Ro (1996:105) education could be considered a sufficiently valid indicator of social status which is also unsuitable for the Uzbek case, because women with a high level of education could be related to either a low or a high income household depending on their current circumstances. Moreover, education in the former Soviet Union was considered as a demographic rather than economic variable, thus it is not as clearly linked to higher material rewards or status as it is in the West (Gilmore 2002).

Taking the above into consideration the decision was to measure social status by a combination of income, education and occupation. However, in Uzbekistan in the period of transition the issue of social status is subject to continual debate. It is difficult to fit Uzbek women into the usual social scientific categories, thus most of the women I have chosen as informants are highly educated professionals, however, according to their income status, some of them can be defined as belonging to the category of the poor and consequently lower class. As Martin (1987:5) states:

> "The edges of the clusters 'middle class' and 'working class' are fuzzy, as they should be for groups formed on the basis of complexly overlapping characteristics in a state of constant change."

Furthermore, the general definition of middle-class families common to Western societies like resource allocation on 'recreation or luxuries' and available means that to rely on 'banks, pensions and credit accounts' or freedom to choose the roles of housewife or self-fulfilment jobs outside the home (Martin,1987:6) are not applicable to Uzbek society. Therefore, when classifying the women-respondents in this study as middle-class women some deviations must be taken into account. The core of the middle-class of Uzbek society consists of the intelligentsia and highly qualified specialists. A definition of intelligentsia describes it as the part of the population who received a higher education and occupies professions such as doctors, school teachers, scientific researchers, university lecturers, and people involved in the arts. In recent years the members of this class that had been privileged in the Soviet period have formed a new group of impoverished intelligentsia. This trend was due to a decline of allocation of the resources and cuts in budgets funding the institutions of government.

The living standards of middle class women (*intelligentsiya*) have decreased significantly during transition (Akiner, 1998). During the Soviet period employment in such spheres as teaching, the medical profession, science and culture was very prestigious. Then the high-level government officials, a small part of the humanitarian intelligentsia, scientists and technical specialists, officers, a thin stratum of the working class (for the most part leading workers of Communist Party members) and the workers of trade and provision formed the middle class and constituted fifteen per cent of Soviet population (Sivkova, 2001). During the Soviet times the ideas of personal enrichment and welfare were never deemed to be of high value. The Soviet ideology propagandised the notion of serving the State and the people, not oneself.

After independence *functionaries* of government institutions, officers, medical professionals and teachers (*budgetniky*) started to "filter" down the social strata. Their places were gradually filled by economists, accountants and computer programmers. The latest to join the ranks of the middle class were private tutors, drivers and other people who serve the rich (ibid). However, this situation is mainly the concern of the capital of Uzbekistan - Tashkent. In rural areas people are not so rich. In rural areas *militzionery*, taxmen and auditors could be considered to be rich persons. Thus in Uzbekistan the middle class cannot be defined by material (financial) indicator like in Western countries (property, real estate, higher education, bank savings and land). In Uzbekistan today higher education does not guarantee a job, and a job does not guarantee sufficient income.

In the period of the new economic situation public spending has sharply declined. The salary of teachers and doctors today is not enough to maintain the family. In general employees in Uzbekistan paid from the state budget - doctors, teachers, scholars and the military – live below the poverty line. Their monthly salaries are between $7 and $30 (Taksanov, 2003) and all stratum of the population in Uzbekistan have suffered shortages during transition. Independence has brought shortage and this had a serious affect on the group of women studied. The period of equal opportunities has ended. Paid work in the state establishments and institutions is not able to support their workers on the same level any more. Women who belong to the so-called middle class have become very vulnerable and more sensitive to changes. Their professional and cultural skills have turned out to be less valuable in a market oriented economy, and their dignity and self-respect makes it very difficult for them to give up their profession and

start trading business or take less prestigious jobs, although, some of them are forced to look for unofficial sources of income.

Middle-class women in Uzbekistan gained a relatively little attention in sociological research. Far more has been written about poor rural women than those belonging to middle-class groups. But this does not imply that the situation of middle-class women is not in itself problematic. Middle-class, highly educated, intelligent women continue to suffer from bad relationships in the family, poor health, economic hardships and gender inequality no less than women from lower-class. The fact that women's economic status and education improves does not mean that women would automatically be immune to the effect of other structural problems such as patriarchy or gender inequality. These also concern women's health status. As Blaxter (1990:237) states: "there are healthy and unhealthy people in all classes and circumstances". The experiences of a specific group of women can shed light upon the overall position and problems of women in society. Another point is that little has been written about urban Uzbek women in relation to health, illness, lifestyle etc. The scholars who wrote about these issues have focused their studies primarily on rural inhabitants (Karimov, 1991; Kandiyoti, 1999). A study of urban women is thus potentially significant in drawing attention to the way of life, adaptation to changing circumstances, and coping strategies of urban community of Uzbekistan.

Therefore, taking all these into account I decided that in order to get more specific information it would be necessary to take women from approximately same age group, social and marital status. The commonalities between them justify considering them as one group in some sense. It was decided to use 'a small, homogeneous sample, the purpose of which is to describe some particular subgroup in depth' (Patton, 2002:235). The field study was restricted to one city, which was the capital of Uzbekistan - Tashkent, and a group of women was selected who would be easily identified.

My first intention was to find one or two women's polyclinics or hospitals or women's Health Centres and conduct interviews with women–patients. Therefore I anticipated no difficulties in locating a sample of women for my study. Taking advantage of many personal contacts I managed to meet with medical staff of these clinics. I expected that after explaining the purpose of the research these people would be able to facilitate contacts with any women patients in their clinics. The problem was that women in Health Centres or polyclinics were reluctant to talk, because they usually were in a hurry and were more concerned to see a doctor than to talk to a stranger.

Moreover, despite the very friendly and helpful attitude of the medical staff of those clinics, it was very difficult to find a suitable place to conduct an interview, where recording devices could be used, and where women could feel relaxed and confident.

In the hospitals this approach also failed. The interviews came out to be very formal; women were trying to present the hospitals in a very good light, trying to avoid any complaints about the hospital or their own condition. I realised that it would be difficult to extract sufficient data from women who feel themselves obliged to say only positive things about the treatment and medical services. The problem also was that they were reluctant to open up to an independent researcher from a foreign university. People were reluctant to talk to strangers especially when they saw a tape recorder. This fear is no doubt in part due to the political situation in the country.

Given that it turned out that a systematically chosen sample from the clinics and hospitals would be difficult to obtain and a random sampling of the entire female population of Tashkent City is impractical, I decided to seek suitable respondents from a number of sources where such women could be found. The principle was to get access to one neighbourhood in the city and then use the snowball sampling that has come into increasing use in recent years. The system of using women's own network proved to be good in the pilot fieldwork, when each woman was asked to provide contact with another woman of her age. In Uzbekistan it is better to be introduced in order to be more trusted and thus develop more confidential relations with women. When I approached women to take part in the study, their initial reaction was to try to understand who I was and whom I was working for. Once I had explained that the reason for my intervention in their life was to find out about their feelings and experiences for academic research most of them were willing to participate.

Interviews were conducted with 20 middle class women from Tashkent city, ranging in age between 38 and 54. The reason for choosing this particular age group was that women of these ages have experiences from the past and are mature enough to see the changes in their own lives and in Uzbek society and develop their own perspectives on the events that took place after independence. As Blaxter (1990:30) states 'in middle age, concepts of health become more complex, with an emphasis upon total mental and physical well being. Furthermore she argues that 'a rise in experience of illness symptoms was marked for women in middle age, but reversed in the 60s before rising again in old age (p. 57). Thus the period of 40 –50 appears to be one of

poorer health for women, therefore much attention should be paid to the women of that age range.

Another reason is that most of the studies on women's health problems in Uzbekistan were primarily interested in young women of reproductive age. That could be due to the fact that a high rate of population growth, being conditioned by both a high birth rate and a relatively low mortality rate (Yarkulov, 2000:1) has resulted in a fact that '38.4 per cent of population in 1999 were children of the age of fourteen, and less than five per cent were people over the age of 65' (The Ministry of Health of Uzbekistan, 2000:15). Therefore, an increase of the proportion of women of reproductive age was observed. As a result scientific literature and research and government policy alike have focused increasingly on topics of reproductive issues of women in Uzbekistan (UNDP, 1999:59), devoting less attention to women outside reproductive age, e.g. middle-aged women. In Western research there is increasing attention paid to women in mid-life (Woods, 1996), whereas in Uzbekistan that category of women has been neglected.

Fewer studies addressed the issue of role overload in older women; consequently experiences of women in mid-life have been often undervalued. This study is intended to fill this gap. Women in their mid-life 'have many other health needs which are just as important' (Kenner, 1985:1). It is equally vital to give the same close attention to women who are beyond reproductive age.

Out of 20 women interviewed fourteen have higher education; the other six have secondary special education. In terms of occupation: nine were housewives, one a ballet dancer, one a school teacher, four university lecturers, one a paediatrician, one a head of a human resources department, two NGO workers, and one retired.

As has been mentioned previously, the economic status of respondents was blurred, therefore data on the financial situation was difficult to obtain. Most participants were reluctant to answer questions about their economic situation. Several of the respondents interviewed were unaware of their family's income, especially those who were solely supported by their husbands. That also could be due to the constantly changing financial situation depending on the availability of additional earnings from illegal activity, to unstable economic situation in the country, and the existence of a black market exchange rate. Taking into consideration the delicacy of the subject the question on income was dropped from the study. None of the participants reported receiving any governmental support.

Only three out of nine housewives had never worked, three worked as medical professionals, one was a physical education teacher, one accountant, and one university lecturer.

Marital status: Fourteen women were married, two divorced, two separated, one was unmarried and one woman's husband went missing.

Number of children: Seven women have three children, five have two children, five have one child, and three have no children.

Religion: Nineteen respondents considered themselves Muslim. There was one atheist.

Before independence most informants were professional or white-collar workers. But during the transition period some of them experienced occupational downgrading or left paid employment to end up as housewives, due to the increased competitiveness in the labour market. Yet, a few of the respondents managed to improve their financial status as a result of new employment in trading or international organisations.

The limitations of the study include a lack of representation from women of non-indigenous ethnicity, respondents with disabilities etc. Therefore, although the sampling produced was designed to include women with diverse roles and experiences the results cannot be generalised to all women.

3.6. Interview Schedule

As mentioned above the objective of the research was to determine women's coping strategies in their daily lives mainly in regards to health. Given the obvious limitations of space, it was necessary to be selective in reviewing material and to concentrate on a small number of key parameters that create conditions for different forms of sickness and healing. These parameters include social structure and organisation, types and patterns of medical problems, general features of culture and religion that shape what health and illness mean, and how practices of healing could be carried out. Several questions were used in the interviews in order to determine these parameters. Attention was also paid to health related behaviours, including weight problems, exercise, smoking, contraceptive practices.

The interviewing was carried out in two phases on two field trips to Tashkent - one in the summer of 2002 and the other in the winter of 2002-03. Interviews were conducted in two languages: Uzbek and Russian. Most women used both languages

during interviews. Immediately after each interview notes of observations about the environment and other factors related to the situation and interaction were written up.

Each interview lasted between one and one and a half hour on average. The face-to-face interviews took place in the homes of participants or at a location of their choosing. Most interviews took place in the interviewee's homes, although some women preferred, for personal reasons, not to be interviewed at their own homes. In those cases interviews took place either at my own home or at the women's work place. Thus, Gauhar, 42 had reconstruction work taking place in her house; Asal, 39 said that her children would not allow us to talk without interruption; Yoqut, 39, lived with her in-laws and preferred to be interviewed at her work place (Tashkent state school No. 34).

The interviews included basic demographic information, women's health history, their attitudes towards their health, health history in their family, their attitudes towards bio-medicine, alternative therapy, religious practices, problems with access to health care, the choice between free and pay health care, family health responsibilities and personal leisure patterns. In order to find out more on health beliefs and attitudes and health related behaviour I asked women about everyday complaints, diseases and their consequences on the individual's daily life, what drugs were being taken, psychological status, feelings of social support or isolation, sources of stress etc. The respondents were also asked to indicate how many illnesses they have had, and how they have treated their illnesses.

Key questions of the interview covered the major area of life experience: education, employment, marriage status, children and health problems. There were also questions on religion and social milieu. In order to cover the factual diversities in women's experiences in key spheres of their lives, where necessary, I asked additional questions on women's parents, in-law relatives and past experiences.

Open-ended questions were designed to encourage informants to articulate their personal understanding of their beliefs and practices regarding their health status, problems with contemporary health care, their own problems and concerns.

At the beginning of the interview I briefly explained the aims of the study, the reasons why I wanted to conduct this research. It was important to be sure that women understood my intentions, the seriousness of my task and the importance of this work for me and for them. Ann Oakley (1981:49) argues that "without feeling that the

interview process offered some personal satisfaction to them, interviewees would not be prepared to continue after the first interview." Thus, I intended to repeat interviews with women so as to establish a rapport and be able to gain fuller information from my respondents. The most frequent question women asked me was if I was going to publish interviews in Uzbekistan. My answer was that only academics from a foreign university would read my research findings, but no one except me would listen to the tapes and all the names and personal details would be changed. I reassured women, that I would not reveal any confidential information they gave during interviews. I assumed that Uzbek women were not used to interviews in their daily life. I was afraid that they would not believe that I am not specifically interested in their private lives, which could make it harder for them to respond sincerely. To overcome this problem and to establish mutual trust and confidence I tried to answer all their questions about myself, my research and explain carefully why I am so interested in their lives. Most of the women were satisfied with my explanations and talked freely and openly about their lives, with the exception of a few women I tried to interview in the hospital

Ann Oakley (1981) also states that the traditional precepts in the textbook code of ethics with regard to interviewing women recommends the researcher to avoid personal questions and establish a subordinate position with the interviewees in order to maintain professional respect and competence. However, the feminist approach to fieldwork is to behave differently from those with other perspectives and follow the practice to answer 'all personal questions and questions about the research as fully as required' (p. 47). Feminism fights for breaking all barriers between women. I would argue for a balanced approach, i.e. to establish a rapport on the one hand and avoid unnecessary involvement between interviewee and interviewer on the other. Thus having too close relationships with women studied could 'complicate the research' (Reinharz, 1992:264). As Michael Patton (2002:365) states:

> "As an interviewer, I wanted to establish rapport with the person I am questioning but that rapport must be established in such a way that it does not undermine my neutrality concerning what the person tells me."

It is not enough to simply pose appropriate basic questions, and listen and record what women say. It is necessary to maintain control of an interview in order to obtain quality responses. In other words 'to make good use of the short time available to talk' (Patton, 2002:377). Staying focused on the purpose of the interview is also very important.

After assuring women of confidentiality and anonymity, individual interviews with women were conducted, using open-ended questions and a frequently modified interview guide. All names have been changed to protect informants.

When I asked for permission to record the interview all the women agreed. Each interview began with the collection of basic personal details - age, marital status, occupation, education, and composition of household. The first phase of the interviews were used to collect basic factual data on women, such as current health problems of their own and in their families as a well as a data of a more general nature, concerning attitudes to bio-medical and traditional patterns of health care, religious practices etc. I tried to enable them to relax and make them feel more comfortable, so they could forget about the tape recorder. However, during most interviews women asked me to switch off the tape recorder from time to time, and even stop writing notes, because they did not want me to record some parts of their interview.

As a result I was able to collect extensive data on various issues, particularly on women's perceptions about health, illness and their choices of treatment. Women's statements collected during the interviews about strategies to improve health, concerns, attitudes, and values, personal responsibilities etc., were sorted into related topics based on similarities of meanings. From these topics wider themes were identified and concomitantly sub-groups of topics were aggregated. Thus four main themes were developed relating to issues that seemed to have a major impact on women's health.

An examination of the literature showed that 'many topics discussed freely in Western societies are taboos in other parts of the world' (Patton, 2002:393). That statement is true for Uzbek society as well. In Uzbek society one can ask people about their age, marital status, number of children, and reasons for the small number of children. But questions about husbands or their income, expenditure, savings or workplaces must be avoided. For instance, although it was difficult to understand how Yuliya, 52, a housewife, with three daughters and granddaughter has managed to live just on her husband's salary, she refused to tell exactly how much her husband earned and how much she usually spent. It was very difficult to break the ice, and get women to speak freely, sometimes it was not even possible. The reason for this was probably that most women and their husbands were highly educated and professional, but in times of transition many had to abandon their previous jobs and take less prestigious but better paid jobs in trade, or some became unemployed. Intimate relationships and sexual problems also produced a lack of response. The topics of this study were in some cases

'not part of typical public or academic discourse' (Reinharz, 1992:23) and therefore demanded more a sensitive and careful approach. I also had to consider 'the ethical dimensions of interviewing about particular topics' (ibid, p. 22).

On the whole, despite rare exceptions, women-respondents were responsive and informative during the interviews. As a result of their willingness and cooperation I was able to collect extensive data on various topics specifically on insights about health and health related issues.

In order to maximize the diversity of the sample, after the analysis of each interview, subsequent participants were sought and interviewed based on previous experiences and on a variety of situations. Once all the interviews were completed the interviews were coded, in order to process the information into categories. The coding was done by identifying diseases, health problems, repeated phrases, concerns, meanings etc. Then it was compared with each previous interview, the literature and observations.

All interviews were transcribed from the audiotapes. The transcribed interviews were analysed using ground theory and methods of constant comparison (Glaser and Strauss, 1967). Information from recent publications, magazines, newspapers internet was also analysed in the same way in order to confirm the interviews data and to check the validity of findings.

Chapter 4
Women's Health Status

4.1. Introduction

This chapter discusses the findings of the fieldwork that was carried out during summer and winter of 2002-03. The empirical part of the research was structured around the experiences of a group of twenty urban Uzbek women.

The interview data revealed a complexity and diversity of opinions concerning women's perceptions of health and health related issues. The main focus of the interviews was on the examination of all kinds of health practices and experiences. Nevertheless, it was assumed that the identification of social trends and events would be relevant to the study, because it could help to make sense of social problems that impact on women's health and well-being. I decided to structure the analysis of the empirical work around women's experiences of ill-health, sources of stress that influence health, women's life-style, health practices as well as their social context. During the analysis wider social and historic circumstances were introduced and explored on the assumption that they were important, because they shape the construction of lay people's medical knowledge and influence women's opportunities and options with regard to health related issues. Therefore, the attempt has also been made to investigate ethnic traditions and customs and religious ideas in general as an illustration of the setting in which Uzbek women live.

4.1.1. The Impact of Socialism on Women's Health

The research is focused on the oral histories of women that shed light not only on their present life, but also on the past experiences of their lives during the period of socialism. In this respect I tried to underline some features of what impact seventy years of socialism has had on women's health.

In the Soviet Union, 'extreme emphasis' in health cares system 'was placed on the socialist-oriented priorities of access and equity' (Twigg, 2002). The first and most important fact was that medical care, drugs, and medicine were free and accessible for everyone. Easy access to medical services meant that people made use of medical services not only when they were sick, but also to have regular medical check-ups. Every year people had to undergo check-ups involving all specialists in the polyclinics:

therapists, gynaecologists, neuropathologists, etc. This system of regular examinations allowed doctors to detect any cases of hidden diseases earlier, so people could take preventive measures or receive proper care. Immunisation was compulsory; it was helping to reduce the incidence of infectious disease considerably (McKee, Healy, Falkingham, 2002:73). As Tabyshalieva (1999:51) states "greatly improved healthcare meant that for the first time, women made up more then fifty per cent of the population" in Central Asia.

Women's reproductive health was under special government control. Soviet women were entitled to genuine maternity benefits. The total length of the maternity leave was three years and three months, with eighteen weeks of partially paid leave and up to three years of unpaid leave. The mother's job had to be retained for her during this absence (Posadskaya, 1993:169).

Sickness benefits were paid for the first three days of illness (and then could be prolonged if the illness was severe), at 70-100 percent of wages depending on the length of employment. Women were able to stay away from work when looking after their sick children without fear of losing their salaries.

"There are 256500 ante-natal and post-natal clinics throughout the Soviet Union and around 8000 million roubles is allocated annually to maintaining kindergartens, nurseries, after-school work with children and pioneer camps" (Pilkington, 1992:205). People with chronic diseases were obliged to undergo hospital treatment twice a year. Eighty per cent of the people who spent their holiday in a house of rest or sanatorium[4] received their pass free or had it partially paid for by the Soviet social insurance system (Moskoff, 1984:125). Local Trade Unions Committees (*Profsouz)* in each enterprise were in charge of the distribution of places in sanatoria and resorts. People with chronic diseases were given priority.

During the interviews many women complained that they lost this opportunity to have sanatorium treatments, which almost all of them had every year before. They also miss the opportunity to send their children to pioneer camps during the summer, where they themselves spend the summer during their youth. Previously the 30-70 per cent of

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[4] The house of rest was designed to provide a place for workers on leave, it also served as a place where a doctor could send a worker who was considered overtired. A sanatorium, was a health institution, run under medical auspices, where rest was combined with some form of treatment. (See Moskoff,1984)

the cost of pioneer camps was paid by Trade Unions, and for families with many children they were free. Most of the women I interviewed reported that they could not now afford to pay for their children's' holidays in summer camps.

However, despite tremendous efforts and the investment of huge sums in health care one must bear in mind the negative features of socialism and its approach to health.

One negative factor was that a great deal of medicine was in short supply during that period (McKee, Healy, Falkingham, 2002:74). For instance there was a shortage of oral contraceptives and hormonal pills, to such an extent they were almost unknown in some parts of the country, especially in rural areas. One of the most difficult negotiations between women and the state was over the provision of access to birth control (Pilkington 1992:211). "...Soviet health authorities categorically disapproved of any interference with woman's hormonal activity or modification of her menstrual cycle" (Scott, 1976:151). In 1968 the Soviet Union announced that it would concentrate on the mass production of the intrauterine device (ibid). Condoms and the IUD (Intrauterine Contraceptive Device) were the most common contraceptives apart from abortion. "The failure to develop anywhere near adequate provision of contraception has made women dependent on abortion as a method of birth control" (H. Pilkington, 1992:212).[5] The UNDP Report on the Status of Women in Uzbekistan highlighted that in 1990, contraception was used by 12.2 % of all fertile women according to the records of medical institutions (UNDP, 1999:62).

This situation regarding contraception forced women to find their own way to avoid pregnancy. During the interviews women shared with me different means of how to avoid pregnancy. The most popular methods were coitus interruptions, the calendar method, douches, one woman applied aspirin inside vagina. They admitted that none of these methods were reliable and eventually they had to go through with abortions anyway.

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[5] Abortion was first legalised in 1920, and made illegal in 1936 and then legalised again in 1955. Abortion was introduced to prevent illegal abortion, which were much more detrimental to women's lives. Abortion was free if by medical indication, at any stage of pregnancy. In 1970 the vacuum method has been introduced. This method is much simpler and has less complications and side effects (Mandel, 1975; Pilkington,1992; Buckley,1989; Heitlinger,1979; Halle, 1933).

Gauhar, 42:

" Wow, what only I didn't try...Firstly, I applied douches after each intercourse. Sometimes I mixed water with vinegar to make it acid. I also counted the days when I supposedly had to conceive. But all that didn't work at all. Every month I was agonising, waiting for my period. It was such a relief every time, when the period began. But if I was late for two-three days I usually started to panic. I took hot baths. I put mustard in the water. I put hot water bottle on my stomach; sometimes I just sat on hot bottle."

'The average Soviet woman had six to eight abortions in her lifetime' at best, at worst eighteen (Eisenstein, 1993:311).

Several respondents said that they had to suffer alone, in silence, because they hid their pregnancy from their husbands or otherwise they would have made them keep the baby. In such cases the women had to take on full responsibility for the abortion. They had to find the doctor, find the time, and sometimes find extra money and pay the fee. Moreover, although abortion was legal in the country, it was not considered as an illness by the family. Women usually did not have time to rest, they were supposed to perform their household responsibilities, as they hid from their families that they had undergone an abortion. Although a voluntary abortion qualified a woman to take unpaid sick leave, thus protecting her against dismissal or disciplinary action for unauthorised absence (Mandel 1975:116) at home she was supposed to perform her usual obligations.

Women reported that their doctors and gynaecologists were very cautious and instructed them on the potential dangers, however, the supply of conventional birth control methods was limited, and therefore, they had not much to offer except the IUD. Thus, eventually after two, three abortions women used the IUD, although many women reported side-effects like abdominal pain, heavy bleeding etc.

Mukaddas, 38:

"My mother had fourteen abortions, and she is very healthy. She had never complained about abortions, but maybe that is because I was very young, she never shared it with me. But my gynaecologist told me that if I went through it once more the consequences would have been very dangerous. So, right after abortion I inserted the IUD, it is almost twelve years now."

The data suggests that women's health was compromised enormously due to the highly ineffective contraceptive methods used in the Soviet Union.

Another disastrous impact on women's health resulted from, environmental pollution. As was stated in the UNDP Report (1999:63) "an uncontrolled application of chemicals in agriculture (poisonous chemicals were applied in cotton fields) were the major causes of environmental problems in region."

Although the main impact of chemical pollution was on rural inhabitants, the urban population - especially the youth - was obliged to take part in a cotton picking campaign each autumn every year. Cotton fields were generously sprayed with pesticides. However, not only the exposure to different kinds of chemicals, but very poor hygiene and bad living conditions affected women's health badly. People used to live in barracks, 50-70 people in each, both sexes mixed. There were no facilities like toilets or bathrooms (bodily function were performed in the open air in the field), but even drinking water was of very bad quality. All that predisposed everyone to different kinds of diseases. Women were the most vulnerable. Greenberger (1998) argues that there was mounting evidence that women are uniquely vulnerable to the effects of environmental hazards because women face greater exposure than men due their comparatively small size. They suffered not only infectious diseases like viral hepatitis, meningitis, dysentery, but also urino-genital inflammation due to the bad sanitary conditions. All these diseases had an enormous impact on women's reproductive abilities later in their lives. Each autumn the hospitals were overcrowded with patients suffering from different infectious diseases. However, women who were lucky to avoid such diseases had suffered anyway from disorders of the menstrual cycle and other gynaecological problems that became chronic if left untreated. Consequently women suffered miscarriages, prematurely born children and infertility later in their lives. As Tabyshalieva (1999:52) states the Soviet authorities created not only an environmental crisis by transforming the 'region into a machine for cotton production' but also sacrificed the health and dignity of millions of girls and women.

However, despite the above facts it should be mentioned that the Soviet health care system was provided free for all strata of society; the universal social protection, accessibility and free health care system, generous maternity benefits, all contributed to improving the health status of population (especially that of women) during the Soviet period. As Hilda Scott (1976:191) stated, the socialist governments gave priority to the

distribution of public funds for social purposes such as health, education and culture, public transportation, social welfare services, and support for prices of some basic foods and other necessities, such as children's clothing.

However, other factors like disastrous ecological problems, the underdeveloped family planning system, were permitted without regard to the demands and interests of people. The persisting double burden of housework and employment, child care, and 'exceptionally limited public services', might have been 'responsible for the fact that the morbidity rate for women was twice that of men' in the Soviet Union (Moskoff, 1984:134). The administrative and command system had been sufficient to maintain and strengthen the overall situation in the health care system. However, less attention was paid to improving working conditions, and ecological problems, which consequently undermined all positive factors of the endeavours towards improving the health status of population.

During the interviews women gave their remarks on the changes in health care system after the collapse of the Soviet Union. The data reveals a diversity of opinion, however, the notion that after independence the situation in the health care services significantly deteriorated predominated in the interviews.

Munisa, 39:

> "From my own experience I can say...When I gave birth to my oldest children, that was during the good old Soviet system, the nurse used to visit us at home every ten days. We were obliged to visit polyclinic every month with newly born babies till they were one year old. We had to go through the regular check-up with the kids. Every month – neurologist, surgeon, blood test, and so on...When I gave birth to my last son, nobody cared. Before doctors checked the condition of babies every month, today only if you ask them. I think there are no specialists left in the clinics. All fled the country. Even vaccination, for example, before they used to come to your home to persuade you to get vaccination, today you have to go to polyclinic to find out yourself. It is good that I have experience, I know that children must get that vaccination, but what about young mothers, nobody cares..."

Munisa also emphasised that the attitude of the doctors towards the patients has changed. The doctors and nurses did not pay much attention to women who had not paid

them in advance. She complained about poor sanitation and hygienic standards in the hospitals.

Oydin, 44, recalls:

"In the Soviet period everybody had to go through the regular check-ups in the polyclinics. I used to work for the computer centre in the Academy of Sciences, there was a Decree of the Ministry of Health to work in front of the computer for no more then four hours forty minutes, with a break after every fifteen minutes. Today nobody follows this order. I can work eight hours without a break... I also remember that I used to take all my employees to the polyclinic assigned for Academy employees for the check-up, which was scheduled for every year. During such check ups, hidden diseases could have been discovered, people could ask questions about their health. Especially it was good for men. Women usually go to the doctors; they always suspect something wrong with them. But men they are different, they do not pay attention to the changes in their bodies therefore they die very easily."

Mariam, 52

"Before the hospitals used their own medicine, today you must bring drugs and synergies, and bandages, everything you must bring to the hospital so they can treat you. Our health care system is very good due to the Soviet system. The doctors are very noble persons, I mean old generation, they are not like today's doctors, who get their degree for money, and they know nothing. But the thing is that all good doctors now work in the private clinics. I can understand them; they also have to feed their families. But the mentality of the medical professional is changing."

Nigora, 40:

" I will tell you the story how I called the doctor to my daughter, she had a very high temperature. I've been waiting for a doctor in despair. So from time to time I looked out of the window to see if the doctor, whom I called, was coming. And finally I saw her coming out of our house. I called her; she looked up, waved and said: 'Nigora, your lift is not working!' I started to cry to persuade her to come up, but she refused. She said that she would come tomorrow. Can you imagine? I didn't know what to do with my daughter, and she ... Such thing would not be

possible in the Soviet period. She would have been probably fired the next day. But today, if they fired her she would have said: 'thank you', and found herself another work. For such a miserable salary, she is not obliged to climb the stairs..."

Asal, 39, works as paediatrician, therefore she knows the picture from the inside. This is her opinion on the changes in the health services during transition:

"During the Soviet times when I worked in the maternity hospital newly born babies were treated separately from their mothers. There was special medical staff to look after the babies. Today babies are kept with their mothers straight after the birth. Medical staff has minimal contact with the babies. Mothers today change nappies to their babies themselves. It is very difficult for exhausted mothers, especially to those who had Caesarean section or bleeding or any other complications. They complain, they ask us to take their babies at least for a night, so they have a rest. But administration tells us not to take babies from their mothers even if they had a high temperature. Before, women complained that they saw their babies very rarely; today they complain that they have them too much.

Furthermore she pointed out that the mothers had to wash their babies' swaddling clothes themselves, although there are no facilities or places to hang them out to dry. The patients had to bring their own syringes, medicine, food and even detergent. They must also pay for the treatment if there were any complications during the delivery. Many patients refused to take the treatment prescribed to them by the doctor, because they thought that the doctor just wanted to make money from them. During the Soviet times, the hospitals provided everything for mothers and babies. Mothers who were admitted to hospital often stayed for six-eight days and always without any payment.

Thus the conditions and regulations in the hospitals have changed during the last decade. The majority of respondents indicated that the situation in health care has deteriorated significantly since the collapse of the Soviet Union despite the introduction of a new facilities and technologies in several medical centres. Most of the relatively decent treatments today could be obtained for a high fee only. The interview findings show that the majority of women had nostalgic feelings on the issue of medical situation in the Soviet times, though they admitted that there were negative sides in the past. That could be explained by the fact that most of the life of the generation of women respondents had been spent in the Soviet period. Despite the features of imperfection

and inadequacy of the past system it seemed more familiar to them. Therefore, even seemingly positive changes like keeping new-born babies in the same wards with their mother in maternity hospitals had not been appreciated by mothers or by the medical staff.

4.1.2. Women's Health Patterns and Health Behaviour

Women's health is determined by the whole range of women's activities such as housework, employment, relationships with other people, and the availability of health care, caring for sick children, the food, the housing and many other aspects of life. As Kenner (1985:1) puts it: 'our health is not encompassed totally in our biology'. We cannot separate women's biological functions from other aspects of their lives. Moss (2002) supports this by claiming that 'women's biological characteristics and inheritance, together with institutional, social, and psychological process, affect her subsequent health and well-being'. Thus, this chapter takes into account the 'potential interaction among biological, psychological, and social factors in determining women's health' (Stanton and Gallant, 1995:573). The analysis of women's health begins by looking at the everyday pattern of women's health's lives with the purpose of paying attention to all areas of women's health.

To begin with it is important to define women's own assessment and evaluation of their own health status and assess the importance that women place on health. Self-evaluation of health is considered a legitimate indicator of overall health status, providing a valid, reliable and cost-effective means of health assessments, as it provides important additional information to that obtained from other health measures (Kaplan et al, 2003).

When respondents were asked how they rated their own health, most women I interviewed gave a positive report on their health. No one complained about her health at the beginning of the interview.

Sutanat, 54

" Quite good, concerning others."

Shirin, 50

" Tfu-tfu, I have a very good health."

Gauhar, 42

" No, no problems, thanks God, everything is fine with me."

Although, it is well known that mid-life is the time when women begin to experience their first chronic illnesses such as blood pressure, arthritis, heart disease, diabetes (Woods, 1996:147), Uzbek women interviewed for this study, reported that they did not have any major health problems. Such an attitude could have its consequences. As Helweg-Larsen et al. (2003) discovered, an inadequate understanding of the state of one's health might lead to a reduction in preventive behaviour or non-adherence to medication regimes and treatment.

Most of the women described themselves as healthy despite of the fact that later they admitted that they suffered some forms of chronic or acute disease. Thus, as the interview progressed women started telling the stories of their chronic diseases, like high blood pressure, ulcers, gallstones, anaemia, headaches and others. The reason why they did not relate their problems to begin with is that it is culturally accepted that Uzbek women are not supposed to complain about their health problems.

Gauhar, 39 years old, explained it:

"Before it was that to be a sick woman was a shame and a disgrace. My husband told me when I got sick that he would have left me. He didn't need me if I hadn't been able to cook and wash and clean. Therefore, he never helped me when I was sick. I had to cope with my sickness and with home and children even when I had a high temperature. But now as he has become older he probably has realised that he needs me, that he needs someone to help him at his older age. So he started helping me around the house, especially when I am sick."

Another woman Asal, 39 years old, said:

"My mother always told me never to complain about my health, especially to my husband or his relatives. If he or his mother found out that there was something wrong with me they would have tried to get rid of me. That was not

true, I know my husband never abandons me, but this is always in me, from my childhood, my mother's voice."

Shohista, 38:

"When I married, my mother told me not to tell my husband that I had vitiligo (a skin disease).[6] I had it from my childhood but nobody knew, because I always put makeup on my hands and feet in order to cover the spots. I managed to live like that for 25 years. I never went swimming or anything like that. And when I married I concealed it from my husband. I don't know what was I thinking, my parents begged me not to tell him. So we lived for two years, I gave birth to my son. And then one of his relatives had found out from my medical records that I had this disease. She made such a fuss out of it. They blamed me and my parents that we deceived them by not telling the truth. So he divorced me. I felt so miserable. Why did I listen to my parents, if only I told my husband he would have understood or he not married me at all?"

Thus it is very difficult for Uzbek women to admit to strangers that they have any kind of health problems. When they are young they think that any deviation from the norm could influence their chance of marriage, and then this way of thinking becomes so deeply rooted in their consciousness, that even when they grow older their first reaction to the question about their health, they think, must be positive.

Women measured their health according to a very low standard. Too much concern about somebody's health is seen as inappropriate in Uzbek society. It must be mentioned that the share of country's population that declared their health problems during the medical survey in 1996 was also very low. Only 5.6 per cent of informants said that they had been sick in the last 30 days (World Bank, 2003:87).

Twelve out of twenty women interviewed did not consider chronic diseases to be a state of illness. They accepted it as a part of the ageing process. One woman, Shirin, 50, insisted that she was perfectly healthy although she had hypertension and headaches,

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6 Among Uzbek indigenous populating, vitiligo (*pes*), is considered as a shameful disease. I was not able to find out the real reason for that notion. Women just said that because it was considered untreatable and inheritable, people with vitiligo had a very small chance to get married (both male and female)

and had undergone a cholecystectomy (removal of the gall-bladder by operation) a year ago. She said that her headaches were due to hypertension, and her hypertension was due to ageing, which she considered normal and therefore she had to accept it as it was.

She said she did not seek medical help for her condition because:

> "I know, exactly what doctors would prescribe – strong diet, '*papaverin*' and '*magnezium*', and so on. My father and mother took these medicines. They didn't cure them, but made them addicted to medication, that's all. Mother always carried a full bag of her and father's tablets. I do not want to work for pharmacology, if I have a headache I drink green tea or herbs, or I take a nap. You need a little bit of rest, sometimes thirty minutes is enough...I know if you embrace the illness then you become an invalid...'it hurts here, it hurts there' and then you will not be able to do anything, just think all the time about your illness.... It is when you think or talk too much about disease it will finally occur."

The majority of women-respondents did not consider colds and flu to be acute diseases. For women being ill with colds and flu does not mean the presence of serious illness. Only when they cannot get out of bed, or must go to see the doctor, or must stay in the hospital, they consider themselves to suffer from an illness. Thus women do not think of some kind of deviation from the normal state of health like colds, headaches, PMS, stomach-aches etc, as unhealthy conditions. This correlates with the studies of Blaxter, (1990), Calnan, (1987). The respondents reckoned that these conditions are something that happens to everyone sometimes in their life, they have to be expected sometimes, and therefore it would not be feasible to prevent them. Such conditions must not be described as diseases; they do not need special treatment and should be considered just a part of being alive. Such an attitude helps women to cope with such health problems, by not paying too much attention to them and deal with them as they occur.

When women were asked what they considered to be a serious condition, the majority referred to such symptoms as high temperature, fever, vomiting, and weakness that makes them unable to get up. Ruhsora, 50, said that she had been doing her housework even when she felt weakness and dizziness until she once just collapsed and was taken to the hospital, where she was diagnosed with severe anaemia, fibroids and genital inflammation. She had to undergo a major operation – hysterectomy (the surgical removal of the uterus). She stayed in the hospital for one month and for three

months she had to stay in bed at home and avoid any housework. She said that only after that incident she started to take care of herself.

Such patterns were very common among women I interviewed. Nigora, 40, told her story how she collapsed after doing her domestic responsibilities while having a severe back pain for three months, because she attributed the pain to regular postnatal complications and therefore tended not to pay any attention to it. She also had been admitted to hospital for a month and then spent six months bed-ridden at home after that incident, because of the complications. Yoqut, 39 did not pay any attention to her constant weakness, until she was diagnosed with heart disease due to severe anaemia. All those examples highlight that Uzbek women tend not to pay attention to their ill health condition. Such behaviour leads to aggravation of the disease that could be easily treated if detected earlier. Thus, according to Calnan's (1987:39-40) comparative study of middle-class and working class women's health, the presence of signs and symptoms of ill-health was the norm and did not usually involve a disruption in daily activities. He argues that because of the pressure of family responsibilities or work commitments women had no choice but to carry on working even if they felt unwell.

The respondents in my study explained their behaviour in a way that they did not want to be considered as trivial complainants about their health. Even if they suspected something was wrong they rather waited until the symptoms disappeared or became so severe that there would not be doubt that they were really ill, and could not be seen as an excuse to avoid their responsibilities. As one of the respondents said:

Yoqut, 39.

"at least I felt that I finally gained a right to be sick and seek medical care."

Uzbek cultural upbringing predetermines that women should suffer in silence, never complain about their health and that women must work until they are worn out.

Mariam, 52, in her interview gave her opinion on the whole Uzbek nation:

"All Uzbeks think: 'ah, it will pass.' All Uzbeks think this way. Nobody thinks about their health, nobody works to maintain their health. Preventive measures – no. Uzbeks are scared to disturb the doctor. Uzbek women always

hide their diseases; they are very bashful and hyper-tactful. This is inadmissible. One must look after one's own health."

Several respondents mentioned culturally conditioned shyness. None of the respondents themselves showed any signs of shyness, however, when talking about the overall situation relating to health issues they admitted that Uzbek women very often try to conceal their diseases even from doctors. Women's answers to questions about menstruation and menopause, sexual transmitted diseases, where short and simple. It was noticeable, that women were reluctant to talk about it.

Only three women from the sample admitted that they had the menopause: Mariam, 52; Iroda, 42; and Yulia, 54. None of the three women admitted any adverse body reaction, or emotional changes. Iroda said that she noticed the weight gain since menstruation ceased two years ago; however, she never noticed any hot flushes, or any other signs of menopause.

"Yes, it is difficult to accept that you are not able to bear a child any more. But it can't be helped, right? I only noticed that my terrible headaches have gone. I was racked with head pain since the adolescence. But after the *climax* (menopause), *tfu-tfu*, I feel much better. There were periods in my life when I used to take the painkillers almost everyday for five-six days in a row, and after *climax* it ceased."

Mariam said that she noticed heavy bleeding. When she went to seek medical help, the doctor told her that it was due to the menopause. So she accepted it, but never tried any medication to ease the condition.

"They just told me, that it will be two three times and then cease at all. I do not worry about it, that is the natural process. You just need to endure it. Every woman has to face it, no need to make fuss out of it at all".

Yulia, did not want to discuss this subject. She only said that:

"Whatever problems you have with your health now, the doctors attribute it to *climax* (menopause). I don't want to hear things like that. I

mean, if you have a real problem they tell you not to pay attention, because it is due to *climax*. They are very sceptical, they think I exaggerate it."

Shirin, 50 said:

"No, it is too early. No, I do not yet feel anything. I think it is too early"

Sultanat, 54

" No. I do not have anything like that yet."

Thus although the sample age is considered as peri-menopausal, women were reluctant to talk about it. The literature on women's health problems in mid-life suggests that many women would complain about or at least discuss this problem. I prepared questions designed to get women to talk about their conditions. However, little information was forthcoming. Whether this was because of women's shyness, or because women did not suffer any discomfort in regards to menopause remains unclear. More far-reaching research is needed in this field.

Chronic or infectious illnesses such as heart disease, kidney and liver disease, anaemia, were considered by the respondents to be serious. However, women usually tried to avoid the word cancer, referring to it by the first letter 'R' (*rak*), or just 'that bad disease'. Cancer is considered by many Uzbek people to be incurable; therefore, if someone is diagnosed with this kind of disease it is considered to amount to a death sentence. Women are very superstitious about cancer. When this question was broached during the interviews women's reaction was usually first, to spit over the right shoulder, then to knock the table or the chair (i.e. something made from wood), before proceeding with the conversation.

The data reveal that despite many health-related problems the respondents have shown their own health was a lesser concern in comparison to their family responsibilities. It is not that they did not value their own health at all, but due to their traditional upbringing it is considered that excessive concern about individual's health is unacceptable.

Those women who said they were unhealthy had an official confirmation of invalidity or a chronic disease (Leila, Yuliya). They demonstrated a profound medical knowledge in relation to their illnesses, and spoke freely and openly about their health

problems and choices of treatment. When asked what would be the best strategy to adopt in order to regain and maintain good health, the most frequently named strategies were positive thought and attitude, changes of diet and life style and right choice of treatment.

Most women did not consider themselves to be in bad health as long as they were able to fulfil their responsibilities at work and at home, which concurs with the other research findings elsewhere in the world (Doyal, 1995; Miles, 1991; Smyke, 1991). The majority of the respondents felt responsible for maintaining their health in order to be fit and be able to carry out their responsibilities. (In the next chapter I will analyse how family and work responsibilities could undermine women's health). Here I will give just an example of how concern about their family responsibilities can push women to take radical measures in relation to their own health. Shirin, 50 decided to go through with the cholestectomy, despite receiving medical advice to 'wait and see'.

> "When I had a gall bladder inflammation I went to the hospital, they made the tests and said that I had a gall stone, but they said that if the attack passed there was no need to operate, and it would have been better to left it as it was. I insisted on an operation, because, I didn't want to suffer such attacks again. I was not able to move. I was bedridden. I was not able to afford to lie in bed. They (doctors) told me to rest for two three weeks and follow a strict diet. I was not allowed to carry heavy things in order to prevent future attacks. But I decided to go ahead, just cut it away, and forget about it, and go back to normal live. I cannot live with all those restrictions, who would do all the work otherwise? ... And I went for it. Ten days I was in the hospital, the first days were very awful. But now I am quite good. (*Tfu-tfu-tfu*)"

Shirin has to bring up her grandson, five years old, because her daughter died two years ago. Therefore, being in the position of a chronically ill person was not for her, and she chose a more drastic but quicker way to deal with the disease, in order to be able to fulfil her family responsibilities.

The general impression from this data suggests that concepts of health for women are ambiguous. On the one hand it is assumed that women must be healthy in order to carry out their family responsibilities. On the other hand women are not supposed to worried about their own health and as a consequence they have fewer opportunities to take preventative measures or look after themselves in order to maintain good health.

During the interviews I also asked women what they thought about the fact that women live longer then men do. Not every respondent answered that question but some of them had their own opinion on this subject. Thus Sultanat said:

"Men don't cry.... I think, that is why. Women cry a lot, talk a lot about the vicissitudes of their destiny. With the tears women are saved from the disease. Men never show their emotions, they keep everything inside, they do not share even with their close friends, not to mention their wives. In a sense, they keep everything inside, and then it piles up, and finally comes out as a stroke or something. And even then they try to hide it as long as possible, when it is too late to amend the outcome."

Kamola:

"All men are like small children, they pretend that they are so brave, and fear nobody, but then they are scared to go to the doctor. I never was able to persuade my husband to go to the doctor when he had a gumboil. He waited till he was not able to speak. You will not believe it. But he was just scared! He would suffer two times worse, but he would not go to the doctor. And even if he finally sought medical help he would not comply with the medical treatment as prescribed by the doctor, he never lays in bed, whatever it is - flu, a fever, what ever- he would go to his work. When I was pregnant for the first time, somebody told him that he would have to give blood, if the delivery went wrong. So, he, such a coward, he was so upset with it. Then I told him that my mother would have given her blood in case it was needed, only then he relaxed."

Gauhar:

"I believe that men are too lazy. They eat a lot, but they don't do any physical exercise. Their body is lazy, the whole organism is lazy. Could you show me a man who would voluntarily go on diet, or do any cleansing? No. They love their bodies as they are. They never have a feeling of shyness about their bodies. They feel like they are the kings of the world, and nothing could happen to them. They never think about preventive cares, therefore, when it strikes it is usually too late."

Mariam:

"I think men die from fear. Take for example my husband, when he gets any kind of minor disease, he feels like he is dying. That's all! He is finished! He has the terminal stage of the worst diseases in the world! He is dying, nobody could help him! The end of the world! With such an attitude no wonder they die so easily. My son is the same. My poor daughters, when they are ill they are just ill. They take all the prescription, all the treatments needed, I do not have any problems with them, though they get sick very often. I think women take it as unavoidable; they are ready for any suffering, because they know that with the pregnancy and birth they would need to suffer a lot. But when my son is sick that is disastrous, he will not suffer in silence he will call me every minute, he becomes so irritable".

Munisa:

"I believe men have a lot of pressure on them. They must think about their own families, about their parents. Everybody expects something from them. Thus, I have worries, certainly, but I think my husband must provide for all of us, I rely on him. Women do not care where a man finds the money - he just must. That is his responsibility. His parents also think the same, his sisters think the same, and his mistress also thinks the same. And he must pretend that he is able, he is in power. You know that image that he is a genie from a bottle. My husband twists as he can in order to provide for us, but I am scared, I think he needs some rest, but he cannot rest, because it is going on and on. Women concentrate on their own bodies more than men, men have other thing to do, I think".

There is a great deal of discussion as to why women live longer, although they suffer more (Macintyre, 1993; Popay and Groves, 2000; Pollard and Hyatt, 1999; Falik, 1996; Doayl, 1995). The above excerpts from the interviews show the opinion of lay individuals in regards to that subject, which shed light on the attitudes of indigenous Uzbek women. Their sense of humour, and the fact they try to find the answers to such questions, proves their concern for everybody's health.

4.2. Choices of Medical Treatment

4.2.1. Introduction

A woman's biological characteristics and inheritance, together with the institutional, social and psychological processes, affect her health and well-being (Moss, 2002). In this sense the ability of women to access different patterns of medical treatment inform the multiple ways in which women's health behaviour is shaped. Independence made a wide range of therapeutic alternatives available to the population, providing different kinds of treatment. There are three categories of treatment that women choose: treatment by a medical professional doctor, treatment by a traditional (folk) healer, and self-treatment. The type of disease and seriousness of the illness shape individual actions regarding the choices of medication. The cultural environment surrounding women's lives affects their behaviour, knowledge, beliefs and choices of treatment. For example cultural taboos make women embarrassed when discussing sexual health problems could also have an influence on women's health seeking behaviour. Because of discomfort and embarrassment women could choose not to consult medical professionals, hide their problems and suffer in silence, which in turn could lead not only to severe physical conditions but emotional hardships as well. Economic circumstances are another factor when choosing medical treatment.

The main objective of this section is to analyse the range of variations in patterns of thoughts and behaviour in relation to choices of treatment. Furthermore I attempt to identify the primary factors that affect women's decisions to choose one rather than another form of medical treatment. The data suggests that some women would rather utilise modern medical assets whereas other women are inclined towards unconventional forms of treatment, and yet another category of women forego either choice and employ self-treatment. Some women are systematically trying various therapies in search for help. There is a range of factors that could influence women's decision, such as access to information and facilities, family up-bringing, education, cost and financial resources, past experience, belief in the efficacy of treatment, etc.

Most women respondents think and behave in relation to health and illness in different ways. Even taking into consideration cultural peculiarities and the influence of customs, traditions and religious belief and bias, and educational background, there were a great deal of both logical and irrational elements dominating women's thinking on health.

Women were not always able to explain their preferences and decisions to opt for one or another treatment. However, the data reflects women's diverse attitudes towards selecting between modern and traditional treatments.

4.2.2. Health Services Utilisation

This section presents an analysis of women's choices between state and private clinics and the reasons that affected those choices. The data extracted from the interviews help in many ways to understand women's perceptions and their decisions towards their choices of utilisation of particular medical services. The data shows the diversity of choices of treatment among the respondents. Some women preferred to utilise modern medical resources as their first choice of treatment when others were more prone to seek other medical resources instead of modern ones, depending on their material circumstances, social pressure and personal knowledge. As elsewhere in the world, in Uzbekistan, medical services provides people with diverse and complex alternatives to choose from, although none of them could offer effective medical cure for all health problems. In such a situation of eclectic health multiplicity, women must try to define what are the most effective approaches from a variety of existed opportunities. As noted above the health care system in Uzbekistan has been moving from central planning and government financing to a mixed public and private system since independence in 1991. As the government health budget has shrunk, people have increasingly had to pay for health services and drugs. In 1995 the share of paid services in the public health budget reached 5.8 percent (Population Health in Uzbekistan1996:8). Socially vulnerable categories of patients however, retain the right to obtain 100 percent free medical care. In principle, services for prenatal and delivery care, vaccination, tuberculosis treatment, acute respiratory infections and diseases like diarrhoea, diabetes, cancer and infectious diseases are provided for the population free of charge (Marni and Klugman,1999:31). However, services, equipment and facilities are significantly limited and insufficient. It must be mentioned that many respondents revealed that when they needed medical professional help they chose to turn to the regional hospitals as their first choice, although these kinds of medical institutions were designed for more complicated cases, and patients needed to be referred by the local polyclinics. However, women explained that if they had an acquaintance, or some other way to get to the central hospitals it was better to go straight to the hospital, in order to save time and money.

During the interviews respondents were asked what preferences they had when seeking medical help and what influenced their decisions. Women named different factors including their financial resources, their experience, the advice of friends or relatives etc. The respondents admitted that because of many competing demands arising from their personal lives, their finances and family situations, they needed to resolve their health problems in a way that was simple and less complicated. Thus, their health-seeking behaviour assumed a pattern involving minimal procedures and the extensive use of personal and social resources. Most of the participants indicated that they prioritised their ability to continue their daily activities. Therefore, speed, convenience, cost effectiveness, and ease of access were considered the main requirements when choosing the treatment. Several respondents revealed that quality of service and effectiveness of treatment was considered more significant in the selection of health services then any other reasons.

However, for others their income and the cost of treatment were the most important determinants of women's decisions in seeking treatment. The emergence of private clinics in Uzbekistan after independence provided people with additional choices. Taking into consideration the deteriorating conditions in the publicly financed clinics, the new private clinics and hospitals expanded the scope of people's options. The respondents who applied to private doctors pointed to the fact that in private clinics the doctors and medical personnel were more polite and friendly, they spend more time with patients, and people spend less time waiting in line. Rano, 38, said that even though her salary was too small, and in fact private clinics were unaffordable given her family budget, she preferred to use private clinics anyway. She said that in private clinics frequent visitors usually were granted discounts. The doctors expressed their understanding of their financial situation and suggested where to buy cheaper medicine, or how to manage without expensive medicine. She was pretty satisfied with the services of private clinic. The fact that the clinic was situated close to her house also influenced the decision to opt for a private clinic. When she treated her son's skin disease in a state clinic, she had to travel more than an hour to the medical institution. It was very time-consuming, her son usually became very tired and she spent a great deal of money on transport. Concerning the money she said that her relatives would usually support her with money if she really needed it for the treatment, she also gives private lessons, and her husband managed to make some money on a side. In relation to this, some women choose in favour of private clinics even at a higher price for medical treatment.

It must be mentioned that in some cases women reported that due to the fact that not all patients could afford the medical treatment in private clinics, doctors charged them according to subjective assessments of patients ability to pay.

Women evaluated the efficacy of their initial treatment, in relation to results, costs, and effort and considered if they better opt to try a new one or stay with initially chosen strategy. Today there are many private clinics and hospitals with different medical trends. Patients are searching for better medical care and appropriate treatment. Not all medical services are reliable and safe; most of them are very expensive. However, women got the opportunity to choose medical practices according to their means and resources.

Women also mentioned that in private clinics the facilities were clean and medical equipment was better sterilized, and the cleanliness of medical equipment was mentioned as one of the significant issues in relation to health. Thus the respondents indicated that they would rather pay a higher price for medical treatment in private hospitals and clinics, if they had the financial resources.

Shohista, 38

> "There are no good doctors or modern equipment in the state clinics left. Everything has changed since independence. In the private clinics there are no queues, the equipment is very good, the doctors are all very nice, it is clean there. They hire young professionals. They are aware of the modern medical trends. The treatment in these clinics is not cheep at all. But I prefer to go there. I don't go to the state polyclinic now. Recently I went there because I needed a medical certificate for my work. I didn't go through the entire check-up as I was supposed to do. I just paid the money, 500 som (50 cents), and they gave me a certificate. Nobody even bothered with the procedure to check me before giving a certificate."

Patients' choice of treatment depends on several factors, but the cost of treatment was mentioned as the main problem. Not all respondents had enough money for medical treatment; therefore, most of the respondents had to rely on whatever medical facilities were available to them.

Yuliya, 54:

> "Previously we used to have a special clinic where all my family was registered. But our district polyclinic was not so bad either. It was possible to buy over-the-counter medicine on prescription and it was not very expensive. Today I cannot afford to buy basic medicine. I run out of *validol, carvalol*. If I buy the medicine or seek medical treatment I will be ruined. If you are registered as an invalid you will be treated free of charge, but you have to bring your own syringes, medicine, everything you have to buy yourself."

The study reveals that apart from official payments, informal, out-of-pocket payments have become widespread in Uzbekistan's health care system and account for most of the health expenditure (this practice has survived since Soviet period, when patients presented gifts to pay their respect and showed their gratitude for the good job done by the doctors). Falkingham (2004:250) stresses that:

> " Although there is a tradition in Central Asia of presenting monetary or in-kind gifts to caregivers as a mark of gratitude, this voluntary tradition is being supplanted by provider generated demands for payment as a precondition to treatment."

The respondents pointed out that they usually paid under-the-table fees to the doctors and nurses even in public health institutions, although they were not officially sanctioned. The extent and magnitude of the unofficial payments is unknown. However, almost all the respondents admitted that they paid unofficially in cash, gifts and presents or in other ways for the medical treatment at some points in their life.

One of the respondents, Saida revealed that although she was entitled to be registered as an invalid, the bureaucratic system was so tough, that eventually she had to pay money and give some presents through an acquaintance to the members of the medical committee in order to obtain a certificate of invalidity.

Several respondents were convinced by their personal experience that medical professionals were less sympathetic and responsive, and that treatment was of a worse quality, if they did not pay for treatment.

The most frequent comment on this issue among the respondents was that even if doctors did not ask for payment for their services, it would have been better to pay, in case they needed their help next time. Ensor (2004) assumes that unofficial cost

contributions are one of 'strategies employed by individuals and institutions to ensure their survival'.

Some respondents justified medical professionals for accepting money for treatment. One of them – Iroda - mentioned:

> "The average salary of doctors is around 16000 Sum. This is ridiculous. There is no way a person could survive on such an amount of money, not to mention a whole family. Therefore, doctors and nurses and everyone would accept payment and gifts, until they start earning enough money for a decent life."

The respondents, who happened to incur such unexpected expenditure for medical treatment and drugs, reported that they did not have any adequate social protection by the state or local authorities. In most cases, they used informal support from relatives and friends. Some of them had to borrow money and were obliged to sell some of their property. In such cases the respondents mentioned that they had to limit their other expenses, including food.

Another negative issue mentioned by the respondents was their concern with the quality of medical care, attributed to the fact that highly qualified medical professionals have left state hospitals for private clinics, or for other more lucrative occupations, because wages have been relatively low in health care system. As was mentioned above, a great deal of medical professionals of the non-indigenous population fled the country after independence. The majority of respondents pointed out that in state clinics the equipment was outdated, medical personnel was rude, the patients felt uncared for. The quality of services in public clinics is undermined by inadequate basic equipment and drugs, as well as a demoralised medical staff inadequately trained to be sensitive to patients' needs. For example, Shohista said:

> "I go to the state policlinic only when I need a sick leave. They are quite happy to give it to me for 500 sum without any check-up."

Mukaddas, 39 shared her experience in state polyclinic:

> "When I had a pain in my leg, I went to our state polyclinic, but they told me that the doctor was not able to see me, because it was too late in a day. I had to come the next day. I just turned around and went to private clinic. The doctor

there accepted me at once. But I have a strong belief that one needs an acquaintance everywhere, and among the medical professionals most of all."

Failure of publicly funded polyclinics and hospitals to provide patient with adequate treatment and facilities affects women's choices and diverts them to seek other medical treatment. Another issue is that it is generally known that modern medication can cause the side effects, especially if it used as part of a long term treatment. This fact also could contribute to the fear of taking modern prescription medicine.

Leila, 46, has suffered from a chronic bronchitis from a very young age. She was treated in the hospital every six months.

"What can I tell you? I have problems with my heart today because of all the treatments I have taken. My kidneys and liver are also in a very bad condition. I've lost almost all my hair due to hormonal drugs. I was young and ignorant, how should I have known that all these treatments were so harmful. Frankly speaking I haven't been cured from lung disease, with ageing you grow wiser, and do no take all this filth. In 1987 I was in the hospital. My doctor was writing a dissertation, she used me for experiments. I was like a guinea pig for her. During a bronchoscopy, which was performed on me, they injured the walls of the bronchi. I also developed an allergy to the medication they gave me there. I refused to undergo bronchcopy a second time and refused to take hormones, so they discharged me with the statement that I refused to take any treatment."

Apparently ineffective and painful treatment can divert patients from the modern treatment and persuade them to move to alternative systems. Patients' previous experiences with regard to side effects of modern medicine could also prevent them from taking conventional treatment. Respondents expressed a dislike when doctors prescribed the drugs and did not warn of their side effects.

Oidyn, 44

" I don't know, when I see how the doctors treat other people, I do not trust them. I know there are good doctors but I have no time to find one, therefore I use self-treatment. I read a lot of medical literature, but didn't find yet what I needed,

but to find good doctor is even more difficult. Doctors are not interested any more in their profession, they just work for money, and it turns out, that what's more, today, apart from all other problems in regards to treatment, you have to pay for the treatment."

Although some women were disillusioned about modern medicine with undesirable side effects, many women expressed their strong belief and confidence in the efficacy of modern treatment. For instance Rano, 38, expressed her disappointment with alternative therapy, after bad experiences in the past with the herbalist who worsened her father's condition. She is on very good terms with modern medicine. She said that people with acute conditions should definitely go to professionals, because otherwise one might waste time and then the condition could be irreversible.

The evidence from a number of cases shows that women are gradually beginning to turn to private medical facilities. Significant problems related to the low quality and efficiency of the state health care system results from financial problems that these services have faced in recent years. The introduction of modern medical technologies has been restricted in public services; salaries of the medical personnel steadily decrease. Highly professional and experienced doctors either abandon their jobs in state clinics and get jobs in private clinics or quit their profession in favour of a better paid occupation in business. A great number of non-indigenous specialists have already left the country.

With regard to the problems of health services, the main problems highlighted were the cost of health care, and the need to supply one's own food and bed linen in the hospitals. Thus accessibility to reliable health services depends on the ability of the patient to pay. The situation with private services and practices is yet inadequate. There are a many of shortcomings regarding the regulations; for example there is no system to cover poor people's access to private practices, like insurance.

4.2.3. Self-Treatment

Increasing numbers of women around the world use self-treatment and self-diagnosis in response to illness. Studies on self-medication suggest that it is perceived to be 'convenient and economical and a first step before seeking professional help' (Stevenson, et al. 2003:513). This section examines home remedies in relation to women's role in domestic labour as caregivers. The aim here is to identify, examine,

and describe the self care women perform, explain how women make the decisions to initiate such behaviour and explore women's perception of the efficacy of their choices.

The data collected provides insights about how women manage acute and chronic diseases of their own and their family members with home remedies. The data suggests that women play a dominant role in using home remedies to treat family members and prevent illness. During the interviews I asked women why they did not avail themselves of professional treatment when they or their family members became sick. The most important reason was that self-treatment was considered to be the best treatment. Some women replied that they have to wait two to three days for the symptoms to disappear, without any interference. Fifteen out of twenty women said that they followed the recommendations they have received at the last consultation. The majority of the women (15) said that the cost of recurring consultation with the doctor was not worth it, therefore they just followed the instructions they had previously been given. Women used a complex system of medical treatment and employed it within their families, despite the availability of lots of professional medical resources.

Among the reasons for self-treatment women stated that effectiveness and safety, affordability and availability of home and over-the-counter remedies influenced their attitudes towards using self-treatment. It is generally known that people will treat severe acute conditions of illness in the state hospital with the medical professional specialists whereas minor conditions like headache, stomach disorder, would be treated at home by home remedies as the first treatment option. Most respondents reported that they preferred self-treatment as the first choice of treatment if the symptoms were more or less familiar. The respondents described a lot of home remedies how to treat minor conditions such as fever, colds, etc, from taking hot baths, mustard plaster, hot milk, honey to taking a shot of vodka with pepper. Almost all these remedies are designed to make a person sweat; after these procedures a person is supposed to recover quickly.

Yoqut, 39:

> "I treat children with soup or hot milk or raspberry tea before bed, and then wrap them up in a woollen blanket so they sweat during the night. Then I change their nightwear and in the morning they are quite healthy again."

Iroda, 42:

"I take a shot of vodka, and then drink a lot of hot tea. Then go to sleep. I put on something warm and cover myself with the blanket. Next day I am fresh and sound."

Women were prepared to meet the need for immediate symptom relief and return to their daily activities.

Nigora, 40, and Shohista, 38, believe that the sauna is the best way to cure colds, fever, and flu. Nigora also goes to the sauna on a regular basis as a precaution and to relax.

In Uzbekistan starting from a very young age girls are usually involved in the care-giving process when elderly members of their family and their siblings are ill. Thus, during childhood Uzbek girls learn and accumulate information about the use of medicine available for the cure of simple and minor discomforts and illnesses. They use this knowledge when they grow up, and the society expects women to retain their role as primary care-givers. Most respondents reported that they made most decisions concerning the treatment of minor illness with little consultation of medical professionals. Before making any decisions on self-treatment women usually wait for a period time to see if symptoms were worthy of treatment. Women derive knowledge about symptoms of illnesses from variety of sources.

Munisa, 38, described her sources of knowledge as:

"I think it is my own experience. I can feel if it becomes something serious or just minor disorder. We also discuss with friends all those symptoms and diseases. If I feel something unfamiliar I call my friends and relatives, everyone at hand to help with advice. I also have some books, and I keep some cuttings from magazines. When there is some kind of epidemic of flu or hepatitis the rumours will spread very quickly, so I know what symptoms to look for."

Women buy the first type of medicine for self-treatment of such slight illnesses as coughs, diarrhoea, stomach upset and headaches at the state pharmacists. The efficiency of pharmaceuticals is widely recognised and appreciated in Uzbek culture. The majority

of women (18) reported that if a medical practitioner once had diagnosed them with any disease, the next time they would bypass a visit to a doctor and proceed directly to self-treatment. Respondents tend to use this as the most practical way to solve the problem. Most respondents admitted that it was the most convenient and least disruptive way that required a minimal amount of time, money, and effort. However, the types of symptom, past experience, available resources and women's personal beliefs affected the process of noticing symptoms, identifying symptoms and choosing a treatment path. The respondents indicated that if they were able to recognize the symptoms of a disease with certainty they were less reluctant to seek medical advice and opted for self-treatment, even if they had an established relationship and access to medical care. Only if women were uncertain about their self-diagnosis they consulted a medical professional in order to be sure and to find out the specific cause of the illness.

Consumer medical literature guided many respondents in their self-treatment: Oliy, 51:

> "I always look for information about any symptoms I have. Even if I consult the doctor, I nevertheless try to find out about my condition in the medical literature. I must know exactly what is going on in my body. It is not because I do not trust the doctors, but I feel safer if I gather as much information as possible."

When asked to enumerate the first aid medicine that they keep at home respondents showed me their medical chests where iodine, surgical spirit and bandages for cuts, burns and minor wounds; medicine as a first aid for heart problems; syringes, as almost all women are able to perform injections was found. There is a wide choice of over-the-counter drugs and medicine that are freely sold in state and private pharmacists and drugstores without prescription.

The second type of medicine that women use for minor illnesses is herbal remedies that almost all respondents have at their disposal. The herbs are widely available in the market, or women can pick them up during the summer months in the mountains. Women keep these products available so that they can use them in case of sudden health problems.

Women showed a profound knowledge in relation to health and treatment. All the respondents had their own ideas regarding medical treatment and taking medication. The finding suggests that major diseases identified by respondents included upper

respiratory infections like flu colds, pneumonia; diseases related to poor digestion – liver, gall bladder, kidney, stomach disorders, as well as anaemia and hypertension; and more acute infectious diseases like hepatitis, measles, meningitis etc. Most of these illnesses could be treated at home, with exception of meningitis and hepatitis, although some respondents said that they treated their children's hepatitis at home, because of bad facilities in state hospitals (Munisa, 38, Mukaddas, 39).

The respondents also mention preventive measures to maintain good health with self-treatments. The preventive methods women mentioned were hygiene, an adequate and balanced diet, cleanliness and moderation. In relation to cleanliness the respondents referred to two categories. The first was clean environment, personal hygiene, etc. The second category was inner cleansing. Many respondents emphasised the importance of cleansing procedures in regard to health.

In Uzbek culture the ideal season for cleansing procedures is the spring. Women mentioned different ways of purifying the body. It is believed that cleansing procedures help to get rid of impurities accumulated during the winter months, as it is believed that people move less, and eat a lot of preserved food in winter. Some women adhere to the ancient tradition of drinking the herb *senna* during one day, while abstaining from food, or of eating a lot of green vegetables for several days. Other women follow more radical medical procedures like fasting and enemas. Enemas have become very popular in recent years. It is usually introduced everyday for one week, then every other day for the second week, and then one in three days until the end of the month. Fasting and enemas are used for both preventive and curative purposes. Almost all respondents mentioned them when they were asked about what preventive and curative measures they were taking in order to maintain good health. Allergies, intestinal infection caused by food poisoning, skin infection and many other illnesses were treated with strict diets or fasting and enemas. Several women mentioned methods to clean the liver. As was mentioned above liver diseases like hepatitis and gall stones are very common in Uzbekistan. Almost every family has a member who had hepatitis or some other liver disease. Traditionally the best way to clean the liver and gall stones is a procedure called *Dubash*. Early in the morning around six o'clock, a person should lie in bed on his right side with a hot water bottle close to the liver and drink one and half litres of mineral water. This procedure must be performed six days in a row, and repeated every six months.

Women also use cleansing procedures to heal allergies. It is believed that allergies are caused by pollution, and bad diet.

Most women cure childhood diseases with herbal remedies in order to avoid strong prescription drugs like antibiotics. Diarrhoea and stomach upsets are usually treated with a broth of rice and a strict diet. In more persistent cases women advised to use the water in which the peel of a pomegranate has been boiled. For constipation the respondents said that they usually used the water in which a dried fruit like apricots and plums had been boiled. Kamola, 43, treated her two children when they had hepatitis with herbs.

> "I try to avoid drugs, especially as far as the children are concerned. I think they give more harm then benefit. Everybody knows, what herbs to take for hepatitis, it is not even the herbs that help a lot, but the strict diet."

However, if the symptoms persisted and became more severe, women re-evaluated the efficacy of their initial strategy and considered to seek professional advice, the opinions of friends and families and the medical literature. The strategy of seeking information to add to their previous knowledge and strategies from different sources help women to clarify the diagnosis, and create future approaches to treatment. The use of one or another home remedy is usually based on the experience of the parents of women and the older generation, as well as their own knowledge extracted from books, magazines and other media sources and their past experience. By contrast one participant reported that she did not tend to read medical literature, because she usually matched the typical symptoms of various diseases to her conditions and this approach resulted in uncertainty and made her a hypochondriac (Leila, 46).

There are many advertisements for different brands of medicine on TV, in magazines and newspapers in Uzbekistan nowadays. The efficacy and safety of widely advertised medical products is dubious. However, three women reported that they used advertised products to treat their symptoms on the basis of self-diagnosis (Munisa, 38; Nigora, 40; Iroda, 42). One of the participants reported that she bought medicine from providers, who sold their products door-to-door. Advertising messages claim that people are capable of solving their health problems by using their products without consulting medical professionals. Seven out of twenty women reported that they occasionally used medical products that they had seen were advertised in magazines and on TV. Thus if a

woman's priorities were convenience and ease of access she chose to buy advertised products, despite their high cost. In contrast participants with limited financial resources would give priority to cost-effectiveness and would seek medical advice.

The fact that the respondents with a high level of education had studied civil medicine in the institutes and universities, where it was a compulsory subject for all students, also contributed to their understanding and awareness of health and illness.

The participants showed a broad knowledge of different symptoms of illnesses. Women rely not only on the findings of scientific studies but on personal experience as well. Women explained illnesses and their causation on the basis of a range of ideas from Uzbek cultural traditions to modern medical concepts. Consequently women have a pluralistic attitude when deciding on choices of treatment. Life experience, the interaction with relatives, friends and media are the sources used by women to develop their knowledge.

However, there is always a possibility that symptoms are misinterpreted and continue treating an illness with inappropriate home remedies. The consequences in such cases could be damaging. Fifteen out twenty women reported that they would go to seek professional treatment only if self-treatment failed to improve the condition. Especially when it their own health is concerned women usually opt for a tactic of wait and see, until the symptoms become so severe that they can not be tolerated any longer. Five women, both housewives and employed, reported that they chose self-treatment because of a lack of time to go to the hospital. However, incorrect self-diagnosis and the inappropriate use of self-treatment could delay appropriate treatment and contribute to the development of chronic forms of disease.

Women admitted that they tended to wait for a period of time before making any decisions about treatment requirements. Thus if the condition was tolerable women used to monitor it and look for further signs and symptoms over some period of time. If the symptoms became identifiable they would seek more information from either the medical literature or friends and relatives. Not all respondents contacted their doctors and sought medical advice at the stage when they could identify the symptoms, due to lack of time, or in order not to bother the medical professional, despite the fact that they had access to health care. Mukaddas, 39, reported that because of her intense work she was not able to seek medical aid, when she had a pain in her leg. She tried different means and remedies that she thought could improve her health. She tried hot baths, applied compresses of honey and urine, until she was not able to move. She said that she

was almost sure that the treatment she used could have helped. Then she went to see the doctor, and was told that her condition was very critical. She was prescribed to lie in bed for two weeks and get massages and physiotherapy.

Thus despite the fact that women are very well informed about medicine and treatment, the delay in seeking treatment could eventually lead to serious medical complications. Therefore, the most important requirement is for women to be able to assess the seriousness of symptoms and to be competent in relieving the symptoms without medical professional assistance. In other words, women's ability to judge whether they could handle the problem independently and their assessment of seriousness of disease is equally important.

However, as was mentioned above, such delays in seeking professional advice only concerns women when they are dealing with their own health. In cases of children's indisposition, women usually go straight to seek medical professionals. However, if they are not satisfied with their decision, they usually seek a second opinion or decide not to comply with the treatment regime. Women's own ideas regarding treatment affect their use of professional advice. Mukaddas, 39, said that previously she used to treat her children with drugs and medication but then she switched to herbal remedies despite the doctor's disapproval.

> "My children were sick very often when they were young. I treated them with modern drugs, now, I realise that these drugs had many side effects. Today I try to treat them with folk remedies. I think that my kids spent so much time in the hospitals that I decided to avoid clinics and hospitals, if possible. It is not that I do not trust in modern medicine, on the contrary, I cured my son only with the help of modern preparations."

Women assess the medical prescription and recommendation and evaluate it by comparing it with their own knowledge about the illness. Thus, if women consider the logic of the medical professional to be irrational from their own perspective, or judge the doctor's attitude to be inadequate, they do not blindly follow their advice, but opt for another doctor or medical system. Saida, 51, said that the doctor prescribed her so much medication that she could have been poisoned and eventually died just from taking them. Therefore, when the doctor prescribed her the treatment, she herself selected what she thought was most effective, especially for her children. Saida thought that

biomedicine took very radical approach in dealing with common diseases. Another example of non-compliance is Oidyn, 44:

> "When I have found out that I had I fibroid, I decided not to seek medical help. Because, you know, they told me at once that they have to remove the womb. I don't understand it. They did not want even to try to treat it first. They just didn't want to listen to me, as if there were no other options. I decided that I could manage myself. I started cleansing procedures. I drink the herb infusion *chistotel*. I take a glass of the infusion three times a day before food. I also drink carrot juice in the morning, thirty minutes before food. On Fridays I fast, I just drink melted water. I noticed reduced discharges."

The participants used several strategies when involved in a decision to make a choice between seeking medical professional help and using self-treatment. Some women reported considering their current situation, in other words the availability of resources such as money and time. Other participants weighed up choices and benefits before opting for one or another treatment. Other respondents used whatever was affordable and accessible for them in determining how to manage their condition. In other words the priorities of women to minimize cost and maximize convenience, and take into account life circumstances all influence which route is considered the most practical for women in their choice of medical treatment. The type of treatment each respondent chose was based on information obtained from family, friends, media, and medical literature.

Women's own beliefs in the appropriate treatment must be mentioned as a factor that guided women to opt for one or another treatment. The majority of the respondents believed that natural products were safer, because they involved fewer chemicals, and consequently with fewer side effects, and opted for home remedies and non-medical products as most in line with their beliefs about health. Thus in the new environment of a changing society women adopted the strategies that could easily fit into their lifestyles and accorded with their own thinking about health. Through trial and error and with the help of information they gathered themselves women created their own means of dealing with health problems so that they could act quickly with the resources available to them and a minimal waste of time and money. In order to obtain the best possible results women estimated the value of convenience against the amount of money, time and effort. The consequence of such strategies is that women acquired a sense of being

in control of the situation and confidence that they would be able to effectively resolve the problem.

Thus the findings of the research indicate that women used self-treatment for various minor and chronic illnesses because it was convenient in terms of the time and financial resources required and therefore least disruptive to their current lifestyles. Each woman's unique circumstances (past experience, upbringing available resources, personal beliefs) influenced their decision-making and health behaviour. It should be noted that primarily social networks of friends, relatives and acquaintances influenced women's decisions regarding self-diagnosis and self-treatment.

4.2.4. Traditional Folk Treatment and the Role of Religious Authorities

The data suggests that in recent years after independence the use of the traditional folk system of illness treatment has been increased, due to a deterioration of the state health infrastructure, combined with the inability to pay for new private forms of medical practices. The introduction of private drugstores and pharmacies with imported Western drugs has resulted in a sharp rise of the cost of medicine and treatment, although it helped to reduce shortages of pharmaceutical products. After independence there has been expansion in the numbers of alternative treatments available, and the range of folk treatments offered continued to expand during last decade. During interviews informants were asked for information about which therapies they used, whether therapies were used alone or to complement state medical treatment and how effective they believed the treatment was.

Traditional healing persisted in Uzbekistan during the whole Soviet period. There was no endeavour to integrate the practice of traditional folk medicine with conventional medicine, although traditional medical knowledge and practices were widely used in the society, even in Soviet period. Traditional healers were looked upon by Soviet officials as charlatans who exploited an ignorant population. However, traditional healing practices survived, preserving their cultural folk heritage, from generation to generation. To understand fully the traditional Uzbek approach to healing and its roots, one needs to understand Uzbek ethnic traditions and religion, because traditional healing practices are interwoven with religious and cultural concepts, in a manner explored below.

Medical professionals have not ignored the wide-spread interest in folk medicine in recent times in Uzbekistan's health system. Some doctors I spoke to admitted that they received traditional treatment themselves. During my fieldwork, I talked to medical professionals about their attitude to the utilisation of unconventional treatments. The data suggests that even medical professionals working in the clinic and hospitals were susceptible to a belief in traditional practices. Nevertheless, some doctors expressed their concern that in some cases like cancer, for example, the delay in treatment usually leads to irreversible consequences. However, in many other cases they did not see any reason why not to try non-conventional treatments, especially as modern medicine does not always have a cure for diseases that have a psychosomatic component. Several respondents reported that their doctors themselves had referred them to alternative practitioners. The observations and interview data revealed a surprisingly high interest in complementary therapies. The respondents mentioned many incidences of curing disease by folk medicine where state medicine was ineffective.

Before analysing the alternative practices, it must be clarified that when talking about traditional healers I do not mean professional practitioners accredited or registered with the state, like naturopathic physicians, chiropractic doctors or acupuncturists. This study discusses traditional folk healers who practice within a community, and whose experience based on medical knowledge transferred from generation to generation. In other words we consider inconsistently trained, self-proclaimed, minimally educated religious and folk practitioners.

Economic insecurity, population growth, and environmental problems inherited from Soviet past created serious challenges for the Uzbek state health care system. Therefore, the non-conventional way of treating illness retains credibility among the population. However, it is not only cost factors or lack of access to conventional medical treatment that play a role in the decision to opt for untraditional medicine. The criteria for women's choices included such factors as their faith in the effectiveness of treatment and their understanding of how treatment functions. The data also suggest that some women sought traditional treatment even though the charge there was higher than in clinics. Thus, unconventional healing practices have even flourished in recent years, and unconventional healers continue to exercise a vital role within Uzbek society, despite the fact that most of them have no medical license or medical training.

The data shows that even in the case of an acute health crisis some women I interviewed delayed their treatment by conventional medicine, trying in despair dubious

alternative treatments. Saida, 51, confessed that her daughter was diagnosed with ovarian cancer and was recommended to undergo an urgent operation. However, she was so scared of a major operation for her daughter that she decided to try alternative treatment. On the advice of her friends she took her daughter to an anti-cancer centre. Her daughter had gone through a very expensive treatment. Despite their hope her health deteriorated even more. The healer told her that it was a natural reaction for the treatment and that she should have carried on with the treatment. Nevertheless, eventually Saida decided to seek professional help. Although the operation was successful, Saida was very angry with medical professionals, that they did not try to save her daughter's reproductive organs and removed her ovaries and womb. She was also in doubt whether she was right to take her daughter to the traditional healer, because she suspected that this treatment only worsened her daughter's condition. In this case the woman decided to seek medical professional help after all other sources of treatment have been tried. That could be due to different reasons. One of them could be the fact that conventional medicine today, despite all the technological progress can not offer a magic cure for many diseases, while traditional healers never refuse to treat even hopeless cases, expressing a readiness to show care, and comfort, and hope when conventional medicine has nothing to offer. In this case the healers promised to Saida that they could have cured her without operation. Traditional healers go beyond scientific principles to inspire people's hope and patients obtain effective results from a combination of therapies and faith in it. Most alternative medical practices may be beneficial as long as they do not entail delaying the conventional treatment. The potential harmful effect of such practices was clear in the example of Saida's daughter.

Hepatitis is a wide-spread disease in the country (ABD Report, 2002). Every autumn the hospitals are full of patients sick with hepatitis, among them a great number of children. Staying in the hospital (and one must stay there for thirty to forty days, if sick with hepatitis), is very inconvenient, due to the totally inadequate conditions in state hospitals. The treatment for hepatitis is very simple. However, due to the fact that the disease is highly contagious, sick people must restrict their contacts with others and therefore they are forced to stay in hospital for several weeks.

Many respondents who were mothers reported that they refused to comply with the demand to send their kids to the hospitals, because of poor hygiene there. In fact in the infectious hospitals it is typical to encounter cockroaches in the wards. Gauhar, 42 , said that right after she got the results of her son's blood test, she took her son to the

traditional healer. She swore that he cured her son without diet or any other restriction, just giving her son herbs to drink. He also gave her a herb infusion for the whole family in order to avoid contamination. Munisa, 39, also confessed that she treated all her children at home, because she was afraid to send them to the hospital. Shohista, 38 told the story how her son was ill and spent one month in the hospital, but his condition did not improve, no matter what the doctors tried. Then her mother-in-law consulted a folk healer with whom she acquainted who advised her that the best cure for hepatitis would be water in which worms have been kept for a night. Shohista's mother-in-law persuaded her to give that treatment a try. She was so desperate and in such despair, that she decided to try it. Her mother-in-law took the earthworms, cleaned them, and then put them in water in a jar for one night. In the morning she strained off the water and gave it to the boy to drink. He drunk the water three times a day, and in a week his condition improved. After two weeks he was discharged form the hospital. Shohista said that she would have never dared to try this method if she did not see herself how other children in the ward had been using it, and how quickly their condition improved. The doctors in the hospital also were not against such treatment, although they did not prescribe the treatment themselves, but they did not stop the patients from taking it as well.

Gauhar, 42, used Sufi-folk spiritual practice. She said that the healer she used helped many despairing sick people. He spent ten years in China, in Tibet, and spoke several languages. He picked up herbs at the foothills of Tian-Shan. She went to see him when she had kidneys problems and he performed acupuncture on her, and the pain went away. She admitted that it was very expensive, but in comparison with the expensive medicine it was more or less tolerable and proved to be very successful.

Leila, 46, said that she had found the alternative treatment with the recital of verses from the Qur'an very helpful, since the conventional treatment became very expensive and unaffordable for her. She visited a mullah who lived in her neighbourhood, and she said that she went to him whenever she felt under the weather.

> "I am very afraid of doctors, but the mullah he doesn't touch you or anything, he just reads the verses, and I feel that gradually I become better."

Almost all the women respondents admitted that they sought non-conventional treatment for themselves and for their family members at some points of their lives.

Nine women stated that the treatments they took from the folk or religious healers helped them. Two women stressed that they were very sceptical with regard to non-conventional healing although under the pressure of circumstances or relatives they eventually used such practices, albeit with different outcomes. Rano told the story how her father's condition deteriorated when he was so tired of the agonising treatment in the state hospital, and he decided to turn to a religious practitioner, who treated her father with herbs. However, eventually they had to resort again to conventional medical treatment. Iroda, 42, told the story how she and her husband decided to turn to a very famous folk healer, how they spend hours queuing, and then how the healer performed a very unpleasant treatment which combined intravenous injections of camphor oil with casting a spell. After that treatment she and her husband were very sick, but they believed, that after their suffering the outcome would be successful, which it was not. Despite such negative experiences she nevertheless did not stop seeking out other herbalists. She said that the problem was to find the right one. She said that there was a great deal of charlatans, but if she had found a genuine one he could definitely has helped her.

Most of the respondents described that the folk and religious healer usually received patients at their homes. They did not have any adequate equipment or enough space to accommodate patients. Many of them gave the dried herbs and told patients how to prepare them or just told which herbs to use. In such cases the patient had to find the herbs in the markets. Respondents also mentioned that usually the sanitary conditions at the homes of healers left much to be desired. All twenty admitted that they used traditional healing at least once in their lives.

Thus, although alternative medicine (and by that I mean native health practitioner without medical education) is not widely recognised it can still be used by the public especially when conventional medical therapy had failed. Most women I interviewed accepted modern methods of treatment, for instance antibiotics and surgery, for acute conditions. However, if a woman believed that a disorder was caused by bad spirits she would certainly have turned to conventional medicine for a cure but would also try to go to the native healer assuming that this would compliment another form of treatment and provide additional benefits. In other words, women have not thoroughly abandoned from their traditional beliefs. Despite the fact that they have easy access to modern medical health services, and latest ideas and information, they still believe in the supernatural, albeit to a limited extent. Apparently the persistence of belief in the

supernatural is influenced by the background and upbringing of the individual and reflects her beliefs that are based on the experiences of her parents and older relatives. Many respondents have mentioned belief in the supernatural, in conjunction with the religious Islamic concepts of bad and good spirits, under which generations of indigenous Uzbek people have grown up. Moreover, the inability of modern medicine at times to diagnose and treat some diseases and anecdotal evidence of cures with the help of alternative treatments could assist individuals in accepting the practices of native healers.

The evidence suggests that people do not abandon traditional medical practices and beliefs despite the widespread acceptance and extensive use of bio-medical health services. Pearce (1993:161) argues that the "proliferation of old and new faith-healing sects or groups suggests the search for answers, and the attempt by lay people to gain some control over what happens to their lives". Not all the participants considered using the medical system as their first response to illness because they did not see the conventional medical approach as the safest one, because of side effects from chemicals. Moreover, traditional healers are always available, they rarely refuse to treat a patient, and they share the same culture, beliefs and values as their patients. Moreover, the belief, the psychological aspect of such healing plays a crucial role. The healers usually use that psychological potential of their patients, therefore their treatment works on the basis of self- persuasion and the placebo effect.

Alongside folk healing Islamic medicine also promotes remedies like faith-healing through prayer and the recitation of holy verses of the Qur'an. Such practices are often performed by mullahs and are especially sought after when people suspected an evil spirit to be responsible for ill health. The practice of healing people with supernatural power takes its roots from the Sunni orders followers – "who were frequently credited with the possessing supernatural powers of healing and soothsaying" (Akiner, 1997:261).

4.2.5. The Natural and the Supernatural in Illness Causation and Treatment

Recent studies have shown that an individual's beliefs about the origin of illness and disease contribute to personal behaviour to achieve or maintain health and well-being (Parrot et al., 2003). When asked about their perception of the causation of illness women vaguely discussed several factors like environment, social factors, personal behaviour and heredity saying that they all play some part in disease causation, which I

divided in two categories: natural-biological, genetic (heredity), social, environmental (climate and weather).

Biological factors (infection with microbes and germs) were closely linked to social factors (bad hygiene, contamination from unsterilised instruments) and involved women's medical knowledge and information. Women divided the causes of specific diseases into external and internal factors. A harmful environment, the contamination of food and water, air pollution and even the blooming of spring as well as sudden shifts in temperature and atmospheric pressure and seasonal changes were defined as external causes of diseases. Thus five respondents suffered from a hay fever that they regarded as due to the blooming of plants. Flu and colds were attributed to shifts in temperature. Heredity was mentioned as an internal cause of illness. In other words the respondents indicated that they think that there are some conditions that predispose a person to various kinds of diseases, for example:

Ruhsora, 50:

"You can look after yourself, eat good food, and whatever, but if there is something in your genes, then what can you do about it? I mean, not to prevent, but you must try to cure it. I mean, you cannot avoid it, but you can treat it."

One of the factors in relation to the causation of illness mentioned by respondents was the weather. Several informants believed that atmospheric changes could influence individual's health. Women called it *meteo-lability*:

Sultana, 54:

"I feel discomfort when the weather changes, I even had a haemorrhage in the eye. I usually become very sick, it improves only with the rain."

Ruhsora, 50 also admitted that she noticed how the weather could affect her health.

"When I was young I never related it to the magnetic storms. But while growing older I reacted to every change in the atmosphere. I have a terrible, terrible

headaches, some times for two three days, and nothing helps until it starts to rain."

Mukaddas, 39, mentioned that her body reacted to changes in the weather with rheumatic pain in her joints. She called herself a *barometer*, because she was able to predict changes in the weather. Some women reported the influence of the moon or solar eclipses on their health. Mukaddas, 39, said that she was very afraid of every eclipse because during the days of solar eclipse she would have terrible headaches. Some women said that a full moon makes them very irritable and nervous, or weepy.

Genetic factors were also considered important. Many women complained that they had suffered the same diseases as their mothers, or that they were afraid of some diseases that were common in their families. However, circulatory disorders and varicose veins were attributed to the effects of pregnancy, and to carrying heavy things as well as to genetic factors. Munisa, 38, physical training coach:

"I have varicose veins, I think from my mother, but the pregnancies and lifting the heavy things also added to it. I felt this terrible pain in the legs at the end of the day, I become tired very quickly, and it is very unattractive, I used to wear trousers, I was too shy to appear in a bikini, so I just didn't go to the beach."

Munisa , 38 admitted that there was a history of varicose veins in her family veins. All women on her mother's side suffered from this disease at some point in their life. Mariam, 52 admitted that her diabetes and obesity could be due to heredity as well, all her close and remote relative were prone to be overweight, and many had diabetes.

Although many respondents admitted genetic factors in the causation of disease, they also thought that genetic conditions should not be revealed, because otherwise shame would be attached to the whole family, and that would in turn have an effect on the future marriage prospects of the children.

A common notion among the respondents was that a rapid transition from one temperature to another could also be a cause for diseases like influenza and flu and other respiratory diseases. The respondents generally accepted that in winter one should not go out straight after the hot shower or bath. In summer one should not enter an air conditioned room after working or perspiring in the heat. Wet hair and cold feet can also cause illness and lead to rheumatism. Flu was considered to be common in winter,

and was associated with cold temperature. Diarrhoea and other stomach disorders were considered as summer illnesses, and associated with the heat and with the fact that food could spoil easily and germs would spread quickly in the heat, leading to intestinal infections. For prevention it was suggested by many respondents that to consume garlic and onions prevented colds in the winter and stomach disorders in the summer. Garlic was considered by the majority of women a means to prevent acute infectious diseases. The respondents also mentioned that long exposure to the sun can cause nausea and headaches; therefore, it was advisable to wear a hat or something to cover the head in the sun, especially for children. All these are means of preventing illness.

The respondents also mentioned that in some cases medical professionals and poor sanitary standards in the clinics and hospital were seen to be responsible for causing disease, and patients were not in control and not responsible for their illness. For example, Mukaddas, 39, said that she was infected with viral hepatitis, during her stay in the maternity hospital when she gave birth to her son in 1988. At that time all medical instruments including the syringes were sterilised, and used many times.

> "I don't know exactly, but twenty days after I gave birth I was rushed to the hospital with the diagnosis of viral hepatitis. I had to leave my child to my mother and he was just twenty days old. The only thing I can think of is that I got the disease from non-sterilised instruments that they used in the maternity hospital, because I was diagnosed with the B form, which could only have been caught through blood contamination."

There were many cases of contamination from badly sterilized medical instruments in hospitals. In Uzbekistan sanitary conditions are not always optimal, and the incidence of illnesses such as hepatitis and cholera has been increasing. Thus viral hepatitis affects eight to twelve per cent of Uzbekistan's population (ABD Report, 2002).

It is also believed that people can get a viral infection from unclean fruit, vegetables and dirty hands; therefore, it is essential to wash hands and all raw fruit and vegetables before eating. It is widely believed that dirty hands, unwashed vegetables and fruit and contaminated food contribute to various illnesses such as flu, diarrhoea, and virus hepatitis. In such cases people are themselves responsible for their condition.

Throughout the interviews many respondents mentioned that anxiety, nervousness, brought about by everyday problems were seem to cause ill health and in particular such diseases as diabetes and hypertension, headache and sleep disturbances. Saida, 51 believed that much of her ill health - heart disease, diabetes, and anaemia - was the result of worries:

> "I was very healthy and fit before several years ago my husband went missing, and then my son died a year after. Now I am invalid ... since 1997. I developed anaemia and diabetes. I believe it is due to a nervous breakdown. When it all happened I could not sleep, I could not eat. When my son died I had a kind of stroke, I was not able to move I was deeply-deeply depressed. I became so weak that I was not able to go to work anymore. Even walking with my grandson in the yard makes me feel exhausted. If I walk for twenty minutes I must then have taken a rest, lie in bed for half an hour."

Thus anxiety, worries, nervous break down, or other vicissitudes that are very common at a times of upheaval, could contribute to the causation of disease.

Behavioural factors have been mentioned by several women who said that '*hypodinamiya*' (lack of exercise) in contemporary society could be the factor attributing to ill-health:

Gauhar, 39,

> "My grandmother gave birth at 56. She was very active. She did not know what a car was. She used to go to bazaar everyday on foot. And she never was idle. She had ten children and always was active, never idle. Today people eat too much and exercise too less. That is where all the diseases, such as diabetes, heart disease, obesity come from."

Sultanat, 51:

> "My grandma climbed a tree when she was 67. If you ask me to climb a stairs, instead of taking a lift, I will think first. The previous generation was much healthier. They went through the civil war, the Great Patriotic War, they knew what starving was, and they didn't have all the luxury items that we have today. Even my mother washed the linen outside home, in summer and in winter. Our

grandma's generation was tough. I do not remember my grandma going to the doctor. She ate only what she had grown in her garden. She planted all vegetables in her garden. And she worked all the day in the garden on the fresh air. But we are just sitting at home, on the fourth floor, sitting in the office. ... Our joints have become stiff."

The data reveal that Uzbek women have strong traditional beliefs in supernatural forces by which they explain concepts of health and illness. Not all but some women reported that supernatural forces could affect their daily life, and health in particular. They believe that in most cases spiritual diseases strike small children and babies. Thus, women reported that some diseases could occur as a result of supernatural forces. In other words people especially small children could get sick due to bad luck, evil spirits or of someone's envy. Pregnant women or women with babies are not advised to go outside their home late at night, when the supernatural forces are at their most dangerous:

Adalat, 39:

" I was not allowed to go out after the sunset during the last months of pregnancy and forty days after I gave birth. My grandmother-in-law didn't allow my husband to enter the baby's room when he used to come home later then sunset. He had to wait for some time. As she said the A*jina (*bad spirits), could be brought into the house from the street, because they usually wander around at night. So the baby will be disturbed by the bad spirit."

Forty days after birth (*chillya*) is believed to be the most vulnerable time for newly born babies and their mothers. During this period mother and her child usually spend at home, and visiting is restricted. Even close relatives except the next of kin try to reduce visits or even avoid them if at all possible. On the fortieth day all the restrictions are removed, and the day becomes a celebration of the birth. Only at that day people can come to congratulate a mother and bring presents for a baby. Traditionally parents and their close family members do not buy things for babies before the birth in order not to put the evil eye on the baby and mother. When old women are finally allowed to see a baby, they usually try to avoid remarks praising the mother and baby, on the contrary

they spit on both sides of their shoulders twice and say gently that the baby is ugly. That is believed to avert bad spirits, because bad spirits are usually hunting for good babies. People also put a string of special tiny beads (*quzimunchoq*) around the child's wrist, which is also supposed to protect child from bad spirits. All the respondents who had children admitted that they put *quzimunchoq* on their babies, even to the older children, like 3-5 year olds:

Rano, 39:

> "We put *quzimunchoq* on our son to save him from the evil eye. I think it helps. Some people say that it helps to maintain good energy in the baby's body. I am not sure, but I put it anyway, just in case, I just believe in it."

Adalat, 39:

> "I didn't think it was essential, but my grandmother put it on my son, so I did not oppose it."

When a baby becomes agitated or irritated it is commonly attributed by the indigenous population to bad spirits or someone's envy. In such cases women take their children to mullahs, who treat babies by reciting verses from the Qur'an. This practice has proved to be very effective. Even if the condition is very serious and women take their children to conventional doctors and follow all the doctor's prescriptions, they also turn to the mullah to support the conventional treatment.

Another common ritual to fight against bad spirits is to burn the herb called – *isiriq* inside the house, and allow that the fumes to spread everywhere. These fumes are believed to have the power to kill not only the bad spirits but bacteria and viruses as well. When the person is sick or nervous a pan with burning herb must be taken around his head three times. That means that the bad spirits that have settled in the head must come out.

Munisa,

> "I always burn *isiriq* in the house, especially if someone is ill. When there is a flu or hepatitis epidemic in the town, when my son becomes too excited, or I see that he is depressed, I also burn the herb. I find it very helpful, by the way."

Shirin, 50, replied that she did not believe that *isirig* could fight bad spirits, but she was sure that it could kill bacteria in the house. However, it is considered, that not only babies and pregnant women could suffer from spirits, but also grown-up people could be liable to messages of envy and jealousy from someone. Nigora, 40, told her story about the frequent occurrence of illnesses that she could not treat with the help of conventional medicine. She suffered from severe allergies, from 1981 to 1991, which she tried to treat with drugs and fasting for ten days every two to three months. Subsequently she followed a strict diet for several years, eating only boiled potatoes, rice, sour milk, green tea, but none of these attempts to treat her condition helped. The skin on her fingertips would swell if she played the piano, the soles of her feet swelled if she walked a lot, her eyes and whole face would swell if she ate something from her list of restricted food, and her throat would swell if there was dust in the air. Several times she was treated in the hospital, and two times, when she became unconscious, she was admitted to the intensive care unit. In the hospital she got treatment, but this failed to improve her condition, except when she was on a drip-feed and underwent total cleansing. Once a month she had swellings, and she suffered from a nettle rush practically every other day. Disappointed with conventional medicine, she decided to turn to religious folk healers:

> "The doctors did not promise anything. They treated me when I was rushed to the hospital, and then they discharged me, when the condition had improved a little, but they never told me why it happened, the reason of my suffering. And they never promised that it would improve some day."

She tried different kinds of spiritual healers and herbalists, and eventually, found an old lady, who told her that she had a bad spirit inside her, and in order to take it out, Nigora had to kill a cock and bring his blood to her. She also had to cook *chuchvara*, (a dish consisting of a kind of ravioli) and take it to the mosque.

> "When you suffer so much, you don't care. Whatever they performed on me, let them do it, I just wanted something to release me from that awful disease. I was prepared to do anything, however strange. I gave up myself to do what ever they felt like doing."

When Nigora did what woman said and brought the cock's blood, the old woman put white sheets on Nigora, put her in the middle of the yard, and together with crying out some gibberish, poured the blood on Nigora's head. After that she gave her some white stuff to drink, and when Nigora returned home she felt so sick, that she vomited. After that she felt so tired that went to bed and slept until the next morning, a total of sixteen hours. In the morning she felt like she was born again. Her allergy disappeared in one day after ten years of suffering.

Munisa confessed that she had been going to a woman who 'reads' and have taken her children there.

> "My youngest son was usually catching a bad spirit. The medical professionals were not able to find out what was wrong. He became ill very quickly; he caught every infection that was known. The doctors said that his immunity was undermined. But they didn't say exactly what was wrong. So I took him to this woman, she lives very far away. And after three, four times he became much better. My daughter suffered from incontinence, the doctors didn't have a clue how to treat it. They told me that when she grows up, she will be better. So I took her to the mullah, he treated her with prayers. In order to get access to him you had to stand in a long line. But he usually accepted parents with children straightaway. For ten days he prayed for her, for five to ten minutes, not more, and then she was cured. She has never had any problems since. Now I believe... It depends on whether a person really has these supernatural abilities. There are lot of charlatans. I think when they take a lot of money they are definitely charlatans."

Rano, 38 said:

> "I do not trust in folk treatment, but auto-suggestion and praying – I believe in it. My father when he was terminally ill trusted only the doctors, he hoped that they would be able to save him. The herbalist he once went to see made the illness even worse despite a very good reputation. We all regretted that my father turned for help to him. But even the doctors, the medical professionals, who treated him, advised the use of folk remedies such as herbs, *mumie* (a mineral) or egg shell or even urine. Although my father didn't accept the folk therapy he asked for the

mullah to come and to read the verses from Qur'an. He felt much better after that."

The data in the interviews show that even medical professionals recommended taking these measures to fight the bad spirits especially when concerning ill children. The doctors I spoke to in the Health Centres admitted that they did not oppose such practices as long as they were not harmful.

Shahista told the story how her friend, a paediatrician, sent her son to a mullah:

"You know, I believe in bad spirits, I mean there is something anyway, I don't know exactly what it is, but something definitely is out there. I remember when my son was ill, my parents insisted on taking him to the mullah, or to put a Qur'an above his head when he was asleep. I myself thought that it was his stomach, because he cried all the time. He used to get up at night with a terrible cry. My mother yelled at me: 'Take him to the mullah, take him to the mullah!' I took him to the doctor. He said that everything was all right, no need to worry. I was glad that nothing was wrong, but he persisted in crying, he was very irritable. Then I called my friend who works in a maternity clinic. She said: 'Why you are so persistent just take him to a mullah, you will see the difference.' So I did. After one visit he became calmer. So how would you not believe in it?"

The respondents mentioned that they put garlic, a book of Qur'an, or cloves on the head of the baby's bed, in order to divert the bad spirits from the child. In cases of infertility conventional medicine very often does not have a cure, due to the level of state of bio-medicine in the country. Not everyone could afford taking trips to the clinics abroad either. Therefore, the only way for women who have difficulties conceiving is to try all the pilgrimages to the holy places, praying and so on. While travelling in the countryside one could see a holy tree with numerous ribbons of different colours on its branches. Women make their wishes and tie a ribbon to the tree, so that the wish comes true. Several respondents confessed that they went on a pilgrimage to sacred places once or twice in their life. In most cases they went when they had problems conceiving. Other respondents said that they visited such places not in connection with their health, but in order to gain emotional balance.

Iroda, 42, said that she visited the sacred places in the mountain, the grave of *Shaih Umar Valisufii*. There was a spring near his grave with holy water. She said that after this pilgrimage she did not suffer any respiratory diseases for years. She also admitted that she tried a lot of herbalist and folk healers, and noticed that the effect of their treatment was in inverse proportion to the money they took. That makes people think that some people really posses the supernatural power, but some healers just use the people's suffering to make more money.

4.2.6. Summary

The data in this chapter indicate that the majority of respondents exhibited a pluralistic attitude towards selecting between different choices of treatment. Respondents chose medical treatment that according to what was practical and in accordance with their beliefs concerning medical treatment. The cultural surroundings affected women's knowledge, believes and behaviour. Shyness and embarrassment could influence women's choices. Although the majority of participants said that embarrassment had no effect on their decisions they admitted that a fear of appearing too annoying, the feeling left from past experiences of interacting with health service personnel, resulted in discomfort, that caused women to put off seeking professional treatment.

The data also show that the process of selecting health services was influenced by the quality of services rather than the cost. Some traditional healers and private clinics were sought out despite their high cost for more personalised attitudes and shorter waiting lines. The respondents sought out positive outcomes of treatment irrespective of whether the treatment was conventional or unconventional. The biomedical model has remained the leading and most respected form of treatment in Uzbekistan. However, the data suggests that spiritual practices are still very popular. Despite the fact that many respondents were sceptical about such practices, nevertheless they did not exclude them from their options, when choosing treatment. Respondents did not mention practices like acupuncture or Ayurveda or Chinese medicine.

4.3. Lifestyle Habits

4.3.1. Health and Nutrition

In order to achieve good health 'the individual, first must make full use of available medical facilities' and second 'must actively respond to health campaigns, e.g., changes in diet, smoking, alcohol consumption, physical activity' (Walker,

1999:354). This section looks at traditional patterns of lifestyle in a larger social system and examines women's adherence to dietary habits, their family dietary patterns, the availability of nutritious food as well as physical activities and smoking and drinking habits.

New sociological evidence is rapidly accumulating about role of diet and exercise in promoting women's health across the course of their lives (Bierman, 2002:203). One of the main determinants of the quality of nutrition and associated health risks could be the level of women's knowledge and background, which is closely connected with their education. Low incomes and malnutrition, lack of access to medical care could be an additional factor of ill health. For example, according to the findings of a medical-demographic survey 1996, the probability of better nutrition is higher among non-Muslim women in Uzbekistan, and women with higher education are less susceptible to anaemia, although education does not have an independent impact on quality of nutrition (World Bank, 2003:86). Another finding from that survey was that women in extended families are less susceptible to bad nutrition, because of the availability of additional resources from other members of the family. This study does not corroborate these findings. The respondents who lived in extended families with their in-laws, reported that they were usually the last to eat, and ate only meals that elderly family members preferred, and were compelled to give their portions to their children if there was not enough food. Thus Yoqut became anaemic, Nigora suffered weightloss (her weight went down to 45 kg), while living in extended families with their in-laws.

The transition has had an ambiguous impact on people in relation to food consumption and nutrition. On the one hand higher prices had a negative affect, so that people have to restrict their choices. On the other hand people have access to more information concerning health and nutrition that has increased their awareness of this subject and has helped to promote healthy eating, as healthy food is crucial for maintaining good health.

The standard diet of Uzbek people is primarily a starch-based diet. According to the World Health Organization carbohydrates (rice, flour, grouts and farinaceous products) form a predominant part of most people's diet in Uzbekistan. The reduction in the output of food companies, the appearance of small producers, and widespread street trading have led to a significant increase in the amount of unsatisfactory produce on the consumer market. The rise in imports of food that are often of poor quality is making the situation worse (WHO, 1999:22). Thus, consumption of grain products in 1990 was

128 per cent, while consumption of meat was 48 per cent (Brummer, 1995:29-31). According to the 2002 Uzbekistan Health Examination Survey 54 per cent of women 45-49 years are overweight or obese, especially in Tashkent City, and women with the most higher education (UHES, 2002; 19). These findings suggest that women in the mid-life have more sedentary lifestyle or less adequate diet.

Consumption of vegetables and fruit is usually seasonal. There are a lot of radishes, greens, spring onions and garlic, berries and cherries in spring; tomatoes and cucumbers and lots of fruit in the summer; cabbage, pumpkin, beetroot in autumn and winter. In the last years due to the growing amount of greenhouses tomatoes and cucumbers could be found in the markets in winter, although at a very high price. People consume a lot of marinated vegetables and dried fruits and nuts in winter. The main national dishes are rice, flour, meat and homemade noodles, vegetables. People consume a widespread variety of meat like lamb, beef and horse meat. Islamic law prohibits pork, however, during the Soviet period people consumed pork sausages and ham. Although it is against Muslim Law, drinking and smoking are quite prevalent in some regions of the country. The data collected provides a wide range of views on different diets and its importance for the health maintenance. The respondents believed that there was a close correlation between health and illness and the daily diet.

As a rule, Uzbek indigenous people separate food in the categories of "cold" food (*sougliq*), which is milk, pastry, some kind vegetables and fruits, and "hot" food (*issiqliq*), which are meat, fat, sugar and nuts. The food like rice, all types of grains, potatoes, carrots is categorised as neutral, not because it doesn't have any particular affect on health status, but because this kind of food is considered as dietetic and usually recommended to people at the times when they feel sick. When individual becomes sick his illness could be attributed to too much of 'cold' food which could result in an imbalance in the body. The best way to improve situation would be to consume the "hot" and "cold" types of food in equal proportions.

Thus, people believe that with excessive consumption of "cold" food people can suffer headaches, diarrhoea, and weariness. "Hot" food must be restricted for children and people with obesity and sufferers of high blood pressure. However, people who are anaemic or suffer headaches, low blood pressure, dizziness and tiredness are advised to eat more "hot" food.

Thus, Nigora, 40, said that whenever she has a headache or feels dizzy she knows that she needs to consume fried meat or *halvaytor* (fried flour, sugar and lamb's fat

(*dumba*) mixed together). When people are weak after the illness they are usually fed with the "hot" food. In winter it is also recommended to consume more "hot" food if possible in order to maintain the energy balance. In summer on the contrary, the heat and "hot" food could lead to digestion problems. Women from the sample emphasised the significance of a balanced diet in relation to health. The concept of balanced diet is based on the combined ideas of traditional Uzbek perceptions about "hot" and "cold" food and modern classification of food into proteins, fats and carbohydrates:

Nigora,

> "We all know from school that an individual must consume thirty percent of proteins, twenty percent of fats, and fifty percent of carbohydrates, in order to keep the balance in the body. That was drummed into our heads since childhood".

The access to information and the variety of health related literature means that women employ a pluralistic approach in understanding and using different types of ideas related to diet and health issues. Most of the respondents reported that they adhered to one or another diet from time to time during their life. Apart from generally accepted "hot" and "cold" categories, women follow a diverse variety of diets on many occasions.

Thus, Sultanat, 54, explained that she believes in the diet based on the theory that one must eat food that has been grown on the territory where a person lives. All exported food and products should be avoided, in order to prevent any kinds of disorder in the body. The products should be consumed according to what is in season. Thus, fruits and berries in spring and summer, vegetables in autumn, and grains and meat in winter. At these times human organism accepts what it needs and rests from the other products. In this case, she argues, that the body, will never be overloaded with any products.

Eighteen out of twenty respondents emphasised their adherence to healthy dietary habits and altering dietary patterns of the whole family and their increased awareness of the benefits of healthy diets in relation to good health. Usually strict diet means everything boiled not fried, if meat - only chicken or fish, if lamb and beef then only minced, and different kinds of porridge - barley, buckwheat, oat, and rice, and dairy products like sour milk, cottage cheese and milk. This diet developed as a result of

Russian cultural influence and the advice of modern medicine. Many people adopted Russian cuisine as alternative especially in urban areas, were Russian cuisine was widely introduced in nurseries, hospitals, canteens, and restaurants and other public catering. During the Soviet period people were exposed to a variety of cultures and they adopted various cuisines, not only Russian, but also Armenian, Georgian, Korean, Uygur etc.

However, the traditional Uzbek advice is to avoid dairy products in hot weather; if one is sick to have a rice broth; and different kinds of herbal concoction in the event of severe diseases:

Leila, 44:

> "When I feel sick I just stop eating ordinary food, I drink parsley juice for two days, I also brew parsley's roots, if I can find them in the market. And than gradually I introduce rice and potatoes. I avoid eating meat for several weeks".

Uzbeks have traditionally preferred a high animal fat diet, when it is available (Hatland and Haycock, 1999:173). According to the WHO fats are the source of 24.7 per cent of the energy consumed by Uzbek population, and protein of 12.4 percent (WHO, 1999:20). Apart from heart disease a high fat diet contributes to liver and gall bladder diseases that became widespread, although this could also be attributed to the overuse of chemicals on the cotton fields too. Fifteen out of twenty women I interviewed had one or two members in the family who had problems with their gall bladder or liver, or had a viral hepatitis. One woman had her gall bladder removed (cholecystectomy), seven women complained of chronic inflammation of the gall bladder (cholecystitis) and gallstones. Deficiencies of nutrients containing iron are the major cause for anaemia that is also widespread among female Uzbek population (World Bank, 2003:84). Women who have chronically ill persons in the family reported that they keep to very strict diet.

When the economic situation in the family is far from good, dietary option become restricted. During the Soviet period very little money was needed to pay for medical treatment, study and basic utilities, because of the large governmental subsidies allocated to welfare and basic services. Women I interviewed complained that previously their salaries were enough for clothing, travel and leisure activities, they had

even money to put aside for vacations, and for weddings, funerals, and emergencies. Today, as most of participants stressed, all their money was spent on foodstuff and medical treatment. Some women reported that their food portions were shrinking every year.

Yuliya, 54, a housewife, has three daughters and a granddaughter. She complained that they did not have enough money to buy proper food. Other interviewers made similar points:

> "I do not work, only my husband works. I do not get any state support. I am entitled to twenty sum (approx. $3) for my invalid daughter, but I refused it, I am afraid the neighbours would gossip"

Rano:

> "When my husband was unemployed once, we ate only macaroni. Each and everyday – macaroni. Now my son hates it. I think that is because we have eaten too much of it at some point. Recently when my husband had an argument with his boss, I remember, he was talking to me, and I started imagining those macaroni, I was just scared that if he lost his job again we all would have to go on macaroni again".

Asal:

> "Once I noticed that my daughter had a tiny dark marks all over her face. I thought they were moles, but so many in such a short period... I took her to the dermatologist. She said that it was due to protein deficiency. That was a period when my husband was unemployed, I was on maternity leave, we did not have any regular income, so I economised on everything, and on food in the first place. I immediately started to feed her with meat, and her face became clean after a while".

Government allowances for families with disabled children have been cut after the collapse of the Soviet Union. Today *mahalla* committees have the responsibility to provide for these allowances, which are given only to low-income families. To maintain

order and justice, families who are entitled to such benefits must apply to *mahalla* committee for an extension every three months (National Synthesis Report, 1999, p. 15). Collecting all necessary papers, certificates on income, medical records, etc., not all people have the time and opportunity to go through it every time. Therefore, many women consider that it is not worth it, because the allocations are very low anyway. Yuliya's family eats meat only two-three times a month. Instead they consume a great deal of flour, pasta, barley, potatoes and bread. They eat a lot of bread with each meal. Yuliya herself and her oldest daughter seemed a bit overweight; however, she does not feel like worrying about it. It seems that she tries to substitute the quality of food by its quantity. She believes that proper food is the main factor in maintaining good health. She never tried any slimming or cleansing diets. Her coping strategy is:

> "I preserve a lot of vegetables and fruits in summer, so we can eat them during the whole winter. I do compotes, aubergine paste, marinated tomatoes, cucumbers, salads".

Almost all women in Uzbekistan adopted this practice. There is a special cupboard in the balcony in every flat full of small and big jars. Some people keep the jars in the basements. During the whole summer when vegetables and fruits are cheap, women preserve, can, and bottle. Summer season is very hot in Uzbekistan; sometimes it reaches 42-45 degrees above the zero. In order to do preservations properly the vegetables or fruits must be boiled in big saucepans and the jars must be sterilized at a very high temperature in the oven. The air in the kitchen gets very hot and humid.

Shohista 38:

> "No need to go to the sauna! The sweat comes like a hail from me. I also do not cook these days because the whole kitchen is full of jars, and the stove is occupied for four to five hours and I can loose two-three kilos a day. But you - you must know it yourself. Then I cannot move for couple of days....but, when the work has been done and you look at all these jars full of marinates... Sometimes I say to myself – 'never again', but in winter you congratulate yourself, that you did it".

Women must be very careful in order to not to break the jars and not to spill the boiling water. Women must use all their force to roll the lid and then put the jars aside, cover them with a blanket and wait for two to three days; if the lid was rolled improperly the jar will blow up. This is a very tough job, but most women consider it worth doing. A little bit of suffering in summer, and they will feel tranquil and comfortable in winter.

They were asked if they get any help from someone. The common answer was that although women certainly longed for help while doing such a strenuous job, they found that it was much easier to do everything by themselves than asking somebody's assistance.

Ruhsora , 50:

"I think..., if you want the job to be done properly, you must do it yourself. This is my rule".

Sultanat, 54:

"Ou, ah-ah, my husband helps! He brings everything from the market; otherwise I wouldn't even try to do it. But then I do everything else, he lies on the sofa, and I call him only when I need him to roll the lids. I have to shout from the kitchen, he shouts back, that he is on his way, while he keeps watching TV, and then he appears... and I feel I want to jump out of my skin. It is a very irritable process. Sometime you think you can do it yourself even better...."

When I asked women whose food preferences were more powerful in the determination of what the family ate, women who lived separately from their in-laws answered that the children's preferences determine what food the whole family eats. This is different from the traditional setting. The old women always recalled that husbands and grown up male-children determined the food they wanted to eat, they got the first portions and the biggest ones, then women and only after that small children in the family got what was left. Today's situation has changed although in the traditional extended families the elderly members' preferences are considered. Previously it was believed that children needed less food and less nutrients, moreover children were not

supposed to be spoiled in any way and with the food especially. Today women express their concern about the health of their children. Bad diet is believed to be linked to various childhood diseases and the emotional mood of children, their performance at school, etc. The pattern that is found in a number of cultures where women often accommodate first to children's needs is clearly seen in these data, however, the notion that Uzbek women put their own nutritional needs last in relation to men's is disputable. Today fathers can demand submission from his children and wife, they can demand silence when he is at home, but when it comes to food, he is considered as a person, who can find his food for himself if he needed, but children must be fed with nutrients in order to be healthy. In most families children's needs were put first. Muniza, 38 when she was sick, was not able to do the housework; she noticed that her kids were more irritated by this fact than her husband. They did not want to skip food, or eat sandwiches. They demanded their food three times a day, without any compassion for her bad condition.

Mukaddas, Rano, Oidyn, Mariam, are working women, they stressed how important it was for them to be fed well, because without proper food they would not be able to deal with the work related stress. They emphasized that all members of their families considered their diet preferences, whereas housewives, from the sample (Adalat, Iroda,), admitted that they considered preferences of their working husbands and their children in relation to food.

In Uzbekistan, since the Soviet period, people used to buy food in large quantities. During the Soviet period and especially during perestroika, there were shortages (*deficit*) of such food as meat, vegetable oils (except cotton seed oil, which was believed to contain pesticides), some dairy products like cheese and butter, and so on. Therefore, people used to buy food for future use. People in a private houses usually had a huge storage room in the basement, were they kept potatoes, carrots, rice, wheat flour in sacks. They also stocked up their basements with apples, pears and dried fruits beginning in the autumn. The storage helps people to survive through the winter, when the vegetables and fruit are very expensive. Yoqut, 39, shared with me how her mother-in-law made money. She said that her mother-in-law bought barley or mung beans, stored it in the basement, and then re-sold it in the winter, and she actually made a good profit.

People in apartments had more problems due to the lack of space for storage. Today markets and food stores are full of food products during the whole year. There is

no shortage any more, at least for a time being. However, many people, even those who were well-to-do ten years ago, could not afford to buy some kinds of food because of its very high price.

Women adopted different kind of strategies to provide their families with basic nutrients. However, by making sure that their kids and other family members get a substantial meal they sometimes have to restrict themselves in their own necessities.

Dining facilities in the country have proved inefficient since Soviet times (see Moskoff, 1984). It is not common for Uzbek people to eat out, due to the poor catering. The respondents admitted that they rarely go out for lunch or dinner, and usually preferred to eat at home.

4.3.2. Smoking and Drinking Habits

When I asked women about 'bad habits' like smoking and drinking in relation to disease causation, most women did not attribute the latter to any problems. Women were aware of significant risks to health from the consumption of alcohol and tobacco. However, most of the sample indicated that they believe that moderate consumption would not harm their health.

The prevalence of smoking in the country (smoking at least one cigarette per week) is much higher among men than among women – 40 per cent and one per cent respectively (Country Profiles by Regions, 2001). It must be mentioned that by 1994 the production of cigarettes had doubled from 4.500 million annually in 1990 to 9.000 million cigarettes by 1994 (ibid). Per capita alcohol consumption in Uzbekistan fell from 2.2 litres in 1990 to 0.8 litres in 1996 (cited from WHO, 1999; p. 20). In the last years consumption of alcohol and tobacco products has declined (Hatland and Haycock, 1996:123) but that was not because people were concerned about their health, but because of higher prices and lower incomes. According to data from the Ministry of Health's Institute of Cardiology, more than half (50-59%) of men surveyed and approximately 1.5% of women surveyed consumed tobacco. The fact that women use tobacco products is also supported by the 2002 Uzbekistan Health Examination Survey (UHES, 2002). It is said that one percent of female respondents reported at some point smoking cigarettes and one percent were currently smoking. The report also shows that the highest rate of women smokers is in Tashkent City and among non-Uzbek women. (UHES, 2002:20).

Some women from the sample reported that they did not drink or smoke at all; others admitted that they drank and smoked occasionally. Mariam, 52 a university lecturer, admitted that she quit smoking because she had asthma. Munisa 38, housewife smokes ten cigarettes a day, but does not express a concern in relating it to any health problems. Most women admitted that excessive drinking could be bad for health, damage the liver, cause psychological problems, however, moderate drinking could be beneficial to health. Thus Oydin, 44, assistant manager, admitted that the only way to relax for her was a glass of wine or vodka. She said that her work was very stressful. She works from 9 am until 8-9 pm, sometimes even at weekends. When she comes home she is so tense that she cannot sleep or even eat. On the advice of her husband she started drinking a glass of wine or vodka, two to three times a week, and found it very relaxing. Other women reported that they drink only occasionally on holidays or at celebrations, which could be once a month or even less.

Asal, 39, paediatrician:

> "Aha, when we where young we drank a lot, especially during the cotton picking campaigns. We believed that vodka could save us from bacteria and viruses. And also it was fun, we were young and carefree. But today I have so many responsibilities; I can't imagine what would have happen if I drank. Sometimes when I go to birthday parties or else I can drink but I restrict myself to three to four shots of vodka, because I know I have to be in control and when I come home there is always something I would have to do and I wouldn't be able to do if I am too drunk.".

Many respondents reported that they use vodka on occasion to treat the disease like colds and flu, wine for relaxation. One woman swore that she treated her fibroid with the mixture of vodka with sunflower seed oil taken on an empty stomach.

Traditionally smoking and drinking for women is considered highly undesirable in Uzbek culture. Women (especially of indigenous nationality) do not smoke in public places whereas men can do it openly. However, when smoking women were asked why they smoked they replied that social pressure in the young ages contributed to that habit. Many women who smoke do it in secret, hiding it from their parents and sometimes from their husbands and children. It is known that smoking may be maintained because

it reduces cravings and feeling of stress (Taylor, 1995:76), however, the data I collected suggest that in most cases smoking and drinking for Uzbek women are rare exceptions and no more than a social pursuit. On the whole women consume alcohol and tobacco in small quantities and only occasionally when acceptable.

4.3.3. Sport and Physical Activities

When asked about physical activities, sport and exercise most women expressed their awareness of the benefits of exercise for health. However, none of the women reported engaging in one or other sport activities, except one (Munisa). Six women mentioned that they do physical exercises at home from time to time. Seven respondents admitted that they tried to take aerobic classes or swimming, but because of their laziness or lack of time they gave up very quickly. Despite the fact that in recent years the opportunities for participating in sport have increased, due to the development of sport facilities, women seem not to take much advantage of them.

Mariam, 52:

> "I lead a very regular and active way of life. I walk in the park in summer; I do ten rounds it takes one hour. But going to some sports club, no, I don't have time. I think that my hectic way of life is more than enough. I better do something useful, wash the windows, visit my sisters, help them with their kids, you need time for all these".

Leila, 46, said that she sweeps the yard everyday in the morning and in the evening, which is her physical activity. Asal, 39, said that she doesn't smoke, drinks only occasionally, but never does any physical exercise. Yoqut, 39, said that she would love to do some sports, but as she remembers herself, she was constantly pregnant or breastfeeding, therefore, she never had any opportunity to engage in any sport. Shirin, 50 said that her activity is her grandson, five years old (his mother died). She said:

> " he takes so much of my energy, that I have no time to take a short rest, not to mention sport activities".

She also noticed that if there were some opportunities she would prefer to go to a sauna, because it is more relaxing.

Oidyn, 44 has no time at all for any kind of sports activities. She works six days a week, from nine until seven, she is happy when she is able to walk in the park from time to time. Rano, 39, said that her husband is very keen on different kinds of sports and exercises, she, herself, did exercises only when the doctors prescribed, and only for a certain period of time. Saida, 50 said that she liked to go to the country house (dacha), where she could work in the garden, plant the flowers, etc. She considers this as her physical activity.

Mukaddas, 39 said that:

"Before, I use to be very sporty, I did jogging, swimming, yoga. Today the only thing I can allow myself is to walk, that is a substitute for sport. I like swimming but I do not have time for it at all".

Only Munisa 38, admitted that she does exercise:

"I feel very good when I exercise. It helps me to switch from my home problems, it distracts me very well. I also do massage once a week.".

Probably this is due to the fact that Munisa is a professional coach.

On the whole traditionally sport and outdoors activities were not customary in Uzbekistan. The main reason why women neglected sport activities is probably their cultural upbringing, which did not encourage women's engagement in sports.

Adalat:

"You should have seen yourself, when I used to take my son to the swimming pool, there rarely were any children of Uzbek nationalities. All children there were Russian, Tatar, and Korean. Uzbeks do not bother to take their kids for sports. The Uzbeks are not sporty at all, and they do not want their kids to be involved, they don't care. Yes, that's true – like parents, like kids. In Soviet times, the sport trainers used to come to each school, looking for children, promoting the sport clubs. Today no one cares".

The chapter on Islam and tradition will shed some light on the question why physical activities and sport were not popular among female Uzbek population.

4.3.4. Summary

The Chapter explored women's own perceptions to the health issues in the family and health related issues and identified the social peculiar settings which especially adequate to women of chosen group. Although women's lives are complex, yet commonalities may be found. Some notions and opinions were quite opposite of what is suggested in official sources. The analysis of women's self-assessed health indicated substantial behavioural and cultural risk factors together with socio-economic factors influencing women's health. The findings from the interviews suggest that on the one hand the respondents feel that they are in control of their health, and feel that they are able to maintain good health by leading healthy lifestyles. On the other hand the respondents perceive that ill-health could just happen owing to circumstances beyond one's control. It is widely acknowledged that certain behavioural factors such as smoking, lack of exercise as a consequence can contribute to major chronic diseases. When asked about health behaviour all women agreed that proper health behaviour is good to maintain good health. The interview data reflect clear ideas on what is important in order to keep healthy: eating properly and regularly, exercises, personal hygiene, although not all women followed their own convictions. Most commonly they named a regular and balanced diet, good sleep and enough rest, the ability to cope with stress, weight control as the major habits in maintaining good health. However, lack of income undermined women's ability to make healthy behavioural choices. Some women pointed to the necessity of physical activities and not smoking and drinking, most women did not even emphasize the latter as an unhealthy habit. Most women I interviewed consider diet a major factor in promoting good health (diet to absorb enough nutrients and to detoxify the body). Many researched families experienced changes in food consumption and purchasing patterns due to changes in budgets, and financial difficulties in the last years. Many reported that they started to buy cheaper and lower quality products, which consequently worsened health of all household members. However, the transition period seems not to have changed any pattern in the consumption of tobacco and alcohol among participants, at least there has not been any increase. Physical activity appeared to be very low among the respondents with few exceptions.

Health status is influenced by different factors and maintained by different people differently. Some women are more likely to practice good health behaviour than others. Women who value their own health and health of their family members and who recognise the health risks seek more knowledge and information from different sources, be it special health literature or medical professional opinion. The data suggest that women have frequent contacts with medical professionals and easy access to regional clinics and polyclinics. Today women are being exposed to lots of information that is easily available on the market, on radio and television. All this aids in understanding various medical ideas and issues concerning health and illness. Access to a range of information means that women are able to take a pluralistic approach to making assessments and judgments in relation to issues of health and illness. The respondents seemed very aware of their everyday health, and they expressed that they are interested and concerned about health related behaviour especially food consumption and diet. Thus women create their own ideas about health and illness and the need to seek medical treatment and take medication. They can evaluate the medical advice and compare it to what they themselves have discovered about the illness and medication and what they consider the cause of illness. Exercise, smoking and drinking habits were less popular methods of controlling illness.

Chapter 5
Employment and Family Responsibilities, and Their Impact on Women's Health

5.1. Employment and Housework

The occupational and household roles of women are related to their physical and mental health (Moss, 2002). To obtain a more comprehensive picture of Uzbek women's lives it is essential to discover more about the issues involved in combining a job with the demands of looking after a family whilst running a home. The family and domestic sphere are important factors in the analysis of women's health (Lee, 1998). Household types and employment nature might also have a significant influence on women's health (Arber and Cooper, 2000). In this section I attempt to analyse how factors such as the double burden of employment and household, unemployment, dependence, isolation and housework might increase health related risks among women. I also explore how important domestic labour and formal labour are in shaping women's history of health and illness, and effects of psychological conditions of paid work, and domestic responsibilities. It is well established that this double burden has a negative impact on women's lives, but little is known about how this affects the lives of Uzbek women. In order to test this, I discuss the impact of the double burden in relation to women's domestic responsibilities, the social conflicts experienced by housewives, and the division of domestic labour between family members. In addition, I aim to investigate how important autonomy in the domestic sphere is to women and to explore how women interpret the effects of ill health on their domestic role. Detailed information about these women's family life, their relationships with their husband and other family members, the division of domestic labour, decision making and child care were collected. Through considering this dataed to develop an explanation of how changing the division of labour and domestic responsibilities shifted the position of working women, and the effects of their working life on their family and their health.

Growing unemployment in Uzbekistan during transition and greater competition for employment brings back the ideology of domesticity and placed more emphasis on the social significance of the family. Lee (1998:96) emphasises that 'women are far more likely than men to give up paid work in order to work full-time in unpaid domestic labour'. The situation in Uzbekistan characterises such tendencies.

At home all women within this study, independently of their occupation roles, acted as informal caregivers to their children, elderly parents and husbands. Coupled with the challenges of the transition, the burden of family health responsibilities have led to significant emotional and physical strain. Consequently this has led to health problems and poor self-care among the women respondents. The generation of middle aged women in many cultures find themselves pulled in many different directions by people they care for. They must carry out the demands of aging parents, as well as pleasing their husband and young children. Current economic hardships further intensify conflicts in women's lives.

Out of twenty women I interviewed, nine women were housewives. That could be explained, partially, by the fact that the housewives have more spare time for an interview, while working women could have less time for an interview, especially those women who are at a greater disadvantage. Perhaps, the diminished sanitary standards in the kindergartens due to lack of state funds, and unaffordable prices in private kindergartens, have left little choice compounding women's difficulties in combining occupational activity with household duties.

Large amounts of housework were common for employed women and housewives as well, despite having modern household devices such as washing machines and vacuum cleaners. Within the contemporary family, Uzbek women have consistently been assigned the main tasks of domestic labour despite the changing demands of the market economy. Employed women reported the hard pressures of combining work outside the home with family responsibilities, whereas housewives complained that the household work was endless. Due to the fact that housewives did not work they were expected to do everything at home with minimal help from working members of the family. Many women reported that the feeling of being responsible for a perfect household was physically and emotionally exhausting.

In Uzbek society, women are normally assigned most of the household duties, whereas the man's contribution to household chores usually manifests itself in financial support. However, changing economic and social demands compel women to renegotiate the settled arrangements to free themselves from certain responsibilities. When women meet with a rebuff from their spouses they look to children as a source of support. Many female respondents mentioned the children's role in the division of domestic responsibilities.

The data from this study reveal that some women do all the housework themselves, regardless of their occupational status. Some respondents admitted that they tried to divide the housework equally with other family members, in most cases with their children. These data also identified cases where some women, especially those working outside the home, did not do housework, but assigned it to their husband or children. Not all of the housewives interviewed did the housework themselves, although most of them did consider it as their obligation. Several respondents mentioned that they delegated the housework to their children. In Uzbek society, children of both sexes help their parents around the house from a young age. They wash dishes, clean the floor, sweep the yard and look after younger siblings and grandparents. Starting from 13-14 years, boys usually help with shopping and repairs.

Evidence from the study reveals that in small families with only a married couple and their children, the duties are evenly distributed among all members. However, in the families that include representatives of several generations the traditional domestic way of life usually persists.

The results from the interviews suggest that the types of stress are different between employed women and housewives. The employed women I interviewed usually worked in an occupation with no serious health hazards. Most respondents were employed in relatively safe occupations, for example as teachers or doctors. It is beyond the scope of my study to assess the overall effects of employment on the health of women. However, as is well known, not only hazardous occupations but also psychological aspects of employment may positively and negatively affect a woman's health. Waldron (1983:127) suggests that "increased social contact and social support may improve the health of employed women". However, long hours of standing, sitting in front of a computer, repetitive tasks, airlessness, or poor nutrition due to a lack of dining facilities in the workplace can all be harmful for a woman's health (See Doyal, 1995). The data suggests that inadequate working conditions that prevent women from having a proper diet could have a negative impact on their health.

Rano, 39:

"I always come home so hungry, because there is no place to eat at work. So I start to eat everything I can find on my way. Thus, before dinner, I eat all the ingredients with which I cook, and I always test the meal while it cooks, and then

I eat it with the family and then still I feel that I am not full enough, so I eat sweets and candies and cookies whatever. And then finally I am so full that I cannot move. I know that it is very harmful for my heart and for my liver, and everyday I swear that will not do it again. But sometimes I think it is the only thing I have in life ... I feel that only when I eat I live... Probably, if I was able to find a relatively inexpensive catering facility to eat at during the lunch.... I mean more regular eating.

Several respondents described eating and drinking as a release from work stress, to which more attention has been paid above.

When working women were asked, "How difficult it is for you to balance your work and family responsibilities?" they answered that it was very difficult because working conditions were too tense and sometimes they had to bring their work back home. For example, Mukaddas, 39, said:

"The work is very stressful. The whole day in front of a computer. In the evening I cook dinner, and than I cannot move just lay helpless on the sofa until ten o'clock, and then to the computer again. I cannot manage all my jobs at the office, so I have to bring the files home as well, sometimes until two-three o'clock in the morning I work. I think I never relaxed, even when I sleep I solve the problems. Once I had an emotional breakdown. I felt that in the office everybody was pulling me; I had to run the office, I had to take business trips, I had to do seminars, and then they started reconstruction work in the new office, and again it was mostly my responsibility. At home my kids and husband wanted attention, my father died and I had to organise everything for his funeral. I had no time to mourn and to weep; I was existing just like clockwork. When I collapsed I spent three days in bed, I just enjoyed doing nothing".

Respondents also reported that the heavy time pressure due to the double burden of a combined job and family responsibilities could lead to stress. Some women answered that although it was probably difficult to maintain their multiple role responsibilities, but work outside the home could decrease the stress a woman experiences from their home role as a wife and mother:

Sultanat, 54,

"After spending the whole weekend on the *dacha* (country house) running round in circles, I go to work on Monday and enjoy my work. For me work is escape from my household routine. I do rest at work".

The majority of working women reported feelings of guilt and inadequacy at being unable to provide their children with elementary necessities such as proper meals and help with school work. Women reported that their feelings of guilt occurred when they failed to manage a household the way they thought it should be done. They also admitted that multiple demanding roles often leads to conflicts within the family apart from the fact that their health was neglected due to the overload of a double burden. Five out of ten working women reported difficulties in balancing their work with their family responsibilities. Thus, the combined responsibilities of a job, housework and childcare can increase the health risk to women. As Gauhar, 42, explained:

"My husband doesn't understand that I work the same hours as he does. He wants me to do everything perfectly at home. The food must be on time, clothes must be fresh, and the children looked after. 'If you cannot combine – you quit', he says. But 'perfect', what does he means by that? I do what is required.... I don't know, he is sometime unreasonably demanding".

Working women tend to adapt their lives in order to balance between their primary responsibilities inside the home and the demands of paid employment outside the home, if they want to keep their jobs. The expectations are that a married woman must consider her employment outside home as secondary to her household duties even if she works and earns money to support the family. Many respondents from this study complained that they were primarily responsible for maintaining their house in good condition and were ultimately responsible for the well being of their children irrespective to their status.

For most women in this study employment does not provide them with enough financial support. However, having their own money and the possibility to get out of home and have a professional job can increase their self-esteem and psychological well being. In this respect, their employment generally has beneficial effects on their health. This finding is consistent with the argument that 'paid employment is both a potential

stressor (when added to childcare and marital roles) and also an indicator of potential material and social resources' (Moss, 2002).

For women who do choose to work, the work may also improve their health. As Lee (1998:102) argues, balancing paid work and household work, although stressful, could provide women with activities, 'which develop self-esteem and coping strategies'. This suggests that staying home from work could increase the social isolation of women. Yoqut, a 39 year old teacher said:

> "I grew dull at home, the situation is very nervous, a person goes down, you always stay at home, do not go anywhere, do not look after yourself – you just don't have time, when you have such a tight schedule, you know, all day long, around and around the house....but when I started work after ten years sitting at home it was different. I started socialising; I started to look after myself. The whole year of going to work for me was like a holiday. It was a kind of escape".

When women are satisfied with their employment this could then become beneficial to their family and their health. It could also be argued though, that employed women have less time available for themselves, so they may not be able to care for their health. When I asked the interviewees, "What are the most important reasons why you prefer to work?" they did not mention financial reasons as the primary factor. The most important factors for them were that they liked and enjoyed working, in other words they gain personal gratification from work. Among other reasons were escape from routine and boredom, being active, having a chance to socialise, and then financial reasons. This is probably due to the fact that the occupation of most of the sample (teachers and doctors) are very poorly paid. If women wanted to earn money then they probably had to take different kinds of jobs like trading or shuttle trips. However, if women's paid work did indeed 'provide little intrinsic satisfaction' (Lee, 1998:103) then that could contribute to the factors creating a negative impact on a woman's well being.

School children in these families were also associated with higher levels of distress equally among employed mothers and housewives.

Yoqut, 39:

> "When my children were in kindergarten, they were there until five or six o'clock. Now three of them go to school. My elder daughter can come and go by

herself, she is grown up, but the younger children finish school at 12 or one o'clock in the afternoon. They cannot come from school by themselves, they are too young. Now I work at school, where my kids are, and they stay at school until I finish my work at four sometimes five o'clock in the afternoon, without lunch or any opportunity to rest".

As Doyal (1995:28) states, "indeed those with young children may never really be off duty as working hours even extend to periods of snatched sleep."

Munisa, 38:

"I do not remember when I was alone with my husband. Kids are everywhere... I cook and I wash, and I clean, then I cook again and so on and it is round the clock. When you have three kids that means that if one of them becomes sick then all of them one after the other would be sick. You cannot isolate them, they all mingle anyway. When finally I cure them, there is another round".

Shohista, 38, said:

"My son is sick every two–three weeks. I have to stay home from my work when he is sick, that is for one week at least. I always take sick leave, but sometimes I doubt if it was worth working like that. My employees say nothing, but I feel ashamed. Whenever possible I ask my mother or sister to stay with my son, but anyway it is such a stress to rush to my work, and call home every minute...I feel so sick because I am torn between my work and home".

Most of the women who work outside of the home reported suffering from migraines, weariness, and in some cases even neuroses, which they themselves correlated with their dual responsibilities and with the lack of sleep they get. Housewives also complained of suffering the same symptoms.

Mariam, a 52 year old university lecturer:

"I had severe headaches when I was young. I relate it to multiple births, while I was working on my *kandidat* [PhD] dissertation. I finished my dissertation in four years; I got so tired, because of sleepless nights. Babies at night work in the day....After I defended my thesis my headaches disappeared, my sleep habits have been restored and my nervous system returned to normal. I must admit that certainly I restored my health with the help of doctors, however, the pressures of the lifestyle that I had also influenced my health. I was diagnosed with *teriotoksicosis* (thyroid gland dysfunction). I received treatment between 1986 and 1987 and since then, *tfu-tfu*, thank God, I am much better".

Munisa, a 38 year old housewife, told me that she wanted to go to work. When she used to work in a Polytechnic Institute, she did well at work and managed to do her housework with greater ease. However, the salary was so small that there was no sense in keeping that job, although staying at home was also very difficult for her, as she said she became mentally degenerated.

In recent years public transport services in Uzbekistan became more expensive, and salaries began to fall below the costs of goods and services. Therefore, because salaries were unable to even cover the cost of transportation, women decided that it was not profitable to work and they preferred to dedicate themselves to family work. When I asked another respondent, Kamola, whether she preferred being unemployed, she answered:

"No, whatever, but work for me is everything, even if not for financial reasons. Anyway I enjoy my work. I want to do something useful. I cannot imagine myself as a housewife, I would probably die, I don't know".

Women's occupational activities help to raise the living standards of their family and expand their social contacts. This in turn enriches their intellectual and cultural life, and can raise their self-esteem and consequently enhances their role in the family. Mariam (52), Asal (39), Mukaddas (39) and Yoqut (39) mentioned during their interviews how their self-esteem has grown since they started working. Firstly, they became confident that they were able to earn their own money and be economically independent. Asal explained:

"I know that I can manage on my own now, when I spent time on maternity leave it was difficult, I would say humiliating because every time I had to ask for money from my husband. Now I am my own master to my money. My husband is unemployed now, so what would we have done if I did not work. He always told me to sit at home, he is very jealous. I could probably take another better paid job in a private clinic, but my husband does not allow me, he knows that at my maternity clinic there are no men around. Thank God, I can at least work there".

Secondly, women expressed confidence that they were able to manage without their husbands. As Yoqut put it:

"Before, I was very concerned about my husband abandoning me, what would I do with my three kids. But now I am not afraid any more, now I know, I mean I tried and I know I could manage".

On the other hand the women's activities outside of the home often give rise to tensions and frictions within the family. Mukaddas was close to divorce because her husband demanded that she should look after their two children. His traditional upbringing stated that a man should not undertake any domestic responsibilities (he can share responsibilities or help his wife but no more). This therefore made him very angry with Mukaddas's behaviour. He always started to argue if a meal had not been prepared for dinner, or the laundry had not been done, or the house was unclean. There were several years of constant arguments over such things as who would stay at home if the daughter or the son was ill, who would take them to the doctor, or who would go to school meetings.

"Thank God I have my parents, they helped us so much. I could always send my kids to my parent's house when my husband refused to sit with them. Because of my parents I was able to preserve my work and my family".

These data suggest a correlation between women's employment outside of the home and the division of household labour. However, the notion that Uzbek women still want to rule in the kitchen predominates largely in society, despite some examples where women who assumed the role of the family bread-winner are shifting their

position from a good house keeper to a person who fights for the right to neglect the housework. However, my observations suggest that such a situation happens only in families where women are desperate to work and have enough confidence and power to persuade their husbands to let them. Many respondents showed a lack of resistance to their husbands demands to stay out of work. The housewives complained that the housework was very heavy, monotonous and unrewarding. However, three out of nine housewives did not show any sense of preference for employment. They seemed to be quiet satisfied with their situation and expressed the opinion that being at home might be beneficial. Adolat, 35, housewife, explained her problem as follows:

> "I have too many things to do at home. After sending my kids to school, sometimes I do the cleaning or washing, I go to the market or shops, buy some food, then I come home, cook lunch and there they are. I must go and fetch my kids from school. Sometimes my husband comes home for lunch. I feed them. And you know I have to take my daughter to music lessons three times a week, yes, who else would do that? And then their homework... Oh, well , what else, and many other things. Too much, too much, I must be at home; I think children must come first. And what do you think? A?. No, I cannot go to work as well, oh, no. Enough work at home".

It could be argued that housewives should have more time to look after themselves, have more spare time to visit doctors or take a rest when they feel ill, or do exercises. However, many women complain that the housework is non-stop, and they feel the burden that everything must be perfect at home. As Doyal (1995:38) stresses, 'although they are not formally supervised, most women doing housework experience very powerful pressures, both from other people and from inside their own heads'. Yoqut, 39, said:

> "I was not able to leave the house much, I always thought that I haven't yet done this or that...I always postponed visits to the doctor until I had acute conditions. I always thought if I got a cold or flu I can treat it myself, until I just wasn't able to get up. But at least I thought, that then I had a good reason to see the doctor".

Waldron (1983:119) found that 'housewives are more likely than employed women to report having a chronic condition, such as asthma, allergies, or heart disease'. The physical and emotional health of housewives can be undermined by the requirements of spending longer hours at home. Six housewives complained about their chronic diseases. The reason for this might be social isolation, low self-esteem, and the impossibility of finishing the monotonous and heavy household burden. Another reason could be that woman with poor health are less likely to seek work outside home (Doyal, 1995). Some Western authors explain that housewives have a perceived poorer health because they use the visit to a doctor to compensate for their social isolation (Roberts, 1985) and therefore visits to clinics may have a social function as well (Lewis and Kieffer, 1994). Furthermore, 'employed women have an urgent need to maintain their health in order to meet their multiple role responsibilities' (Waldron 1983:129). They try to eat better, exercise, read a great deal more literature on how to maintain their health and use different cleansing procedures and diets. One working woman interviewed during this study admitted that she does not have time to even think about her health.

Mukaddas, 39:

> "I am afraid of even thinking. I have no time for this. I work all day and then washing, cooking, cleaning, sometimes I do not clean my flat for several weeks, because I have no time, but please, do not tell anybody [*laughs*]. You know how our '*opashk*' (old ladies) like to gossip about everyone. I have no time, I know if I go for a check up they will find something, but I am afraid because then I would not have time for the treatment anyway, so why bother yourself".

When asked about how much time women have for themselves, ten out of twenty replied to having less than twenty minutes a day. One woman said from half an hour to one hour, whilst the other nine found it difficult to reply with a time.

Asal, 39:

> "My own time is very late at night when I have done with all other chores such as cooking, cleaning, washing, ironing, checking the kids' homework and telling bedtime stories to the kids. After all that is done, I go to the bathroom and take a bath, if I am too tired, a shower and that is the time I consider as my time".

When asked, 'Do you take any preventive measures to maintain your own health?" Asal replied:

> "No. I mean you must take rest sometimes. Otherwise you just collapse at some point. But preventive measures... Why? When disease strikes then you must cure it. Even with my kids I treat their symptoms only. If they have aches or pain I give them a pain killer, if a temperature, an aspirin. I believe it is the best way. Preventive measures? No you must live without thoughts about illness, otherwise you become crazy".

Most respondents felt that women need to be responsible for protecting their own health, but have no time and or opportunities for such activities. Thus, health issues and self care often have low priority when women are overloaded by other problems.

Another revelation in this study was that increasing impoverishment has lead to women becoming reproachful towards men for not bringing home enough money. The men have reacted angrily and sometimes this have escalated into violence against the women.

Yoqut, 39:

> "Once I came home and found that I was not able to open the door of my flat with the key. I went to my parent's house and found my kids there. My husband sent the kids to my parents, changed the lock...and he didn't tell me, he didn't explain anything. This is the way he deals with his wife. Now I know we had so many problems at that time. He didn't have a proper job and I complained that I must buy school uniform for daughters. I don't remember now, but really, it was so hard and I needed to find some money, so I asked him all the time, who else had I to ask? But he decided that he could just throw me out of his house. Well, maybe I was bad, but our children, he made our children to suffer. He thought I would come and cry and beg him to take us back. But I didn't go back to him and we managed to live quite well for a year without his help".

In this case Yoqut proved that she could manage on her own, in a situation when she was left with three kids, without work and without money. Women are very

vulnerable in Uzbekistan. Poor women do not have savings of any kind. If they quarrel with their husbands the only place where they can go is to their parents' home. They are entitled by Law to half of the house that they share with their husband, but the court procedure can take too much time. In most cases the participants mentioned that when there was a quarrel it was usually the woman who went to their parents' house until their husband had calmed down.

Many respondents said that the number of fights and quarrels with their husband increased as a result of problems associated with a lack of money. The wives blamed their husband, who replied angrily. In most cases the problems were solved peacefully, due to a woman's traditional respect for the man. Some respondents articulated that they no longer respected their husband because he cannot sufficiently provide for their family. However, the cultural up-bringing do not allow them to change the relations in their benefit.

5.2. Health and Family Responsibilities

Among Western researchers 'the private world of the family has traditionally been viewed as the domain of women' in many societies' (Doyal, 1995:27). As Lee (1998:107) argues, women are more inclined to see domestic labour as their responsibility, while men see 'helping out' means something of great importance. In Uzbekistan, the society and women themselves consider that domestic responsibilities are the main concern for women within the family, despite any economic or social changes over the past decade.

Mariam, 52:

"I know that everything depends on me, anyway, so I distribute the workload evenly. I prepare all I would need for the next day in the evening. Even the dinner I can start cooking in the evening for the next day, so when I come home I will almost have dinner ready. A person can manage if she distributes everything and has a plan. I do not rely on my husband; he would never do anything unless he was not told to do it. You must ask him, otherwise even if it is a fire, he would never initiate it. Now I have a daughter-in-law, but she is pregnant, so I do not want to ask her, but she cooks and cleans sometimes. At least some help. Before I used to do everything myself therefore I adjusted a special system".

These arrangements can have profound effects on a woman's health. Western writers state that in Western societies women put the family first and their own health last (Doyal, 1995; Lee 1998; Oakley, 1981; Roberts, 1981). In Uzbek society this situation seems even worse, because not only do men take this for granted, but Uzbek women themselves reckon that they must totally devote themselves to their family. This is perhaps how most women see their life in general. Some women made remarks about their husband not helping around the house, yet they did not express any anger because they expected more help from their children. Yoqut's, 39, life story illustrates how patriarchal structures in Uzbek families could lead to health disorders or even tragic outcomes for women. During the first ten years of her marriage she gave birth to four children and had a miscarriage after each live birth. Despite the fact that her health was undermined by these frequent births and associated complications, she did not have the time or the opportunity to undergo treatment or have a rest. Her only entertainment was to go to the theatre two or three times a year with her mother-in-law and sisters-in-law. Not only did her own health suffer as a result of a work overload, but also she lost her eight month old son, because she had to sweep the yard in the morning and in the evenings, cook, wash the dishes, wash the linen, look after her two daughters, three and five years old, her parents-in-law and her husband and also feed the chickens and clean their cage. Yoqut did not work so she was supposed to do all the housework herself. Nobody ever helped her, her daughters were too young to help at that time and they needed a lot of attention. Her parents in law were frequently ill, so she had to look after them as well. The day she returned from the hospital with her newborn baby her husband told her to do the housework straight away because his mother was tired from doing the household chores. Thus, Yoqut had no time to rest and went straight to work. She put her son in a *beshik*[8], a time saving device for women, because a baby in a *beshik* could stay all the time without needing to be have their nappy changed.

Once her son got a cold and then a high temperature, so they rushed him to hospital, but unfortunately the doctors were unable to save him. She recalled that she did not remember her son; she did not even manage to take a picture of him because she had not had the time. The worst thing was that everybody blamed her for her own son's death. She admitted that she did not want to live. She was in despair. However, very

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[8] Special device for babies, like a cradle, but the bay is fastened to it.

soon she became pregnant again and that saved her. She gave birth to a boy, who was eight years old at the time of the interview. She also mentioned that her mother-in-law gave him her own family name to show how much she loved him. Little by little Yoqut became more self-assertive. Although she still suffers from her husband's negative attitude, which had changed but not a lot, she decided that she must look after herself, otherwise nobody would care about her or about her children. Yoqut further stated:

> "Today I took on a job as a teacher in the school. The salary is not very good but I also give private lessons. Now I can even help my own parents, not a lot, but at least something. Now I have some self esteem. But I feel grievance, I don't like them anymore, I do not want to spend my life working for them and then nobody will say thank you. If anything, not come try, happens to me nobody will take care of me. I decided to look after myself. I know it is too late, I cannot bring back the time and, my child. But I have to think about my other children. I blame myself now, I was blind, I did everything to please them and they didn't even try to save my son. In many Uzbek families it is the same situation, the wife is not a person, she is just a working devise, and above all free of charge. If something happens to her, they will take another one. It always was like that."

Despite the fact that a woman's workload intensifies due to social upheaval, women continue to undertake the majority of the household work, even if through necessities that they must take other economic activities to earn extra income to support the family. Despite the development of domestic appliances, which ameliorate the hard physical labour, the domestic work can be physically and emotionally strenuous when combined with employment outside the home.

Mariam, 52:

> "I have a very bad habit to do general cleaning every month. I must clean everything from the ceiling to the floor. I must shake out all the books and clean all the chandeliers. Now I have ended up with an allergy to the dust. But I can't ask somebody to help me, because I know that only I can do it as I want it to be done".

The domestic workplace could also be hazardous as an industrial setting or a workplace (Doyal, 1995:36, Calnan, 1987:75). Although Uzbek women are at lesser

risk from domestic chemicals frequently used in developed countries, the unclean water or variety of other toxic substances can pose a more specific threat to their health. For example, people in Uzbekistan traditionally use unrefined cotton seed oil. Because this oil is unrefined it must be fried thoroughly so that the smoke can come out of it, only after that it could be used in cooking. It is usually the women who inhale more smoke from the oil while cooking, which can lead to asthma and other respiratory or allergic diseases.

In some societies at a time when women reach their forties, their grown up children leave home giving them new and positive opportunities to move on with their own lives. In Uzbek society at the age of 40-45, most women have grown up children who may already be married and their children rarely leave home. Moreover, the family is enlarged when a daughter-in-law or a grandchild enters. Three generation extended families are very common in Uzbekistan, both in urban and in rural areas. As a rule newly-weds start their married life in the home of the groom's parents. Despite the conflicts and contradictions between different generations it is still common that two-three generations live under one roof. There are two reasons for this. Firstly, there is a lack of possibilities to expand the living conditions. Secondly, some people prefer to live in extended families due to cultural traditions. Under these circumstances women can experience further strains on their physical and mental well-being. However, for many women the new role of mother-in-law and grandmother could actually increase their status in the family.

Mariam, 52, (whose son married two years ago) said that her daughter-in-law took most of the household responsibilities. She [Mariam] still does the cleaning and the cooking but now has much more time for herself - she can go to the hairdresser once a fortnight and spend more time with her friends. She can also help her sister with her small children. She can look after her health as well as she has time to go through a regular medical checking routine. She said that although she reached the menopause she felt much more relaxed and did not have the terrible headaches that she used to have when her children were small. She admitted that she became more carefree, the last couple of years.

5.3. Looking after Dependant and Sick Parents

Mid-life is a period for women when their own parents become older and consequently sicker and must be looked after. Research on women's health has

identified that women are more likely to be unpaid carers for family members, providing domestic health care for children, parents and husband when required (Arber and Khlat, 2002; Lee, 1998, Doyal, 1995). Caring for sick and elderly persons could be added to the list of women's multiple roles and may considerably jeopardize their well-being and health. Looking after sick parents and in-laws are a primary responsibility for women in Uzbek society. Due to the deterioration of health care and social services during the transition, formal support for the terminally ill and disabled is inadequate in Uzbekistan. All the responsibilities of looking after sick and disabled is placed on the family. Lee (1998:111) argues that because the cost of care giving is ignored it therefore seems 'less costly in economic terms than [the] provision of adequate social services'.

The participants in this study, independent of their occupational status, acted as informal caregivers to their husbands, children and elderly parents at home. However, working women reported that they especially suffered from the double burden of their daily life and from pressure at work. The women whose elderly parents have been living separately indicated that it was their responsibility to assist their parents daily, not their male siblings or their husband. The respondents admitted that their brothers or spouses only supported financially or by providing transportation. Coupled with other women's stresses and challenges this caregiver responsibility could lead to health problems and poor self care for them. Most women interviewed in this study expressed a willingness to look after their own parents. However, the exhaustion, tiredness and stress of seeing how the best-loved person suffers, and in most cases the inability to help their suffering, have led to significant emotional and physical exhaustion, detrimental to their health. Doyal (1995:30) states that a 'women's ultimate responsibility for the well-being of their families can be at considerable cost to their own health." Research on the impact of care giving on women's health includes negative effects such as physical strain and emotional exhaustion, depression, back pain and reduced leisure time (Lee, 1998:115).

Rano, a 39 year old university lecturer, had to leave work to look after her father who was dying from cancer. Although she had extensive social support from her relatives, she had to change her life and move to her parents' house with her son, and leave her husband and work for sometime. She learned how to do injections, enemas, and bandaging. She was lucky though because the doctor visited her father every other day and gave her all the instructions. However, the sleepless nights, the guilt that she cannot spare time for her son and husband and the constant anxiety and agitation from possibility loosing her job made the situation intolerable,

"I didn't know how long it would be, the atmosphere at home was intolerable. I cried every day. The worst thing was seeing him in pain without any possibility to help relieve his suffering. He called my mother every other minute, he wanted to see only her. But my mother was old and sick herself. He was up three to four times a night. We didn't have proper sleep for several months. We were so exhausted. I cried and exposed all my angriness on my mother and sometimes on my son. I feel guilty now. I lost weight, I was not controlling my emotions anymore, but I prayed to prolong his life for a little longer because I was so scared of the idea of loosing him. My father was very capricious, my mother also had a very peculiar character and she didn't hide her attitudes towards my father's capricious behaviour".

Public facilities and social services for the sick and demented elderly were inefficient during socialism and after independence. Even if sick people were admitted to hospital, their relatives had to look after them and feed and wash them.

Social isolation, the need to sacrifice their interests and concerns for the health of their sick relatives combined with weariness and exhaustion from sleepless nights, all contribute to the health risk of the caregivers themselves. Many respondents often indicated feelings of guilt because they were unable to provide professional help to their suffering relatives.

Gauhar, 42, told the story of losing her seven year old child to congenital heart disease:

"I carried him all the time. He was not able to walk by himself and he was always short of breath. So I had to be alert all the time. Even at night I had to get up several times to see if anything had happened. For seven years I was not able to leave him alone for a minute. Two-three times a year I spend in hospital with him. We took him to Moscow for an operation. The operation was very successful and he started to walk. We had to stay in Moscow in order to be observed all the time. But I did not have the opportunity to stay there for longer. So we came back and he died, because there was no good equipment in the hospital as in Moscow, so our doctors could not save him. [*cries*]...If only we were in Moscow, I am sure he would have been alive now".

Q.: "Did you get any support from your husband or relatives at that time?"

Gauhar: "Relatives gave money for the trip to Moscow, there we also stayed at our relatives' flat. My husband looked after my second son and worked to provide for us. I got emotional support from my friends. But at that time I didn't think about myself, I belonged to my dearest son utterly, and completely. For several years I didn't think about what I ate, how I slept, what I wore. I could have gone to the other end of the earth on foot if only it would have helped to save my son".

Thus, the physical and mental health of women is worn down when they totally devoted themselves to this job of looking after sick or frail family members. However, they do not considered any alternatives, like sharing the responsibility with other family members or getting some kind of state support. They fully accepted that that was their destiny and only they can do it, because who else would do this work better? Gauhar said in her interview that although she spent almost 24 hours a day with her sick son and had to carry him from place to place, she would have never allowed anybody to look after him, because nobody would have done it as good as she did.

Respondents who had to give care reported disturbed sleep, irregular eating, lifting heavy weights and social deprivation. Ruhsora a 50 year old housewife told her story about how she had to take both parents to live with her because they had become very ill and were not able to look after themselves. She had to wash them one after the other every morning and then feed them one after the other. She had to get up several times during the night to administer injections and medicine to each of them because both of her parents were bedridden. Her children did help but she wanted them to study. She therefore tried not to overload them and took the most of the work on herself. A year after burying her mother she buried her father. Subsequently, her own health started to deteriorate very quickly because of sleepless nights, carrying heavy things, self deprivation, malnutrition and exhaustion. She was soon rushed to hospital with heavy bleeding and diagnosed with severe anaemia, fibroids and genital inflammation. As a result, she had to undergone a major operation (hysterectomy) and spent a month after the operation in bed. At the time of the interview she was still weak and complained about her poor health.

Ruhsora sacrificed her own health for her parents. She never considered any other option. Traditionally, children should look after their old parents. Public opinion condemns people who send their parents to an old people's home. Only childless people can go there, although the remote relatives usually take their childless relatives to look after them. The majority of respondents admitted that looking after their elderly parents on a daily basis was a serious trial, and most expressed the wish to get more help or share the task with their spouse or other relatives. However, some respondents noted that they would not transfer such responsibilities in fear that others would not do the work as perfect as they did themselves. In moral terms they felt that this would be seen as a betrayal.

Some respondents indicated that they had more than one person to look after, because they were responsible not only for their own parents but also their in-laws. Yoqut shared her story:

> "Nothing was good enough for my father-in-law. I tried very hard to please him. He had a very tough temper, but when he was ill, no one from his family could deal with him. They simply withdrew from their duties. So it was I that had to bear his whims. And nobody thought that at the same time my grandmother was terminally ill, she had a hip fracture, my parents were too old themselves to look after her, so I was just torn apart. The kids, and cooking and washing and chickens, everything was on me".

Mukaddas explained similarly :

> "We lived in my grandfather's home. My grandpa was very ill during his last year. He became very aggressive sometimes and he did not recognise me or my mother, his daughter, at some points. My mother used to come and help me look after him, but most of the time I was looking after him. My husband never even came close to him. But when my husband's parents were ill, I had to rush to their house or to the hospital where they were admitted. Nobody cared that I had small children. One of them was always sick, he had a chronic form of hepatitis, and I had to look after my grandpa. I had to leave my children to my mother or my sister, and go to visit his parents. It was not that there was no one to look after them, my husband has a very extended family, but it is an obligation, you know, just to show my respect".

Women do carry on not because they are healthy but because they have to, they have no other choice. Moss (2002) characterised the caring responsibilities as a 'double-edge sword'. She argues that although support and care for the elderly could provide woman with some 'future social credit or capital' from her children and siblings, it is a 'tremendously draining' job, both physically and emotionally.

5.4. Coping Strategies and Social Support

The importance of social support has been increasingly recognised in the literature on health behaviour (Arellano, 1996; Cattell, 2001; Meadow et al. 2001; Remennick 2002). Sociologists have identified that social network and social support are strongly associated with health (Melchior, et al. 2003). There is good evidence that a person's social relationships, or lack of them, are crucial for maintaining physical and mental health (Oakley, 1993). Graham (2000a:101) argues that material deprivation has a more important influence on psychological health in the study concerned with psychological health, however, access to social support proved to have mediated the effects of material disadvantage. Moss (2002) in turn argues that 'effective coping strategies such as support from social networks' can reduce stress and promote and improve health. Uzbeks are members of large families and have dense and extensive social networks. These in turn cushion some of the problems associated with poverty and social deprivation.

This study suggests that the informants' coping tools drew mainly on the family support network, although this varied with family situation, financial resources, social background and type of employment. Three of the respondents emphasised that they were able to hire help for some domestic chores, such as, Nigora, 40:

> " I started working after three years spent at home on maternity leave. When my daughter reached the age when I was able to send her to kindergarten, I realised that combining employment and household responsibilities was not an option. My parents are both working; therefore, there was no subsequent help from their side. So, I decided that the best option would be to employ a daily home maid. I spend almost all my salary on her, but for me the worst would be to stay at home and be like the home maid myself."

Two working women who had financial support from their husbands and relatives stressed that they considered the option of hiring somebody for help as a last resort because they did not want to rely on strangers. The bulk of respondents indicated that they were not able to afford outside helpers and so housework remained their responsibilities. Three women confessed that they had nobody to rely on, no relatives and had no money to hire help. These women faced the great challenges of all.

Leila, Oliya and Yuliya had no close relatives to whom they could turn for help even in the case of an emergency. Their low income excluded any possibility of taking on a helper. Thus, Yuliya relied mostly on herself and her grown up daughters, who helped a lot. Oliya said that she have managed quite well. Although her pension was not enough to have decent life, she relied on giving private lessons to children. In the summer, she organized mini-camps for 3-4 children. The parents brought the children to her house for a day stay. She would then take them to a lake, to museums, and coaches them. It brings her some income and she has an occupation. She became very friendly with the children and their mothers. The children became well acquainted with her and when they grew up they continued to visit.

Leila does not work due to invalidity, so she cannot do a lot of work around the house and she has a father of 89 years old who needs a great deal of care. She gets an invalidity pension and her father reads the Qur'an, at home, which brings some money to the family. She said:

> "I try to make things as simple as possible. I do not sweep the yard every day, we have got used to eating less meat and I have worn the same clothes for several years. The only thing I ask God for is to give me good health. My father tries to help me, he is never idle. He works in the yard from dawn till sunset, but then he feels sick. I just worry about him most of all, what would I do without him. He is my life".

In between these extreme categories there were women whose parents were, albeit old but, still of some help and women who had such an expanded family clan that even when they themselves were unwell they were able get substantial help from some of their kin.

The women's stories indicated that most of the sources they drew upon for their rest and relief were found from informal friendship networks, which were most essential for them. Women sought and found support among their friends and these relationships provided them with a natural emotional cure of stress. Seven respondents said that in order to discharge negative feelings from their problems, and for emotional support, they usually choose to turn to their friends.

Gauhar,

> "How do I cope? I go to my friends. Chatting with friends if not with one's own eyes then on the telephone. You know how women can speak on the phone for hours. This is the only way I could remember doing in order to raise my mood. If something happens I turn to my friends. If I am just tired, again I call my friends, this is how I relax".

Munisa said that whenever she felt tired from her children she went straight to her neighbour upstairs for a chat. There she could relax for a couple of minutes before going back to the 'battlefield', to persuade her children to do their homework, to clean up after themselves, to listen to their complaints about each other, or to separate them when they fought and so on. One respondent said that praying was the only way to cope with the difficulties. Five women indicated that work was their only escape from the problems.

Shohista, 38:

> "For me work means everything. First of all, when I work I feel accomplished. Also when you are preoccupied with something you do not have time to think about your problems, and problems can also be solve if you work hard, that means you have enough money. I don't know, for me .....when I am happy I want to go to work, when something goes wrong, I also go to work and feel much better".

Oidyn said that she had no time for socialising with friends, although she loves it. But work for her meant everything:

"Before, I had time to meet with friends and relatives but during the last four years, I didn't have a vacation even once. I never managed to go to my friends birthday parties. I miss everything, because sometimes I work until 8 or 9 o'clock in the evening six days a week. But I feel that this is better, because I think if I had time to think I would probably realise how miserable my life is. I do not have children, my husband is unemployed.....if I had some spare time I would probably spend it pitying myself. When I talk to my friends they always ask me how the infertility treatment is going. I think they feel sorry for me. I just want to escape from all this and work is the best solution, I think".

The respondents who lacked the opportunities to see their friends felt themselves to be isolated and considered their situation as regretful. As one respondent put it:

"My husband and children are not a good support in terms of emotional help. They do not share with me and I do not share with them. My friends are more understanding and sometimes they are even more helpful than my family".

Other factors like reading a book, watching the TV and going to the theatre or cinema were mention as important for managing the strain of a working day. Several respondents admitted that reading was the best way to relax. However, due to time constraints and multiple responsibilities such 'luxuries', as they called it, became unobtainable. Women mentioned self-persuasion (Yaqut, 39), praying (Leila, 46), belief in forgiveness (Munisa, 38, and Adalat, 39), belief in destiny and that everything has its own order and the individual must accept all changes as positive (Iroda, 42, and Yuliya, 54) as a way of overcoming difficulties. Spirituality was one of the main factors cited as helping to manage stress, anxiety and pressure. Nigora (40) admitted that she sought counselling in order to manage her family problems, a relatively new form of activity in Uzbekistan.

In order to make ends meet, Adalat has moved to her parents' house with all her family in order to make profit from leasing her own flat. Rano gives private lessons, and translates from Uzbek and Russian into English, she also writes articles on theatre and cinema and she is a competitor on doctoral thesis. Mariam said that she has fifteen private pupils, besides her work in a University. Yoqut also gives private lessons in maths. Yuliya sews her own clothes and her daughters knit. Shohista cooks cakes and

pastries to sell. Nigora writes methodical text books for her students, she even managed to publish one, and works on computer design during the nights. Women from the sample showed their ability to challenge the misfortune despite any vicissitude. They showed courage and strove to sustain their well being and those of their families, despite any hardships.

Muhaddas, Oydin and Shohista, take English language courses so that they might apply for better jobs. Iroda tries to find her way in life with spirituality, she reads a lot of literature on different religions, visits sacred places and attends seminars and lectures on related topics.

When asked who could help them in case of emergency, most women said their next of kin. Women with no close relatives indicated that neighbours and friends were very responsive and helpful. As Gauhar, 42 put it:

"When my son was ill everybody tried to help. Relatives gave money for our travel to Moscow and for the treatment. Friends were very supportive. Everybody who could use their personal connections in the hospitals offered us a help".

Shirin, 50 also mentioned that:

"I have a very extended family. I have only one sibling, my brother, but a lot of cousins and aunts. When my daughter died, for several months I was not able to do anything. I was not able even to wash myself. I didn't have any incentives. All my relatives were here. They organised and conducted the funerals and funeral repast. I didn't even know where my grandson was, at that time my neighbour took him to live with her for several days. My cousins and aunts lived with me for several months they didn't leave me alone for one minute. I lived in a fog. They all had their own things to do, so they took turns to look after me".

Asal, 39:

"I need not any help. The life taught me. I help whenever possible. I live in *mahalla (*so there are always neighbours calling me to see their ill child, to check a blood pressure or to give an injection. I am a paediatrician. So, I kind of serve the whole *mahalla*. But I feel, (not come true, *tfu-tfu*), if something happens people will come to help. Sometimes, when I feel very tired after work the neighbour could drop in for a chat or to discuss neighbourhood events. You

cannot refuse. So I serve tea, and we sit and chat for hours. My parents are old and sick, they also need support so I try to help them, but whenever I need them to look after my kids they are a great help".

Nigora, 40, told the story that when her husband became ill suddenly, she panicked and did not know what to do. Because she was not able to get through to the emergency services on the telephone, she asked her neighbour to call them. The neighbour took her first aid set, went up to Nogora's flat, measured her husband's blood pressure and gave him some medicine. When the emergency finally arrived they admitted everything was done correctly and took him to the hospital.

"I think she saved my husband, he was having a heart attack and I panicked, and who knows what would have happened if I had just waited for the emergency services to come. Now I know everything, how to measure blood pressure, when to give him medicine or call the doctor. I know how to do injections [*Laughs*], almost professionally. If someone calls me for help I take my equipment, I bought this special medical device to check the blood pressure and I go to help with confidence. I believe it is now my turn to save someone's life, or at least to be of help".

Successful coping also depends on the amount of help they can summon up from the other family members. Women usually seek social support, which is associated with coping with emotional stress. Thus, coping strategies were aimed to protect women from the source of stress. Women seek social support to obtain advice, assistance, information and emotional backing. A study conducted by Melchior et al. (2003) revealed that those individuals with adequate social support will receive advice, services, material and financial aid from others, and thus will likely benefit from better medical and non-medical care. Gerhardt (1993:xix) states that social support among the other forms of self-help has been considered within the realms of medical practice benefiting the patient as a person.

The strategies that the respondents used to maintain, and in some cases to restore, their health enabled them to sustain hardships and function continually, despite any adversities. The knowledge that they could be of help as well as the fact that they

always could count on each other makes them more confident when facing difficulties and obstacles.

5.5. Summary

In its period of economic and political instability the Uzbekistan's citizens have faced an enormous challenge to their habitual norms. People have to adjust to new economic and political conditions. Many cultural and traditional values have been re-examined and renewed. During interviews women identified a number of adverse factors that had an impact on their own health and the health of their family members. They considered the uncertainty of their future to be the main factor contributing to deterioration in their own and their children's well being and health. For the generation of women that I interviewed good health had been taken for granted, and although many respondents had to confront their own and their family's health problems, they demonstrated an ability to cope. However, when it came to other social problems like unemployment, financial problems and family relationships, they felt that they had less control over such situations. Health and illness and death are regarded as natural processes and therefore received less emphasis than other socio-economic problems. Female respondents were born and lived most of their lives in a society where everything was provided for the citizens for free. By contrast with younger generation who grab their opportunities and make the most of their lives, my generation of respondents kept to their values and tried to apply them on the new way of life, though very often with not much success.

These data suggest that employment can influence women's health. For some respondents employment outside the home was a kind of retreat, for some a hard burden, which they must carry in order to provide for the family.

The reason why some women are less prone to combine their role as a wife and a mother with their role as a worker, preferring instead to stay at home, could be that with lost privileges and protection for women with jobs during transition women were discriminated against by employers. Women find it more difficult to compete because they have less opportunities to acquire higher qualifications, and thus they give in and become housewives if their husband can provide for the family. Women are expected to spend more time on housework and bringing up children. Consequently women have less time for learning and become less interested in acquiring new qualifications. They

become more dependent on their husband, looses her skills, social connections and self-esteem.

If a man is the sole bread-winner in the family and spends most of his time at work, he has less reason for helping around the house. One of the solutions in this situation could be to have less children in the family, however, for many women the more children she has the less likely she is to be abandoned by her husband. Having more children is seen as a way of reinforcing the family. However, in such cases men have a strong belief that the responsibility for the children and the home is primarily a woman's, no matter if she has a better paid job and spends more time outside the home. Men consider that she should manage everything, whatever the hardships and difficulties are (Yoqut, Asal, and Gauhar). Why should man think otherwise if every woman and man in this milieu, express the belief that housework is a woman's responsibility? It is very difficult to overcome the barriers erected by prejudice and created by generations.

The situation is totally different in the families where the wife is the sole bread-winner. In such families men gradually overcome the prejudices and, voluntarily or under the pressure of the circumstances, eventually give up and take over the household responsibilities and child-care tasks, for which he is not traditionally prepared. In this case the man must not only overcome his own prejudice, but also public opinion, his parents' and relatives' attitude, and probably the mockery of his friends. Not every man can withstand this situation. Therefore the process goes very slowly. Some women reported that they now have more things to take care of. That they are taking more responsibilities for providing for their families, but they also do the same amount of household work as before. One of the women interviewed said that only after years of quarrelling and misunderstanding, and lack of support from her husband and being on the verge of divorce did he admit that her work was much more important for their family and that one who had a better paid job must minimize their time spend on household, otherwise she just would have to give up her work (Mukaddas, 39). In this case the assumption that man's job is not necessarily more important than woman's has won. Only the creation of a mentality which acknowledges this assumption will make it possible that men will more equally share the household responsibilities with their wife.

On the other hand not only prejudices and traditions make woman dependent but the economic hardships in the country have led to a situation where woman are more easily out competed by men, mainly due to a woman's reproductive role. Thus,

employers are reluctant to hire a woman in her reproductive age. As Marsh (1996:15) states, "If a period of national revival coincides with a serious economic crisis, women are the first to be driven out of the labour market; and the number of women in top professional positions and representatives bodies decreases". In the Soviet period, women's right to work was legally supported by the Constitution. Today enterprises oriented on market economy can not afford to give a job to a person who would spend most of her working time on sick leave or looking after the children. In a new transitional society women's domestic and maternal responsibilities make them seem as being less reliable and efficient in the eyes of an employer. The move to the market economy has helped return traditional gender roles, where the role of men is in a productive sphere and women in a reproductive sphere. It is true that women in the Soviet period undertook less demanding and less prestigious work, as teachers, nurses or doctors. However, it made it possible for women to manage work and home responsibilities better due to less pressure at work and more free time. The provision of state facilities like nurseries and kindergartens also helped in freeing women from a significant proportion of their responsibilities. Today conditions in the state kindergartens are not as they were before. Kindergartens are understaffed, because fewer women want to work for a meagre salary, hygienic standards and catering facilities are very poor due to cuts in state provisions. Thus, women are very concerned with the conditions in kindergartens and reluctant to send their children there and private ones are not affordable to all. Therefore, women prefer to keep their children at home if they have opportunity not to work. This is probably why nine women out of the twenty I interviewed were housewives.

The findings concerning the women's role as a caregiver suggests that even among the relatively egalitarian stratum of Uzbeks women function as principal caregivers in their families, often at the expense of their own well-being. This may be due not only to the cultural peculiarities but also to the underdeveloped state care provision offered for the elderly and disabled. There are only twenty eight old people's homes for the whole country (Gender I Razvitie, 1998) The respondents who provided care for their family members said that their health had been affected. Symptoms included back pain (from heavy lifting), tiredness and stress-related ailments. Nevertheless, all the respondents accentuated the importance of carrying out their commitments to their children and parents, even if it was for expense of their own health.

Chapter 6
Women's Perceptions of Religion, Faith, and Traditions

6.1. Introduction

This chapter integrates the main changes in women's attitudes and perceptions on such topics as religion, faith, and traditions among others. It emphasises the effects of the expansion of old traditions on the lives of Uzbek women in the last decade, and explains the impact of religion on women's health related behaviour. Traditions and changes that relate not only to religious practices but also to ethnic customs are included in the analysis. In order to see how women's lives are affected by structural and ideological developments, it is necessary to provide some background to the national religious heritage and traditional components. I would argue that health related problems within the observed groups of population could be understood better through a thorough analysis of the cultural context in which respondents find themselves and how it defines their reactions to issues of health. The chapter on Women's Health considered several aspects of the relationship between health and religious and ethnic traditions. The present chapter aims to uncover women's attitude to ongoing ideological changes in the country, and the consequent impact on their lives. I consider it important to scrutinise the impact of the resurgence of Islamic tradition on the status of women. This is because the renewed interest in tradition together with economic hardships could have a profound effect on patterns of equality. The data reflects how religion is integrated with all aspects of Uzbek women's lives.

From ancient times ethnic Uzbek traditions and customs were uniquely interwoven with Islamic practices. Religion, despite the seventy years of atheistic ideology in the country, is fundamental to the lives of many Uzbek women. Most of the indigenous population are Muslim. 'Some 90 per cent of the total population of Uzbekistan consists of Sunni Muslims of the Hanafi school' and even the 'openly hostile Soviet attitude towards the Islamic creed and way of life failed to eradicate the Islamic influence (Yalcin, 2002:980; 16). During the Soviet period atheistic Marxist ideology was 'incorporated with indigenous customs' while 'religion was discouraged and at times actively persecuted' (Birgerson, 2002:138).

Respondents felt a great deal of ambiguity towards Islam. There is a general agreement that Islam is an essential component of the national identity and cultural legacy, and therefore it is impossible to separate Islam and Uzbek cultural traditions. On the other hand there is a clear manifestation of absolute enmity and hostility towards the manifestation of Islamic fundamentalist trends, although socio-economic conditions favour the growth of fundamentalist revival of Islam (see Ray, 1999). There are some concerns that traditional Islamic influences may have a negative impact on economic development in the country. According to Lubin (1994) even during the Soviet period the indigenous population was encouraged by the Soviet state to pursue better education and training, but because of their preferences for traditional life-styles they continued to occupy lower paid non-prestigious jobs.

In order to mark the transition to independent nationhood, the government utilised Uzbek ethnic and Islamic traditions as cultural national symbols. As I mentioned above there are some differences between Islam in theory and in practice in Uzbekistan. Strict adherence to Islamic rules (*Adats*) and observation of Islamic obligations and proscriptions (*Shariat*) were not practised on a large scale after the Socialist revolution. However, Islamic rules have been preserved and observed generally during marriage customs, funerals and circumcision ceremonies. Islamic rules in certain circumstances were very significant in daily Uzbek life. The Soviet regime successfully aimed to annihilate the influence of Islam in society. However, despite its endeavours the regime was unable to reach the core of the national constructed unit, where the system of religious standards and patterns was preserved, 'with its educational institutions' and 'communication structures' transmitted from generation to generation (Yalcin, 2002:99). "What has returned today in public life – argues Yalcin - is, however, the mobilized version of what survived underground" (Ibid).

After the Silk Route ended its run in the 16 century, Central Asian countries became the most remote of the major Islamic countries. For centuries they were cut off not only from Arab Islamic influence, but also from economic and cultural contacts with other countries, due to their isolated geographical position. In 1868 Uzbekistan fell under Russian rule and in 1917 accepted Bolshevik Socialist rule. After that, for seventy years Islam was kept tightly under the control of Communist State. As a result Central Asian Muslims became the most secularised in the world. The Muslim Spiritual Board of Central Asia was established in 1943. All Muslim clerics had to be registered with the Board. Despite the fact that Islam gained, to certain extent, increasing influence

during Soviet period, "as a result of greater tolerance to religion throughout the Soviet period" (Akiner, 1997:284). Islamic Muslim's schools were abolished, many mosques and institutions were closed. Muslim women were given civil rights, and religious dress was discouraged. As Tabyshalieva (1999:52) states " The traditional cultural values of Central Asia survived throughout the Soviet era, despite the many advances that were otherwise made in science, culture, healthcare, and politics." Many Muslims began a dual life. They gained atheistic secular education, many becoming Communist Party members; however, they continued to follow some Islamic traditions. The dominant Muslim sect in Uzbekistan is Sunni. In comparison with the Sufi and Shi'a sects Sunni trends were more fatalistic and therefore appeared to be more broad-minded in accepting the rule of any power. Islam has been preserved in the country during secularism but 'declined to the status of a religion of private conscience.'(Horri and Chippindale, 1997:228). 'Islam remained the constant element of the region's cultural and historical identity that each generation owed to the foregoing' (Yalcin, 2002:99).

During the civil war in 1920, following the Russian revolution, the country was devastated. Many children lost their parents in this war. These children were brought up in the Soviet institutions and effectively absorbed a new communistic way of life and later were actively involved in the communist party movement. They were the first local activists to join the emancipation process.

Rano, 38, commented on this change as follows:

"I had two grandmothers. Both were from the Fergana valley. My father's mother was very religious; she wore a *paranja* (overcoat with a horse-hair veil) all her life. She was illiterate, married young, and the revolution had made little impact on her life, she continued to perform prayers five times a day, observed fasting during Ramadan and she never watched TV. My mother's mother was sent to the Soviet institution, because her mother was unable to sustain her three daughters and a son by herself. Thus my granny was brought up under a strict influence of modernized communistic ideology. She abandoned *paranja*, cut her hair and wore stylish western clothes. She studied Uzbek literature in the institute. She was very emancipated. We were exposed to two different influences from our emancipated grandmother and the other grandmother who strictly adhered to Islamic traditions".

The process of emancipation was hastened by the fact that due to poor living conditions young children had been separated from their families and come under the influence of communistic ideas, in the social institutions where they were offered a protected environment.

Today, after independence from a communist ideology that created a highly educated, liberated female population over seventy years, women, have been subjected to a confusing mixture of competing ideologies: nationalism, Muslim revivalism and westernisation. A resurgence of Muslim traditional practices such as wearing the veil, polygamy, submission to husband or father, goes against women's expectations cherished under socialism. Social transformations during transition such as the religious revival, and clerical fundamentalism in particular, could have unpleasant and restrictive consequences for women. This is because they bring a resurgence of traditional patriarchal attitudes towards women's position in society.

Thus, during the Soviet period the authorities tried to establish ideological dominance with the help of communistic slogans and dogmas, but there is an attempt to alter life according to the Law of early Islam. Taking advantage of political discrepancies the first step in this alteration has been taken towards changing women's status. "Women and Islam" is the most popular subject in the official press today. Social problems and an increase in crime have been linked to the process of developments in women's emancipation and their equal rights with men, implying that emancipated women pay less attention to the upbringing of their children. The debate among Uzbek politicians and writers takes place on the radio, television, and in the press is about the idea of returning woman to her family responsibilities established by the ancient traditions. The process of national revival went along with the revival of Islamic traditions, but lack of experience and religious knowledge have led to peculiar interpretations of Islamic rules, disproportionately emphasising the definitions of Islamic norms with regards to women's secondary position.

Shirin Akiner (1997:193) argues that "the great majority of women have not shown any inclination to exceed the limits sanctioned by society" and that could be regarded as a sign of backwardness. However, despite the notion about the relatively backward position of Uzbek women, the data I collected gives little evidence that women in Uzbekistan wish to give up all they gained during the Soviet period. However, it should be taken into consideration that modernisation of life, education and

assimilation of multi-cultural norms of relations has been spread and adopted mostly among the urban educated part of the population. New modernized ideas introduced by the Russians have been combined with traditional patterns of life on a very superficial level. In rural areas, on the contrary, Russification has been seen as an inadmissible infringement of national identity and traditions and as a betrayal of religion.

The sequence of the events in Uzbekistan shows that it seems that Uzbek middle-class urban women could easily adapt to any situation they have been put in. After the revolution, women abandoned *paranja*, (although, the process was not as smooth as it was presented by the Soviet ideology), and accepted emancipation, European styles in fashion and at home, acquired atheism and took advantage of all legal rights the Soviet system had offered. Today in the changing society, despite the fact that they accepted Islam to some extent, they are not eager to give up their positions. Thus, they accept a revival of Islam only up to a certain level, if it does not eliminate their achievements and attainments.

However, women need to make constant adjustments in the face of changing socio-economic and cultural-traditional conditions of everyday life. Switching from one ideological form to another could bring disorganization into women's lives and confusion about identity. Thus the meaning of women's lives cannot be properly described and understood without taking into consideration changing circumstance, particularly in areas such as religion. The objective of this chapter is to discuss a significant issue of women's beliefs; to understand women's behaviour during a critical period in relation to Islam; to learn women's own perceptions of and attitudes to religion. It is very important to ascertain if there has been a reversal in women's lives, and if so, then why it was a reversal for some women and for others an opportunity to progress.

6.2. Influence of Soviet Heritage on Women's Religious Choices

Most of the women I interviewed identified themselves as Muslim. Although the majority of respondents admitted that they considered themselves Muslims they did not adhere strictly to all Muslim traditions. That could be due to the fact that Islam, was repressed during the Soviet rule, and many people were not acquainted with true Islamic norms. On the other hand in many Islamic countries the observations of such traditions as funeral rites, dress code, marriage, divorce, dietary rules, and others are mostly cultural choices rather than Qur'anic and there are no precise norms, except the

common ones like "Five pillars" of Islam. Islamic law *Shariat* was legally prohibited in the Soviet period and after Independence.

Some women confessed that they believed in God, in a Supreme Power and in a Supreme Spirit, but rejected contrived unwritten practices. One woman acknowledged that she was an atheist, although she admitted that she believed in some kind of a Spirit that has protected her. She became an atheist because she was a scientist in the first place, but also because she was disappointed in a state Church and priests. This is her story:

Oliya, 54, scientist:

> "I studied different religions. I studied religion in Kiev, and I got a degree. However, the teachers there were very dishonourable. That deterred me from official religion for ever. I believe in some kind of spirit that protects me, but I do not attend the Church. Sometimes I have the urge to go there, so I go, and listen to the service, examine the icons, and watch the process.... But I do not like people whose duty is to bring faith in God to ordinary people. They are not sincere in their duties; they are so artificial and false. The priest must help people, but I don't see it. All priests ride about in Mercedes. In my family there were two religions - Islam and Orthodoxy. But my parents never pulled me to their sides".

Soviet propaganda in literature and films contributed to the creation of the image of clergymen as hypocritical, cunning and deceitful. Consequently, children learned from a young age that clergymen did not accept science and knew only how to learn verses from holy books.

Religious people were less likely to access higher education, because in order to enter an institute or university, one must have been enrolled in the Komsomol. The older generation realised that it would be better for their children to put religion aside, if they wanted them to prosper in their future lives.

Saida, 51, a housewife, said that she lost her belief when several misfortunes befell her family. Her husband went missing in May 1994 and her19 year old son died a year later in suspicious circumstances, after that her daughter divorced and had to undergo hysterectomy, and now at twenty eight her daughter had become an invalid without the opportunity to have children. In this case the woman had her personal

grievance, she could not be reconciled with her multiple loss, and therefore, she started to argue with the God about the injustice. She admitted that she had lost her belief, because she prayed and prayed, but that did not help, on the contrary, matters worsened. She explains her husband's disappearance and her son's death by the fact that at that time the Wahhabi movement was wide spread in the country, religious leaflets were disseminated, many young men were abducted, and there was general unease. After the bombing in 1999 the government initiated the persecution of Islamic fundamentalist leaders, the purge of Wahhabis and fundamentalists had begun. Islamic influence that revived after independence has been put under the strict control of the ruling government once again. Uzbek authorities expressed concern about the spread of Islamic fundamentalism and gradually introduced measures to control forms of Islam not authorised by the state (See Melvin, 2000, Akiner, 2000).

6.3. Islam in Everyday Life

In reality Islam, unlike some other religions for example Buddhism and even Christianity, is not only a religion of private consciousness. Islam is a way of life rather than just a religion. It regulates family and domestic life (marriage, inheritance and sexual relations), determines social behaviour, ethics, dress, conduct justice and punishment and so on. Therefore, despite the fact that there was no legal validity for Islamic Law during the Soviet period, Islam was a potent conservative force powerful enough to resist the enormous changes imposed by the secular regime. Religion that was persecuted during the Soviet period has been preserved in social consciousness as a national characteristic, and in this form it was strong enough among the majority of the population. Traditions were deeply rooted and maintained in everyday life and this could explain the survival of Islam for all these years. That could be explained by scrutinising Soviet policy towards Central Asian nationalism. On the one hand they sought to discourage and even eliminate any religious ideas 'which they saw as a potential rival to its power'. On the other hand in order to avoid arousal of negative public awareness the authorities had to loosen the interference in 'matters of local custom' to some extent (Rubel, 1971:234). Moreover, as Birgerson (2002:138) argues, Islam for the Soviet power was 'a useful way to control the population'.

The restrictions on religion were manifested by the fact that almost nobody celebrated Islamic holidays like *Hait*, (Id al-Fitr, a celebration of the break of fasting) *Uraza* (fasting during the Ramadan). People, rarely knew how to pray properly, almost

nobody wore religiously prescribed clothes, (it is obligatory for Muslims to cover their heads). However, the funerals and weddings were carried out with all religious observations among all indigenous population, despite official prohibition. Thus, for instance, during funerals the corpse had to be washed in accordance with the Islamic ritual, then wrapped in a white fabric, three times for men and five times for women, versus from the Qur'an have had to be cited: "*La Illahi ila Allahi, va Muhammad Rasuluhu*" (There is no God except Allah, and Muhammad is his Prophet). No coffin was permitted - the corpse had to be put in the specially dug pit, in the sitting position with its legs pointing towards the East. Even where senior Party leaders had to be buried, and the body was put in the coffin for the official ceremony, it had then to be taken from the coffin. All rituals were observed in privacy within their families. There was no way, that an individual of Uzbek nationality, whoever he was, atheist or not, could have been buried without traditional Islamic observations.

There are examples here of what Foucault (1977) calls 'counter-memories' – subterranean practices sustained as forms of resistance to dominant forms of power. During the weddings, which must have been registered in the registry office first, the newlyweds usually requested that the mullah observe the Islamic ritual (*nikoh*). The mullah carried out the *nikoh* only if the man and woman had the marriage certificate issued by the Soviet authorities. People usually tried not to publicise that they had undergone the *nikoh*. During the *nikoh*, the bride and groom must have been seated in different rooms or on different sides of a partition. The mullah cited a special verse from the Qur'an, and than asked the groom what he had to provide for the bride. After specifying the obligations and duties of both sides the mullah would ask the bride three times if she agrees to accept what the groom offers and be his wife. Only on the third time should the bride give her answer. After she said 'yes', they were considered to be husband and wife. The *Shariat* gives the bride the right to accept or decline or specify the details of the contract[9]. During the Soviet period that ceremony was not publicised, and did not have a legal status. However, parents persuaded young couples to undertake the *nikoh* ceremony, explaining that it was just Uzbek custom. Today the official status has been given to *nikoh*. After independence, idealization and reincarnation of Islamic traditions have been manifested in everyday life.

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[9] Although in Uzbekistan it is only nominally, all the negotiations concerning duties and obligations of the groom are usually solved in advance

Circumcision, another Islamic tradition, has been observed by the majority of the indigenous Uzbek population, because it was considered the major attribute of adherence to Islam. Uzbek boys, aged three-to-five, must be circumcised, due to Islamic Law. This procedure takes place both in private homes, where the mullah specialises in this procedure performing it on the children with rushes sticks and in clinics, by doctors administering local anaesthesia. Although, almost everywhere in the country the medical establishments perform the operation free (or for a trivial fee, usually people gave small presents to the doctors, like flowers and chocolates) and after one or two hours the child is free to go home, some people persistently preferred to do it in their homes with the help of mullahs. Adalat, 38, housewife:

> "We did it at home. My husband wanted to take my son to the hospital, but I refused, my parents insisted on doing it at home, they said that the boy must remember this event. But if we took him to the hospital he would just have thought that something was wrong with him, that he was sick or whatever. Everything passed pretty well, although when he started to cry, I regretted that I didn't take him to the hospital, but it was too late".

During the circumcision, the woman should not be present in the room; she should stay in the other most remote room, and must put her hands in flour presumably in order not to be able to rush to her son, when he starts to cry. Yoqut, 39, school teacher:

> "I put my hands into the flour, and I was crying, and my mascara melted and leaked, and my sister also had put her hand in the flour and she also was crying, and than I looked at her, she was like a clown, with all her make –up and flour smeared around her face. And she looked at me and probably I was also like a clown, so we started laughing at each other, through the tears".

Iroda, 42:

> "Oh, no.... I regretted it so much that I let my relatives persuade me to do it at home. They took him to their house in the village, Oh, I remember, all those strangers in the house, I didn't know who they were, and then suddenly, I realised that I lost my son from my sight, but it was too late to reverse anything. My aunts took me to another room, I started to weep, but all the women in the room seemed so happy. They brought the basin full of flour, and told me that I must put my

hands in it, or otherwise bad spirits would come, and everything could have gone wrong. And then I head him crying, and he cried so pitiably ' Mama! Mama! Let me go to my mama!" And then he screamed so badly, I thought I would lose consciousness. But I was helpless".

After the procedure has been performed, the boy would lie in the bed for several days, and everybody, neighbours, relatives, friends should come to visit the boy and bring him gifts and presents, to help the boy to overcome the pain and cheer him up so he could quicker forget the unpleasant feeling from the procedure.

However, most of the women I interviewed had the circumcision performed on their sons in the clinics or hospitals, with local anaesthesia. Most women did not want to make their sons suffer, whatever the tradition had taught.

Rano, 38:

"We took my son to the clinic. My father, although he was very ill, my mother, my husband all went with us to support me. The doctors took my son to the operating room. The nurse told him that she wanted to show him something, and he was so curious that he easily went with her. Then I don't know what happened but in a half an hour (which seemed a century for all of us) they brought him back, one of the surgeons carried him in his arms, and we took him home. But at home it started; probably the anaesthesia had run out. So he started to whimper. But then he fall asleep, and got up only the next morning. I think we got off lightly".

After bringing the boy from the clinic the same celebration was observed. Religious tradition also requires sacrifice of a sheep, in honour of this event. Circumcision is usually recommended by the doctors themselves when there are medical reasons for this operation, but, many people do it only for to religious reasons.

Uraza, fasting during Ramadan, became popular during the years after independence. However, few respondents or their children indicated that they strictly adhered to this tradition, whereas their husbands seemed more enthusiastic on fasting during Ramadan breaking it with the sumptuous feast (*iftar*).

Such matters as polygamy, virginity and circumcision have never been discussed openly in the scientific literature or in the press. In Uzbekistan such traditions and customs are usually the themes for ethnographic studies. However, these facts are a significant part of everyday life and exist in the forms of unwritten law, steadily implemented among each stratum of society. Very often these customs contradict constitutional Law, which secures the main human rights.

Concerning polygamy all the respondents in my study opposed it. There are cases in Uzbekistan where men take a second wife, illegally, because the Soviet Law and the Uzbek Law prohibited polygamy. There is no official evidence on that issue though although it has been discussed in the press and on Uzbek Radio. After independence there was a discussion in the press about the possibility of the legalisation of polygamy with the approval of new Islamic tendencies, for instance to improve the situation of single mothers or widows. However, the tradition of polygamy seriously undermines women's social status and legal rights. Women who married as second wives have found themselves in a very unpleasant situation. Their social and legal status in the society becomes very low. For instance, they cannot lay claim to the inheritance, in the case of their husband's death, because of the illegality of their situation, not for themselves and not for their children. Husbands can easily abandon them without support. She would have to register as a single mother in order to receive financial support from the government. Some women cannot even appear in the husband's family, because of the secrecy of their status.

There could be a number of reasons why women do this. The first reason could be love -a woman in love could believe in all the promises of her beloved, for example, that he would eventually leave his first wife, or that he would protect and support and provide for her and their children. Another reason could be that for divorced women or elderly spinster it is a better option than living alone. The institution of cohabitation is not in practice in Uzbek society. Therefore, even if polygamy is not legitimate in relation to State Law, at least it could be legitimate in relation to God. However, the respondents of the study showed their negative reaction to this issue. Mukaddas, 39, gives her opinion on this topic:

> "I think that the problem was in the way the marriages were arranged in Uzbek society. It is usually the parents who decided whom their children are to marry. Thus the son obeys his parents' decision and marries the girl whom he doesn't like at all. The two are very young, they live at his parents' house, they do not have their own

family, just a communal house, and they do not have any privacy. But they have their own needs. Take my friend, for example, his parents didn't allowed him to marry the girl he loved so much. So he married the girl his parents found him. After two or three years, or may be straight away, who knows, he started seeing his other girl again, and then she gave birth to his child, and now they did *nikoh*, (religious marriage). People do not understand that they make their kids unhappy, on the contrary they prove that they did it with the purpose of making their kids happy".

Arranged marriages are still common in the country. When I asked women would they arrange their children's marriages, some of them said that they would do so. Ruhsora, Mariam, Oydin, Sultanat, said that their marriages where arranged by their parents, although all of them had their right to choose, and were not married by force. Sultanat, 54:

"With our upbringing and our traditions it is very difficult to get into relations which could lead to marriage. And the parents usually want the best for their children, and would pick the best. But it is not like in the old days, when they traded the children for the dowry. If you don't like the person you can wait for another opportunity".

Usually the mother of the groom asks her son if he is ready to get married. If he says yes, then she starts to ask among acquaintances and relatives if they have their eye on somebody. Usually the offer comes from different sides, so the mother has several girls to choose from. She goes to the girl's house, supposedly, incognito, talks to the girl's mother, and asks the neighbours about the family history. If she likes the family, she will ask the girl's parents if her son and their daughter can meet. The meeting usually takes place in the open air, somewhere in the park or in the square under the supervision of the mothers from both sides. There are some common places in Tashkent where one can observe these events. The boy and the girl talk for several minutes and then go away. If they liked each other they would tell their parents to go ahead. If they do not like each other nobody would bear a grudge against the other party. Several respondents in my study admitted that they saw their future spouses only once or twice before the marriage.

This tradition is still valid, although young people meet each other at schools and institutes and at work and eventually fall in love. In this case parents are happy to marry them, but they follow the tradition of going to the girl's house, asking agreement from her parents, even though everything has been decided between them beforehand. In this case the groom's parents are released from the humiliation of refusal.

Traditionally a girl must be a virgin before marriage, although this is not mentioned anywhere in Islamic law. There is no way to find out the roots of this law, because there are no sources of information where this problem is scrutinized. These themes are taboo for Uzbek society. However, the law on virginity has been deeply rooted into the social psychology and could be the cause of serious problems for women, although nobody expects the man to be a virgin. These views are strongly and widely held and so have a profound influence on shaping the lives of women. This unwritten law became a cultural stronghold of paternalistic a patriarchal society and is still valid among all strata of the indigenous population. Even the high level of emancipation of Uzbek women, was not able to solve this problem. It could be argued that as long as this situation exists in the country the discourse about women's emancipation is still significant. While there are debates about women's equal rights in the productive sphere, there is no discourse about women' sexual rights. That could prove the fact that women were not fighting for their equal rights, they just accepted what they were granted by the state. They passively supported official policies without an attempt to express their own views and demands. If we assume that during the Soviet period women did not have any choice but to comply with the state policy, than it could be expected that after the independence women would take the advantage in order to acquire further achievements in the sphere of gender equality. However, the data from the interviews suggests that although women are unwilling to give up the Soviet achievements, they did not express any aspiration to improve their position. There are still no independent feminist movements, which could organise women into parties, to fight for their rights, influence the decision making, and introduce amendments and adjustments into the legislation in order to enhance their status. The respondents were very reluctant to talk on the issue of virginity, although women who did talk expressed their negative attitude towards this tradition.

Ruhsora, 50:

"You never know what kind of family will be your daughter's in-laws. I myself would never check on my daughter-in-law. But who knows. It is Uzbek

tradition and we must respect it. Therefore, I am, myself surely very concerned about my daughter".

From ancient times celebration of the bride's virginity was one of the main attributes of Uzbek weddings. Women recalled that their grandmothers spent their wedding nights in the room separated by a partition, with several women waiting on the other side of the screen, for the groom to appear as a victor. Today the situation has changed but not radically. It is a widespread tradition among rural and urban indigenous inhabitants, at all levels of society . After the wedding party, one of the bride's female relatives would stay in the groom's house for the first three nights after the wedding to support the bride, in case something would go wrong. This woman is called a *Yanga*. The *Yanga* instructs the bride on what is likely to happen during the first night and provides her with a white cut of fabric. Uzbek tradition calls for public proof of the bride's virginity. The fabric on which the bride should show the marks of her blood, the proof of her virginity, must be shown publicly. This is a terrible experience for the bride, for the groom, for the *Yanga* and parents of the bride. No allowance is made for women's physical deviation like too elastic a hymen to bleed at first intercourse, or a hymen stretched during exercise. The positive result of this event would be celebrated on the third day after the wedding. The bride would be taken to her parents' house where her proud mother would receive the daughter and all her new women- relatives. The event takes the form of a second wedding party with dancing singing and lots of food.

Most women were brought up to consider that it is a tradition and there is nothing humiliating about it. Girls are taught to preserve their virginity for their husbands and it is inculcated in their consciousness that the honour of the whole family depends on her chastity. Thus, from an early age girls (even from the most modernised families) are not encouraged to engage in sports activities, because it could lead to rupture of the hymen. Even today girls' behaviour at home and outside is strictly controlled by the parents. Independence of girls is not welcome and is considered to show a lack of respect and obedience towards older people. On the one hand if a woman makes attempt to seek a future husband the tradition condemns her behaviour, on the other hand if woman is sitting around for too long it is considered her fault as well. A woman should be attractive but no way should she attempt to attract.

Adherence to this tradition makes people to seek marriage for their children as early as possible. That concerns not only girls but boys as well. Although the boys are less restricted in their sexual behaviour, it is considered that it would be better to marry them, so they do not strive for disorderly sexual relations. According to a demographic survey the average age when women get married was around twenty; 87 per cent of women before nineteen years old were not married, whereas 75 per cent of women between twenty – twenty four years old and nine out of ten women between twenty five to forty four were married (Medical and Demographic Survey (1996) cited from UNDP Report, 1999:p.23). According to the law of Uzbekistan, the minimum age for marriage for women is 17 and 18 for men. A young woman over twenty is considered to have been sitting around too long, not because she is a burden for a family, but because her chances to get married decrease each year. The women I interviewed said that they could wait until their daughters finish higher education (usually twenty one-twenty - two years old), but after that they would not wait longer and would find them a suitable husband if they did not find someone on their own. A child's wedding is considered to be the most important event in the life of a family. People put aside their savings in order to spend them on their children's weddings.

Even in Soviet times equal rights, a high level of professional qualifications and education of Uzbek women coexisted with traditional old patterns of behaviour like obedience to the family rules. Upbringing of children in a spirit of submission and obedience towards one's elders remained unchanged in the private sphere, while the modern (Soviet) style was accepted in public life. Thus, women's independence was supported by the state but simultaneously suppressed by family and community. (*mahalla*). As Tabyshalieva (1999:52) states:

> "Women from Central Asian national groups were expected to lead a life of double standards; as productive, equal to workers according to the Soviet System, and as obedient, second-class citizens according to their ethnic traditions".

Divorce is also undesirable in Uzbek society. Asal, 39, confessed that she wanted to divorce her husband, because she believed that she would have been able to sustain her family much better without him. Her husband demanded too much attention, and sometimes she was fed up with his attitude. But she had to think about her children. It would be very difficult to marry her girl and even her boys, if she divorced her husband.

"You know our Uzbek traditions, people usually ask where the father is? Who is their father? Why they divorced? That restrains me very much. Sometimes I think I can't bear it anymore, but then I think about my children and decide to be patient for their sake, because public opinion overrides everything."

6.4. Women's Attitude to Religion

This section reflects the importance women attach to certain aspects of traditional Uzbek life within the domestic sphere. When asked about their own faith, belief and religion women showed diversity in their attitudes and perceptions. Everybody had their own relations with God and it gave the impression that despite the complexity of opinions and perspectives most women do believe in a Supreme power, although some emphasised their negative attitude to traditional (fundamental and Wahhabi Islam, or the Church), and the revival of 'old' traditions like religious dress etc. The revival of Islam in recent years has led to the occurrence of new unfamiliar rules, taken not from the Qur'an but from other cultures like Iran, Saudi-Arabia, Turkey. Thus, for instance the religious dress that some women started to wear, has nothing in common with traditional religious Uzbek dress, known as "*paranja*"(which women abandoned in the 1920s, during the *Huzhum*). Some men started to wear a small white cap, similar to the Jewish skullcap, which they adopted from the Saudi Arabians, while the Uzbek traditional cap the '*Duppy*' (a square embroidered cap) people wear only on occasions like funerals or weddings. The respondents shared the concern that the restoration of Islam takes the form of outward manifestation. Whereas the mandatory requirements like prayer, alms giving, justice, prohibition of drinking and smoking remain less important.

Oidyn, 44:

"It irritates me so much... all these over the top religious clothes. This all comes from outside, and has a detrimental and inadequate impact. I cannot wear trousers in the "*Eski Shahar*" (old part of Tashkent) everybody looks at me with condemnation. I reckon that there is no religious authority in the country that could explain to people why, and what is needed to be done, and how it is to be done. Our religious authorities do not know themselves what are they doing and why.

My father-in-law studied in the religious seminary, he was a true Muslim, and he never judged or criticised and he never forced anybody to take on the faith".

Traditionally no Muslim should convert unbelievers by force; everyone has the right to choose Islam or ignore it. Consequently women expressed the opinion that they do not want to be forced, and emphasised that their choice must be free. They also pointed out the difference between their personal faith and religious traditions, which they detach from one another.

Yoqut, 39, a teacher, said that even her mother-in-law, an old woman of 68 years, did not accept the revival of some traditions and the birth of new ones.

"Women started to cover their bodies and even faces, but who are they? Why they trying to hide their faces, when they have spent most of their lives with open faces? They try to pretend that they are saints. They started to criticise other people if they didn't follow their way, but probably they have much more to be ashamed of, and therefore they try to make other people feel less righteous".

New religious leaders in contemporary Uzbekistan search for reasons to explain the importance of wearing veils. One reason for this was that women's ankles and wrists could encourage men's sexual desire, and therefore, women must cover themselves to prevent men from sin. One of the respondents replied on this statement, (Nigora, 39):

"Probably it is men who should put out their eyes? For so many years women and men have been mingling together, women wore short skirts, dresses with open arms, and men were in very good control of their sexual desires. Why now? I cannot agree, that this is a step in the right direction. For nearly seventy years these traditions have been absent and everybody was happy. And the religion, and other good traditions have been preserved. What if we all together put on *Chadra* again, will it change the world? Would people become more pious? And another question is who demands *chadra* for women? Mullahs? No. But our so-called progressive writers, singers, who have been bogged down in depravity, who themselves lead a depraved life. Those who sin they would usually cry as loud as possible in order to find a scapegoat".

This opinion support women who now feel threatened that women might lose the freedom they gained under the Soviets. This is a common opinion of women I interviewed, because the sample mostly consisted of women who are more free thinking, wear western style clothes and are more independent economically, and have more enlightened, loyal and educated parents and husbands. Women should learn more about our religion so they can defend themselves, and can preserve what they have already gained. Women also must learn more about their legal rights; otherwise they will be unable to exercise their rights due to their legal illiteracy. Women who complied with wearing the veils were mostly from less educated backgrounds. Some women reported that they were forced to put on veils by the brainwashing in the family and in the neighbourhood that women with open faces would be attacked, so they wore veils in order to be secure.

Most women I interviewed reported that they started to follow other Islamic traditions like praying, fasting during the Ramadan, almsgiving, but did not consider wearing the veil as an option. Asal, 39, a paediatrician, said that she did believe in God when she was young, but never observed any traditions because before she married she lived in the *mahallah* (neighbourhood) with the European milieu. However, when she married and got a job in the maternity hospital (where most of the employees were traditional Muslims) she became very religious. She said that before she started to work she could not even speak Uzbek. Gradually she became involved in all religious observations: she learned the verses from the Qur'an(*Sura*), now she prays in the morning and in the evening, gives alms to the poor, and observes fasting during Ramadan. She admitted that her parents had never pushed her or her sisters to observe the traditions, because there was no pressing from the social milieu, although today everybody around her at work and in the mahallah became very religious so she had no choice, but to follow common trends.

Iroda, 42:

"During the Soviet period we were cut from the information on the religious themes. After the break-up I have managed to get the literature that referred me exactly to what I wanted to read. Now I do not feel lonely, because I started praying, and now I feel that there is Someone who supports me and protects me. I do not go to mullahs, but since I turned to God, I became very healthy. I do not get ill with flu or colds, I feel that my immunity has enhanced".

Many women rediscovered the faith after the collapse of the Soviet system.

Shirin, 50, housewife:

"My father was a communist, I didn't believe in God either, I didn't believe in Mullahs, never went to them to be *read*. But Life has punished me, now I believe more. If something is going wrong in the family I send my son to Mullah. But I never go myself, I still do not believe totally, but I trained my kids for that".

Sultanat, 54:

"I am not superstitious, I believe in Allah. My grandmother fostered the faith in us, while my parents gave us secular (atheistic) education. I believe in my hearts of hearts. I know some prayers. I do pray and read *Namaz* (obligatory prayer), but not regularly, only during Ramadan. Although I cannot fast, I have cholysistitis, but during Ramadan the whole family usually gets together, we read the *Pataha* (Al-Fatiha, the first Sura from the Qur'an). All my relatives fast during Ramadan, we definitely sacrifice sheep, give alms to the *Musjid* (Mosque) or to those in need. I am not fanatical but I consider myself Muslim, I try to follow all the Commandments from the Qur'an".

Oidyn, 44:

"I am not a religious person, absolutely. But I believe that when people die their spirits are still around us. I see them in my dreams and they help me to solve my problems. Only recently I started to pray, because I became very nervous, and my sister-in-law advised me to start praying. I think it helped. But I pray only when something bad happens and if everything is smooth I just forget to pray. I believe in Justice. And I think in order to achieve justice one should pray. But the prayer will help only if the person himself is pure and innocent".

Gauhar, 42, felt that during the Soviet times people believed in God even more than today, although nobody paraded it. But people were honest; nobody did any harm

to each other. She thinks that faithful people must be tolerant to each other, but today there is no tolerance to other nations, to other religions, people became very greedy, they can kill each other for money, and religion was even used by the politicians to achieve their political goals.

> "My mother was a very religious person, although she didn't pray, but she read the Qur'an, and she knew Islamic history, therefore, I always believed in God, even during the Soviet times. However, I started to believe even more when my son became severely ill. I think if you believe in God you can bear all the troubles, and achieve a lot in your life. .... Wahhabis do not understand what they are doing, they want to take the power over the people, they don't care if people die, or suffer .... They can do everything for money. True Muslims are broad-minded and forbearing.... We all serve one God. Today a lack of faith made people like they are now... "

Sultanat, 51, said:

> "The new Muslim preachers and imams try to fill in the spiritual vacuum, but they themselves are not ready and not educated enough to take such objectives, because they themselves are corrupted and have a limited thinking, and the most unforgivable is that they are all mercenary, greedy and corrupted. The true Islamic experience has been relinquished by the clergy themselves and by people. Some people express new passion for religion, show their devotion, but in most cases it is more social manifestation than true belief. They do not search for the truth; they just want to take up the features that are on the surface... You know? Sometimes I see a young girl covered from head to toe, but if you ask her about Islam, the history of Islam, I doubt that she could answer".

Many women I interviewed believed in some kind of Supreme Power. They think that an individual must live without breaking Commandments, and only that would be reckoned, but not all these rituals and established religious practices, as they are sometimes too contrived, and make people's lives very complicated, and could even distract people from God.

Mariam, 52:

> " I think that everybody has his own God, and there is one God for everyone. I do observe *Uraza* (Ramadan fasting) as far as possible. I try to observe such traditions as respecting my elders, forgiving enemies, attending funerals and weddings, but I try to modernise them as far as possible. When we married off our son we decided to cut down all those *togoras*.[10] We did the minimum of what was demanded. And everybody was happy. Because we managed to save money and send the newlyweds on their honeymoon".

Not every woman could allow herself to ignore this tradition. For women who live in *mahhalas* or whose parents are very traditional all this *togoras* are necessary. Many complained how difficult it was to observe the traditions, how many quarrels had come out of that, in some cases the strict following of these observances has led to misunderstandings and even to break ups. This is because for weddings the number of *togoras* must be even, and for funerals - must be odd.

Munisa, 38, housewife, considers herself a Muslim but on the other hand emphasises that she is a very modern person. That means that she believes in Allah, but does not follow all the observations, despite her husband's insistence. She thinks that all the observations that occurred in the last years have nothing to do with the real faith.

> " This is all social and contrived. I do observe some traditions like *Uraza* and *Hait*, but it is nothing to do with the true belief. But you must follow all these traditions because otherwise people will talk about you. It is ridiculous, it means that if you sin, but comply with all the observation, then you are better than those who do not harm, but do not abide the traditions, which sometimes are not even Muslim at all?"

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10 (*Togora* is a big bowl. During the weddings the groom's and bride's sides exchange forty bowls of food. This is not a religious tradition but cultural. It came from the times when the weddings were organised in this way when all the relatives and neighbours had to bring one togora of food for the wedding. It was very convenient, so there was no need to cook a lot of food for the party who organised the wedding. Today it took a nominal form, because togoras usually comes not exactly at the day of the wedding but before, and it is very complicated for both sides, because they have to decide what to bring and what to send back)

Rano, 38, university lecturer, also admitted that although she believed in Allah, she could not abide by all Muslim requirements. Her father was a communist and her mother also was very atheistic. But they managed to bring her up in a way that she believes in God. Her father became very religious at the end of his life, he started to pray five times a day, observed the Ramadan fasting although he was very ill, even made an attempt to take part in *Hajj* (pilgrimage to Mecca), but he was not able to afford it, because of a lack of money, and due to his ill health.

6.5 The Major Sources of Women's Concern

This section includes questions and findings about women's hopes and concerns for the future in terms of their own status and expectations for their children's well being. The data suggests that the majority of respondents did not relate health issues as their major concern. The evidence from Calnan (1987) suggests that although health is one of women's main concerns it is only valued in relation to allowing the individual to carry out their daily tasks and fulfil their obligations (p. 25). He argues that issues of political stability, 'well-being of other family members, and to a lesser extent material wealth' 'competed with health for attention' (ibid).

Eighteen out of twenty women from the study expressed their anxiety about the economic situation in the country, along with the high rate of inflation, political instability, fundamentalist threats, and increase in crime. Several respondents referred to lack of money for food and clothes. Some women mentioned their worries about the prospect of losing their job. Fifteen women put family problems and the well being of their children above all other issues. Almost all women except three with no children expressed their worries about their children's future, their safety as well as difficulties in providing higher education for their children. Boris Vasiliev (2002), a Soviet writer, said in his interview:

> "The times of upheavals splits not only the society but the family itself: distorted ideas about what is 'good' and what is 'bad' begin to work. An arduous burden of unrest falls on a woman's shoulders, she begins to feel a fear for unpredictability of events, fear for her family future, fear for her husband, who could lose his job, fear for her son, who could be murdered, fear for her daughter, who could be abused, because the familiar and safe order does not exist anymore".

As a result of constantly changing circumstances (only the currency in the country has been changed three times since independence, from Soviet roubles to sum-coupon, and then to Uzbek soms; the script of the Uzbek language has been changed twice – from Cyrillic to Latin, etc.) women experience anxiety and concern more frequently, which in turn contributes to deterioration of their health.

Munisa 38:

"As I see the situation – it has worsened after the disintegration of the *souz* (Soviet Union); we used to live a quiet life. Today we are not quiet and calm. I used to go to the shops and walk in the street quietly. And today we are afraid for our kids, and for ourselves and for our jobs. My husband is always nervous and anxious, he tries not to break the law, and even working hard he cannot provide for his children. For example, today they are young and need only food and clothes, but tomorrow, how will we pay for their education I don't know. Thank God, my parents are quite healthy yet, I cannot complain. But if something happens tomorrow I don't want even to think about it, we just have money for today. I am very concerned about my children, I am afraid that they can fall under a bad influence, you know drug addiction and abuse has become very widespread in our country during recent years".

Asal, 39, said that today she is obsessed only about money because she has to think about her three children, and her and her husband's salary (they both work as paediatricians) is not enough, so everyday is a struggle. When she gets her salary, she divides it into piles for her daughter's kindergarten, for public utilities, for transport fees, and what is left is enough only for half a month.

"...how do we live I don't know myself. I think we live with our eyes shut. We do not want to confront the reality, but I feel deep inside, that some day when we open our eyes....., the disaster will strike! I don't know. I don't know. I want my children to obtain higher education. There is no certainty. There is no certainty in anything..... at all. What is going on in schools today? There is no discipline, no good teachers, if you want your children to enter the university you need to hire a tutor to teach them, we do not have money for that, or you yourself must teach them, but I have no time".

Saida, 51, said that she did not see the future for her children in her country. All her children have applied for 'Green Cards' to America.

"Injustice is everywhere. Before I used to believe in justice, I believed that you could overcome the difficulties. But today everything is worse and worse. I am anxious about my children, how my grandchildren will live. I told them to apply for the 'Green card', even if they fail they will try and try again until they get it. I do not want them to live in this country. Let them go. I will die here, it doesn't matter. I want my children to settle down, they do not have a future in this country".

Leila, 46,

"I think that it became worse. Before I was able to live on my salary and go for vacations. But today my pension is enough only for one trip to the bazaar. My pension is not enough even for public utilities. My father earns some money by reading the Qur'an that is how we manage. Otherwise I don't know. For medicine we have no money at all. Therefore, I do not go to state clinics. I know they just write the prescription and that is all. I do not buy clothes; we live on what we have. My overcoat is from the Soviet times. That was a time!"

All these women's feelings of instability could be attributed to the association of tremendous stress connected with the occupational downgrading, income cuts, increased inequalities, insufficient subsidies for the health services and as a result difficulties with adjustment to the new reality.

Ruhsora, 50, also said that perestroika had an impact on her and her family. She was glad that her children managed to get an education, and her parents were treated in the state hospitals during the Soviet period. She expressed doubts that today her children would be able to enter the university, because higher education becomes more expensive day after day.

Women showed their concerns about their children's education, because during the Soviet era people valued education more than anything else. Today the economic

situation could provide a ground to shift from the higher education to vocational education or acquiring skills in practical work, because higher education has become less available to the ordinary population. Many, however, consider it is a parallel to the collapse of their social perspectives. Mukaddas's opinion:

> "It is very difficult to say..., before everybody was equal, today there are only very poor or very rich. Frankly speaking I don't know where our country is going. Our people's mentality is not ready for democratic changes. Our people became so angry because they cannot find means for livelihood. I go to the regions very often and I see that people do not eat meat for weeks. People in the regions do not get their salaries for three-four months. Sometimes people get sacks of wheat instead of salary. I am just scared. Yes, today I have a job, so I can support my family, but what would I do, if I lose my job, I am the sole breadwinner in the family. Or take my kids' education, for example. Even on my good salary, I don't think we would be able to enrol them at the university. I am very, very scared when I think about all this stuff. Look how bribery and corruption are flourishing in the country".

Only one woman from the sample said that she hoped that the future would be brighter. She called herself an optimist. Although she also mentioned that in the old soviet times an educated man was rated highly, whereas today money plays the major role. If the person is uneducated but has money he would be valued instead of an educated man.

Mariam, 52:

> "But nothing is in vain, everything that has happened is not in vain. We will see the brighter future. Yes, today we have problems, in medicine in particular, because many specialists have flown the country. But look at the rest of them who stayed, I mean the old guard. They love their jobs; they will treat people without a fee that is the Soviet upbringing. If you are the doctor you should think about your patients first and then about you money. I believe in those people. They cured my grandson, he had a squint. They did not have any equipment but they did everything they could. And free of any charge!"

Women were also asked to comment on their relations with their children, husbands, and relatives to identify any changes for the last ten years, as well as the reasons why they thought such changes had taken place. Women reported that their relations with their children and husbands had not changed noticeably, although several of them did report the changes. Women attributed these changes to several factors. One of the factors was the trend to shifting woman's position back to her 'natural' place, and man's losing his position as breadwinner.

Some women revealed that since their husbands started earning more money, they became less interested in family matters, and spend more and more time outside. That made their family relations more stressed.

Nigora:

> "Before, we were a family, we were a team. He worked and I worked, we had merit salaries. Now he brings money to the family, but he became very stressed, he had a heart attack, I worry about his health, and I know exactly that it is due to his tense job. And you know, now he shouts at me, he thinks that he can shout at me and at my children because he brings money home. He spends his time wherever he wants, he says he works till late, but who knows? I do not complain, you should understand me... but if he goes on like that he will drop dead soon".

Many women complained that they were obliged not to see their husband's inability to provide for the family, mixed with the feeling that women themselves become less competitive in the job market due to their gender and age. Many women, from the sample, expressed their concerns that for them finding a new job will be more difficult than for the younger ones. The respondents reported that aging contributes to their concerns about their future. Not only do they have fewer opportunities in the job market, but their health is also deteriorating, and the chances to get decent health treatment decreases from year to year.

Most women were more pessimistic rather then optimistic about their future, in terms of their views on economic and social development in the country, although a one sided pessimistic interpretation of women's attitudes and perception would be misleading. Many results from the interviews suggest that hardships that women have

faced the last few years have empowered them and affected them in the sense of their self-esteem, feeling that they could be competent and independent despite all the uncertainties and instabilities in the society.

Shirin was talking about her life course, how her daughter died, about her husband being alcoholic and other misfortunes but also how she managed to sell her flat, and buy two flats instead, then she had money left to marry off her son. Now she lives with her husband and grandson in one flat and the other she provided for her son and his new family.

> " If my husband was not able to do it, I did it myself, and the way I was able to do it, probably it was not the best way, but at least I provided for my son. With the help of God everything will be all right".

She admitted during the interview that she needs a great deal of courage, health and energy because she needs to bring up her grandson, but she had confidence in herself. She did not complain, she just moves on with her life.

> "The worst thing already happened (her daughter's death), so I survived. Now I must live for my grandson".

The contradiction of the transitional period is that it provides the basis for risks as well as opportunities. The desire to overcome the economic crisis with as much loss as possible could encourage women not only to adapt to the new situation but also to benefit from the changing conditions. As Bourdieu (1990:62) argues 'the tendency of groups to persist in their ways'... 'can be the source of misadaptation as well as adaptation, revolt as well as resignation', as women outlived the economic and social conditions 'in which they were produced'.

It seems difficult to adapt to the current societal transformation, because women's consciousness was influenced by seventy years of policy, which guaranteed people's security. The environment women have found themselves in is too different from the one they were displaced from, 'because they are objectively adjusted to conditions that no longer obtain' (Bourdieu, 1990:62). However, there is no way back, therefore people need to realise that transformation and development could not be achieved without any loss of social and individual values.

Women spoke freely about their feelings of anxiety in the context of recent changes in the society. The respondents related their own lives with the events of deep societal transformations. Although women used a variety of coping strategies, including social support, to overcome the difficulties, economic and cultural barriers restricted some of their endeavours to adjust to negative consequences of transition smoothly. Women expressed their sadness about losing past achievements yet realised that there was no way but to adapt their previous way of life to new norms imposed on them. Almost all the respondents expressed their regret about the recent transformation, but a few revealed some positive changes that offered them or their husbands a better economic situation.

6.6. Summary

In this chapter I tried to reveal perceptions of Islamic and cultural traditions from urban women's perspectives. In fact the picture in the rural areas or in the regions like the Fergana valley could vary from the facts presented in this chapter. This information was collected from women who are highly educated, in most cases they were brought up under the tight atheistic control of secular society. The fact that many are reluctantly perhaps adopting some religious practices attests to the extent of this revival in the country. Indeed, most of the respondents admitted that they do believe in God, in a Supreme Power, in some kind of Supreme Spirit, even the woman who declared herself an atheist. Perhaps after independence Islam has filled the vacuum left by the collapse of communist ideology. During the first years of independence the alternation from communist ideology to Islamic heritage in Uzbekistan has been spreading successfully. New mosques have been built, seminaries and religious schools have been reopened, even the President of Uzbekistan made the pilgrimage to Mecca (*Hajj*). Many women reported that they started being more Muslim after independence when they became more exposed to religious information through literature, radio and television. Thus women, I interviewed indicated the importance of adhering to certain patterns of religious behaviour like doing good deeds, having good intentions, in other words following the commandments. However, they signify that a good believer must not try to impose one's own perceptions on others. For most of them choosing Islam, was not a free choice but following their national heritage and family traditions. On the other hand the fact that people are more prone to turn to religion when they become more mature, could also contribute to the fact that the respondents gradually rediscover the faith for themselves. Many women mentioned that their parents became very religious later in

their life. Being religious for most respondents had a lot to do with sound intentions, doing good deeds to others and having a pure soul.

The idea of independence, substituted the former communist ideological foundation of power, and even revealed itself in the same forms of coercion. There is still a danger of radicalisation of the process of revival of Islam in the forms of fundamentalism. A spiritual vacuum, as a consequence of the collapse of communist ideology, a decrease in living standards, ethnic and social unrest, a rapid growth of religious devotion, proliferation of religious organisations together with the low level of religious knowledge, all these could be a precondition for fundamentalism. There are also other factors that could impede the growth of fundamentalism, and that could be adherence to a secular way of live among the educated urban middle-class. As the data reveals many women do not consider giving up their achievements they gained during Soviet times. However, many women expressed their concerns about the increase of demands and restrictions from the clerical authorities, and will possibly spread to the other spheres of life such as education.

Some women admitted that they started observing Muslim traditions only because of social pressure, which is stronger in some neighbourhoods than in others. Some respondents on the contrary confessed that they were disappointed in religion, due to their personal misfortunes, or due to the disillusionment in the clergymen. None of the women-respondents knew how to pray properly or perform ablutions, none of them took pilgrimage to Mecca, and none visited the Mosque on a regular basis.

In the country where Islam was preserved not as a theological trend but more as a way of life, cultural, traditional and religious aspects have been mixed, and today people have been left to decide on their own what to choose. As one respondent said even the clergymen themselves did not know what was right and what was wrong. Especially when the revival of Islam comes from different countries with different Islamic trends. For instance Turkish influence is more modernised, Saudi-Arabian enforces the strict Hanbali Sunni rule, whereas Iran follows Shi'a trends.

Most of the respondents expressed their concern about women's clothes. All women I interviewed spoke out against the Muslim tradition to cover women from the head to the ankles. Thus, even if women are ready to accept some Islamic norms and rules, they are not prepared to give up all they gained during the years of emancipation. Consequently even in the remote regions of the country the brides preferred the Western fashion white dress for the wedding, while the groom usually put on the *Ton*, an

embroidered dressing gown and Chalma (a hat with a feather) over his European style suit.

Another sphere where women are totally against Islamic traditions is polygamy. None of the respondents experienced it in her life, but all of them expressed very negative feelings on this question.

The majority of respondents expressed the wish that the country would keep the balance between tradition and modernity, and would be able to take the rational from both directions. Almost all of them were of the opinion that Islam should not be politicised, and that the state must be separate from religion, and that religion should develop as it did in the Soviet times - only in the private sphere.

During interviews women identified a number of adverse factors that had an impact on their own health and the health of their family members. They considered the uncertainty of their future to be the main factor contributing to deterioration in both their own and their children's well being and health.

The data I collected on the topic of 'religion and tradition' have shown the diversity of opinions among women. It could be argued that most women adopted a passive strategy towards newly revived religious traditions. However, women indicated that they have not followed these traditions blindly; on the contrary, they adhered to the challenge selectively and choose what was most acceptable for them. Their so called passivity is rather a deliberate strategy in coping with the new order, which was imposed on them involuntary. An increased religiosity among these women does not prevent them from asking critical questions and behaving in a way that seems more appropriate than that of conservative trends.

Chapter 7
Discussion

7.1 Introduction

This study examined a group of twenty middle-aged, middle-class urban Uzbek women. It focussed on their health problems, health responsibilities and health services utilization, their perceptions and opinions on Uzbek health culture, traditions and life style habits. More specifically, it concerned 'Uzbek women and Transition', which encompassed the coping strategies of women during the first decade after disintegration from the Soviet Union. The aim of the study was to investigate how middle class Uzbek women managed and adapted in times of constant change in the country and also in their lives. Although the study cannot be considered representative of the lives of the female population of Uzbekistan, it is the first study of its kind and details the existence and experiences of many middle-aged, middle-class urban Uzbek women. In this way the study is significant in drawing awareness to the lifestyles, behaviour and beliefs of the urban Uzbek community. As mentioned previously the reproductive capacities of women have come to attract more attention and interest among local scholars, whereas topics regarding health, beyond reproduction, are given less attention as they are considered of lesser significance. Therefore, the attempt has been made to identify the influences and insights, which have not been considered by previous researchers. These include women's own perception of the context of situation, personal and cultural networks, belief and choice of treatments, the role of the health care system in their lives.

This study also aimed to find out how women cope when the professional sector of the health care system becomes less accessible due to the tremendous challenges of inflation, population growth and limits of government spending on health care. In attempting to fulfil this aim, a method using in-depth interviews combined with observations and analysis of secondary data provides an understanding on the variation, complexity and similarity of the phenomena of the socio-cultural process that currently exists in Uzbek society. The body of literature related to health, which includes gender, socio-cultural and political issues has been investigated. The literature review has shown that most decisions and actions about health and sickness take place at the lay level and is dealt within the family. Therefore, the objective of this study was to analyse

the non-biomedical culture perspective on health an health care and search for the range of variations in patterns of thought and behaviour.

Throughout this thesis I have presented empirical evidence of life during the period of transition. The empirical part of the research produced several types of findings. As shown in this research, the transition had a profound impact on the lives and well-being of women, of whom some suffered or felt ill-treated by the imperfect social system that replaced the better Soviet one. The findings of the study indicated that some individuals benefited from the transition of state control to a market economy. However, the majority of respondents faced burdensome and demanding changes in the process of adapting to new and not always adequate conditions. As all the respondents were born in the Soviet Uzbekistan all of them shared the experiences of gradual transformations from one social formation to another. Most respondents remembered the Soviet past as a period of tranquillity and certainty, although several mentioned the difficulties with obtaining goods, drugs and contraception. In relation to the present they talked about pressing concerns regarding economic hardship, a deteriorating medical service and education system, insecurity and ideological disorientation.

Through discussion of the consequences of the Soviet past, the new market economy and Islamic cultural roots, the research focused on women's health in the sphere of the family life and its responsibilities. It was assumed that the political and economic vulnerability of these women were especially important to study when examining the most immediate costs and strains of the transition. Comparing the diverse attitudes and perceptions of the health and well-being of women may provide solutions to the numerous factors that shape the differences and similarities in the adjustment of women to their new social environment. The study confirmed the initial hypothesis that the shift towards a market economy resulted in increasing socio-economic differentiation, insecure livelihoods and declining health and well-being for women. The findings suggest that deterioration of the status of women is related to a dysfunction of social structures and socio-economic deprivation.

Further in this chapter, the theoretical findings given as the reasons for enhancing patriarchy in Uzbek society during the transition, which influences and defines public consciousness and behaviour, will be incorporated with empirical interpretations of women's experiences. These experiences, grounded in the research, explain that factors such as the resurgence of religion, economic recession and political authoritarianism. These factors all contribute to the reinforcement of social relations, which place women

in an unfavourable position in society and consequently influence her health status and health seeking behaviour.

7.2 Dynamics of Transition and its Impact on the Well-being of Uzbek Women

The transition period has brought many changes in both living conditions and life styles and has increased poverty and social stress on women in Uzbekistan. These changes have challenged the ability of women to access health care and to properly maintain their well-being and health. At the beginning of the transition women had adequate access to basic health services and relatively good health status indicators. The Soviet system promoted a universal health care system to 'its entire population, to be paid by society, and free at the point of service', in other words it offered medical care 'from the cradle to the grave' (Field, 2002:65). The Soviet system defined health as the product of the state's health care system and therefore individuals lacked a sense of responsibility for their own health. The transition undermined the State's capacity to maintain health care at previous levels. During transition health issues created by social and economic factors emerged. Transformation brought a reduction in existing health care resources, which made women more responsible for their health and their endeavours to maintain their own health and the health of their family more difficult.

As noted in the literature review chapter, gender inequality and patriarchy have been preserved in both the family and the sphere of politics in the country. A clarification of this phenomenon, which causes the persistent subordinate position of women, has been analysed in chapters 4, 5, 6 on empirical work through the acceptance that these phenomenon are a distinct form of social organization and the roots of such phenomenon must be traced in historical progression.

In chapter 4 on the historical background it was emphasised that the 1917 Soviet Socialist Revolution demolished the Central Asian political and economic state order. This initiated a wide scale modernization through launching a programme of compulsory education, women's emancipation and secularisation of the society. The lives of Central Asian indigenous female populations changed enormously after the revolution. Women were not only allowed to abandon *paranja* (a cover from head to toe) and get out of *ichkary* (special place in the home allocated to women), they also obtained equal access to education, employment and health care. Legal rights were

granted to women allowing them to initiate a divorce so that they could "gain custody of their children after divorce" (Tabyshalieva, 1999:51) and get an equal share from joint property. The Soviet Government passed a law to ban such "practices as polygamy, the payment of *kalym* and marriage without the consent of the bride" (Akiner, 1997:268).

The socio-economic changes during the Soviet period resulted in the wide-scale participation of women in public life and in employment. The equal opportunities offered to women in employment were "accompanied by fairly generous tenured maternity leaves, family benefits and childcare facilities" (Chanet, 2000:183). Women became more economically autonomous. A new generation of emancipated women came into being as a result of these revolutionary changes. It seemed that the gender problem was solved; women gained equal rights, obtained equal opportunities and acquired honoured status as mothers and workers. As Lapidus (1982:xi) states, "if no feminist movement had emerged within the USSR, it was because these questions had been happily resolved". There were no adequate gender studies in the Soviet Union because gender inequalities were "more or less supposed to have been eradicated" (Chenet, 2000:191). However, the literature review and empirical data suggest several contradictions and drawbacks concerning the equality of women.

As an independent state, Uzbekistan initiated the process of building a new social and political system (Yalcin, 2002:138) and redefined its national identity (Akiner, 1997:262). The former Soviet ideology was rejected and a re-evaluation of Islamic heritage was emphasized in the nation-building process. However, the creation of a new civil society with the formation of truly democratic relations was undermined by several objective and subjective factors. Firstly, the entire economic integration of all Soviet Republics was destroyed after the collapse of the Soviet Union. The new trade relations were difficult to establish due to strong competition in the world market. In particular, this was related to Uzbekistan's disrupted economic and financial system, production inefficiencies, highly monopolistic market structures, falling output, huge budget deficits and hyperinflation (Yalcin, 2002:182). The rapid rate of demographic increase and interethnic tension further exacerbated Uzbekistan's social problems.

In response, Uzbekistan adopted a cautious gradual approach to market reforms and authoritarian control over all political and economic issues. Therefore, some aspects of a command system were retained in the economy and in the social sphere. At present all political opposition parties have been banned and the president's power executes the full control over the process of social transformation. Furthermore, transition has

resulted in a significant drop in living standards. Among the new category of poor are former middle-class educated professionals. During the Soviet period even the stratum of the population that was considered as 'poor', "had jobs and other sources of income, had adequate housing and enjoyed free health care and education" (Country Briefing Paper, 2001). Currently, people who were previously well-off are experiencing hardships and have to struggle to make ends meet because the government cannot afford to maintain and subsidise health care, education and child care at previous levels. Women started experiencing difficulties due to job redundancies and in 1999 women accounted for 63 per cent of the officially unemployed population (Country Briefing Paper, 2001).

Impoverishment and loss of economic independence represents one part of the problems that affects the well-being, status and health of women. The other part is that in the last decade there has been a significant process of 'Islamisation' in the society. After Uzbekistan gained independence there was a resurgent trend in all spheres of life towards Islam, coupled with a growing sense of Islamic identity. Both factors set a foundation for enhancing patriarchy. As Yulina (1993) argues, 'if there is a revival of religion occurring in the country, it will simultaneously be a revival of patriarchal traditions'. During the years of independence, Islam was put forward as a course of resistance against economic limitations. Such a revival puts a counter discourse of gender equality and patriarchy on the agenda once again.

The rise of Islamic fundamentalism contributes to the further exacerbation of social and gender tensions, which were witnessed during the last decade, as it uses Uzbekistan's economic difficulties to mobilise supporters. For example, sending women back to their family, they believe, can easily treat the rise in unemployment (Akbarov, 1997; Bashbekov, 1997).

Overall, religious fundamentalism aims to develop different forms of control over the productive and reproductive activities of females in order to further the subordination of women and preserve patriarchal hierarchies. Radical transformations in the society demand self-sacrifice and cutting down of the necessities in life. The solution has almost always been at the expense of women's rights. Participants in this study view the issue of Islam and religious identity as a complex and intricate matter. The data suggest that Islam was considered as a part of national identity on the state level and as a spiritual way of coping in private life. Many participants have turned to

religion during the last years to establish their weakened position after the collapse of communism.

At the same time people are wary about the potential threat of Islamic fundamentalism in the region and would rather accept any secular political power, even if it were authoritarian, rather than Islamist.

Many respondents indicated that the Uzbek middle-class, middle-age urban women were ready to embrace Islam as it could help them find stability during a time when other values have been lost. The respondents admitted that they would exercise spiritual practices and observations, but they rejected the idea of changing the dress code or accepting secularisation and polygamy. Several respondents revealed that conversion to Islamic rituals like praying and fasting helped them to regulate their life and put their emotional status in good order. Other respondents said that during times of grief, when they almost lost hope, praying and placing trust in God saved them from distress and helped to withstand such adversities. However, incorrectly understood Islamic practices influenced the decision of women to seek medical help, which in some cases had negative repercussions.

It is apparent that full participation in the workforce has not ended the oppression of women within the family. On the contrary, it usually led to the doubling-up of women's work load as they become responsible not only for doing a full days work but also for domestic work within the house. In many countries, although more and more women are gaining financial autonomy, they are still likely to occupy jobs at the lower income level (Arber and Cooper, 2000:133).

The generation of women studied in this research found themselves in a very difficult position and could therefore be named the 'lost generation'. They are not too old to retire, but competition in the marketplace from men and the younger generation makes it almost impossible for them to succeed.

Women who relied on state support for most of their life found themselves at a crossroads. Family duties of a woman regarding their younger children and their aging parents constrained their opportunities and ability to meet the requirements of the market economy. At the same time, being better educated and Soviet born did not assist in accepting Islamic law without question. As Akiner (1997) and Takhtakhodjaeva (2000) comment, women became trapped between the past and present, without being able to find a niche suitable for their moral values and corresponding with their social

requirements. Arber and Copper (2000:124) argue that the health and well-being of middle-aged women is influenced by their previous life experiences. These experiences define their identity 'which influence their attitudes and behaviour and distinguishes them from preceding and succeeding generations'. In other words, their lives have been shaped by a different vision of the world.

For women who experienced emancipation it is much harder to give up their achievements. For example, accepting Islamic norms would mean not only that women need to come to terms with limitations in external manifestations such as dress code, but they will also have to retreat from public life, consequently losing economic independence. The loss of economic independence will result in a submissive position within the family. These issues affect the health of women directly through their emotional well-being and their economic circumstances.

The challenge for Uzbek women is how to preserve their achievements while accepting and adjusting to an inevitable shift in restoring traditional, patriarchal views in both private and public life. The process of transition from a socialist economy to a market oriented one presupposed the proliferation of pluralism and liberalism. However, the data suggest that traditional family values have grown, while the feeling of independence and individualism are developing at a very slow rate.

In the public domain, according to the Constitution of Uzbekistan (1995), Uzbek women have equal rights with men in all spheres of life (Country Briefing Paper 2001). The Labour Code of Uzbekistan (1995) and the Family Code (1998) lay out privileges and protective measures for women and take into consideration their reproductive roles. The Women's Committee of the Republic of Uzbekistan was established soon after independence in 1991 in order to implement state policies and help administer and regulate the Government's adherence to improve the status of women. In March 1995, the President of Uzbekistan initiated a presidential decree on 'Enhancing Women's Role in the State and Social Development of Uzbekistan'. The year 1999 was declared the "Year of Women". All these measures were implemented to draw attention to gender problems within the country and to encourage women to fully participate in public life and increase their participation in political and social spheres.

Despite all these government initiatives, women remained discriminated against in public life and were therefore most susceptible to impoverishment. The market requirements restricted the competitiveness of women in employment, especially in the private sector where a male-dominated working force is preferred. According to the

Country Briefing Paper (2001), the ideologies that 'defend men's right to work over women's right, on the basis of gender ideologies that see men as the main provider in the family' are re-emerging. Some of the privileges of women, such as maternity leave, guaranteed by the Labour Code (1995) also negate the employability of women. Private sector employers are reluctant to hire female labour because all these privileges are to be paid by the employers. The research findings suggest that women today have the freedom to choose between work and family. However, not all women voluntarily give up their outside work, but are instead made redundant. Therefore, it could be argued that the introduction of a market economy during the transition has further restricted the choice of women in labour. For the country and for society it represents a substantial loss of professional capacity if women remain unclaimed.

Thus economic hardships, reduced employment opportunities, reduction of state benefits and privileges and resurgence of religious and patriarchal traditions all contribute to a reversal of female emancipation.

Structural alterations in health care resulted in,

- Reduction of real public spending on health;
- Ineffective budgetary allocation in the health care system;
- Deterioration in the quality of state medical care; and,
- Loss of highly qualified medical personnel.

Socio-economic changes have had immediate consequences on the health status of women through,

- Reduction in real income;
- Increased stress from occupational downgrading;
- Increased burden of family health responsibilities;
- Rising disparities and inequalities in access to health care; and,
- Amplification of patriarchy in public and private live.

All those transformations have had direct implications on the status women,

- Women became trapped "between tradition and modernity" (Akiner, 1997) or between "the slogans of communism and Islamic law" (Takhtakhojaeva, 2000);
- Women experienced tension and pressure from occupational downgrading and an inability to find their niche in an environment of constant

changes (by protecting their spiritual values and sacrificing their life to their families, women may lose opportunities to improve their social status);

- Women of the middle age group became trapped between the demands of family members from different generations ; and,
- Social changes of women in the groups studied caused psychological and physical problems related to mid-life physiological transformation.

The repercussions of these changes are,

- For the most of the middle age women transition became a period of disappointment and disillusion; and,
- In such situations, women place more emphasis on survival than fulfilment.

The positive feature of the transition is that a wide range of therapeutic alternatives became available after independence. The findings from this study suggest that while searching for medical help women tried and used various therapies from conventional to traditional (folk) treatments. The utilization of alternative practices increased after independence. The emergence of private clinics in Uzbekistan expanded the scope of medical choices. When greater selections are available women can make careful assessments in choosing more advantageous treatment.

Whatever transformation takes place in society it will result in women becoming susceptible to the broader political agendas of the nation. During the Soviet Period women made remarkable advances in education and professional careers. Development in the lives of women had an effect on their self-consciousness and had an impact on their family relations. However, along with a recent shift in ideology, such advances have been increasingly jeopardized by the significant rise in religiosity and its close resemblance to patriarchal inclinations and a state mechanism of close control.

The political agenda or ruling power does not always take into account the actual needs of women. The political goals of the Soviet state were to involve women in the workforce. However, this resulted in a double burden for women because they were overwhelmed with home and family responsibilities and because no endeavours were made to free them from their family duties. Today, an appeal from fundamentalists to restore the family responsibilities of women restricted their access to financial resources

and therefore exacerbated social and gender tensions. Doyal (2002:188) emphasises that in the patriarchal societies where women are discriminated against, women become especially vulnerable to poverty due to an unequal distribution of income and wealth. Graham (2000:101) argues that in most societies 'women are more likely than men both to be poor and to be responsible for maintaining' the well-being of their families. In addition, Lorber (1997:101) emphasises that the overall social status of women makes them more exposed and vulnerable to the 'illness of poverty'.

The gender roles in Uzbek society have been formed under the strong influence of traditions, customs, religion and stereotypes of the status of women (UNDP, 1999:9). Those stereotypes formed the roles of women and men in society and influenced the distribution of responsibilities between women and men in public and private life. The structure of the social institutions (such as *Mahalla*), domestic households and state organizations were all arranged in such a way that the submissive position of women was maintained despite constitutional and legislative prohibition of gender discrimination. Although women in this study did not mention their communal obligations as a major one, they emphasised their dependence on the rules and regulations of *Mahalla* and mentioned how deeply it influenced their social behaviour.

This study shows that despite the fact that Uzbek women were economically independent and often made a substantial contribution to the family budget, the patriarchal inferiority of women remained intact at the family level. Even when certain groups of women made some progress, for their rights, it was always limited and retained under a condition of domination by the patriarchal power.

7.2.1Cultural Genesis of Patriarchy in Uzbek Society

To understand the question of a firmly embedded attitude to gender inequality its history needs to be revisited. The historically constructed system of hierarchy and the cult of authoritarianism were an integral part of Uzbek culture that has been deeply entrenched since ancient times (Gleason, 2001; Yalcin, 2002; Akiner, 1998). The Soviet political system never attempted to eradicate such practices because it helped to maintain the policy of subordination to the party leader, although the Soviet state did attempt to undermine patriarchy within the family. The legislation and ideology were intended to weaken male privileges in private life. However, patriarchal order on the state level in the form of a party leader remained inviolable. Therefore, as Ashwin

(2000:118) states, the Soviet system was in itself 'a blend of traditional and revolutionary norms'. During *perestroika* Gorbachev's policy, which was aimed at restructuring the economy, there were no indications of liberalization or democratisation in private life (Eisenstein 1993:311, Lapidus 1993:153).

Moreover, the state promoted a system of subordination and managed to use it in its own interests, i.e. to make Central Asian Republics comply with the overall interests of the Soviet Communist system. Although the idea of the ancient hierarchy was criticised by the Soviet ideology and was declared as despotic, the Soviet system of subordination to party hierarchy was proclaimed as democratic centralism. The nation, obedient to authority, was easy to manage. The hierarchy system of obedience to 'big brother' in Moscow, to local communist leaders, to parents and to the husband was manifested through *hurmat* (respect) and deference to elders and seniors.

An adherence to the tradition of *hurmat* developed the spirit of patience, especially among women. Though even men respected the authority of their parents, disobedience towards their mother was considered beyond the bounds of possibility. Such dedication to tradition has been fostered through the ages and even today it engulfs the consciousness of Uzbek people. The reason for that could be from 1917 when the Soviets included Central Asia in their territory. At this time the majority of Central Asian populations were rural inhabitants. Industrialization was not introduced until the Second World War, when most industrial enterprises from Western Soviet Union were transferred to Central Asia. However, even after that the Uzbekistan economy remained predominantly agrarian with 60 per cent of the population comprising rural inhabitants. Therefore, the division of public and private, or public and domestic was not developed in Uzbekistan on a large scale, as far as industrialization contributes to the separation of domestic (family) from public (state).

Nicholson (1986:201) states that industrialization in the Western countries undermined the family as a production unit and provided men and women with the possibilities to act in the outside world 'as individuals rather than as heads of households or as dependents of such heads'. However, in Uzbekistan, family and kinship, not the individual, determine the relations in society. As Ashwin (2002:119) argues, "early Bolshevik dreams of the transfer of domestic functions from the private to the public sphere were never realised except to a limited extent in the realm of child care".

The process of separation was gradually introduced during the Soviet period. Spheres of domestic relations such as health care and education were brought up to the state level. However, care for disabled and elderly people, food processing and garment making remained predominantly domestic responsibilities. Despite the fact that the Soviet regime removed all the obstacles for women to fully participate in the work force at the legislative level, it failed to introduce sufficient industrialization for the precise division of private and public. Therefore, the family unit in Uzbekistan continued as an industry in producing canned food, cloth and home appliances. The family as a social institution played a significant role in social construction, uniting people, providing people with social support and reinforcing national identity. The institution of the family has played a major role in mobilizing people and offering them a source of spiritual resources once again. However, the impact of the transition seems to affect the division between private and public so that people could no longer continue with their previous life style.

Uzbek indigenous women felt more secure in the family than as individuals in society. As the participants in this study emphasised, the family provided women with substantial social support throughout their life cycles. These findings correlated with Western feminist discourse on the bargaining with patriarchy by women. "In a patriarchal relationship, a woman gives up her independence in return for the promise of protection" (Fee, 1983:8). During the earlier years of life when women have young children, there are always elderly relatives who can look after them while the women work. In the later years of life, women are able to count on the support of their grown-up children. During the times of transition the institution of the Uzbek family helped everyone to cope successfully with the present ordeals of life. Solidarity between family members could provide a great resource when coping with a decline in living standards. Moreover, women gained an extraordinary amount of influence in the family as they grew older. For example, they had little control over family matters when living with their in-laws, but after they become the mother-in-law they enjoyed strong and effective control upon all family matters, including financial ones.

The existing culture of obedience and respect towards the elderly has other consequences for Uzbek social life. As the findings of the study suggest, women were generally reluctant to give up their older parents and relatives to social care institutions ('*dom prestarelyh*' - old people's home) and preferred to look after them at home. However, this burden although voluntarily was the complete responsibility of the

woman. It exasperates existing burdens for women and contributes to their health problems. In order to look after disabled or sick relatives women usually have to give up outside employment and become dependent on the provision of their husband. Moreover, the fact that women accept the role of a primary carer in the family and put the needs of others before their own needs causes poor nourishment, a lack of time to look after themselves and a lack of rest and recuperation. These all have a direct impact on the health of women and contribute to diminishing their status and well-being.

The example of Western women who were encouraged by feminism to devote themselves to their careers demonstrated that that they had to postpone the creation of a family until later on in their lives. As Lapidus (1982:ix) states,

> "In virtually all industrialised societies, rising levels of female labour force participation have been accompanied by rising divorce rates and declining birth-rates, provoking widespread anxiety among many observers that the family itself is threatened by current trends".

In Western countries, women as individuals felt a need for their own financial and social security before they were ready to create a family. As Callero (2003) states, 'the globalisation of late capitalism continue to destabilise traditional practices' and increase the 'individualization of social life'. Uzbek women, encouraged by the Soviet communist regime also managed to pursue a career. Yet, they never considered postponing or sacrificing family matters. In this study, participants mentioned how important it was for them to set up a family. Many mentioned a point in their life when they had to choose between a family and a career and they all choose the family. This study showed that women who choose family relations over financial independence a paid high monetary cost for staying home. Women who choose to work managed to gain more or less financial independence, although relations with their husband were seriously undermined. Yet, however difficult it was, they always tried to strike a balance between public work and family life. Neither education, nor participation in the labour force prevented Uzbek indigenous women from creating a family and having many children. The generous maternity leave, social protection, childcare facilities, as well as strong ethnic traditions, all contributed to this phenomenon.

It could be argued that patriarchal relations of hierarchy have been maintained in Uzbek culture not only by men, but also by the women themselves. This could be another explanation as to why patriarchy has been so deeply rooted in society. Among

the most powerful influences that helped form and maintain the attitudes and behaviour of women, respondents mentioned family traditions and social patterns. Many of the women interviewed indicated they were more or less conscious about the behaviour and attitude they adopted in their family and that they were inclined towards passing that attitude on to their children. However, the observation provided some indications that the young generation influenced by modern trends of Westernisation and by being educated abroad might radically overturn the traditional family influence.

From generation to generation traditional relations have been emphasised in Uzbek families, thereby enhancing the patriarchal authority structures that are based on stereotypical attitudes of inferiority and with deference to seniority and elders. The consequences of such relationships are shown in families where women have an inferior position and the power is distributed unequally. Such women have less potential and capacity due to the gender based stereotypes. As a social institution, *Mahalla* played a particularly strong role in formulating public opinion of adherence to traditional family values and in controlling the implementation of customs and supervising the behaviour of members of the neighbourhood.

Patriarchal order was preserved in private life of Uzbeks. Patriarchy restricted the opportunities of women and even contributed to their poor health. It overloaded them with family responsibilities, caused them malnutrition, and insufficient care about themselves and their children. A tragic example in this study is Yoqut's story about how she lost her son from being so overloaded with housework that she neglected her son's poor health.

Adherence to national traditions as functional means of national identity in turn helped to preserve and maintain patriarchal norms in Uzbek society. Although the Soviets considered patriarchy as an obstruction to liberating women, numerous endeavours were made to uproot the remains of the past. These endeavours were to a certain extent unsuccessful. The reason for this was probably a gesture of passive national resistance to the policy of eradication of national distinctions propagated by the Soviet rule. The national traditions were preserved at least at the family level; they helped to maintain the idea of self-identification and united the nation around Islam, though it was sustained clandestinely.

If during the Soviet times women were encouraged by the state to strive for liberation and abandon the relics of the past through participating in public life, today women have found themselves on a course of continual negotiation between two forms

of patriarchy: private and public. In private, men entertained their authority over women in family matters, whereas in public the state and particular religious establishments expose their prerogatives on women. The women interviewed in this study perceived tensions caused by gender inequalities in their family. None of the respondents regarded these inequalities as being justified. However, participants did not show any signs or endeavours to adopt more radical behaviour against gender inequality. As mentioned in the chapter on Islam, women did not consider participation in feminist movements or request equal treatment. Instead they resorted to less radical strategies. For example, they persuaded themselves that they could follow strong social traditions, as disturbing familiar traditions could bring more disruption than order into their lives. The women interviewed in this study believed that by passive and persistent behaviour they could gain much more than by radical measures.

As Western feminist writers suggest, the issue of women's health is directly linked to the state of women's equality in the society (Vlassoff, Moreno, 2002; Stacey, 1994; Smyke,1991). In Uzbekistan, the poor health of women is often the result of their unequal status in the family, especially if they live in an extended family where they must be obedient not only to their husband but also to their husbands' parents and even their husbands' brothers and sisters. Coupled with the deterioration of the public health system the burden of family health responsibilities have led to significant emotional and physical strain, malnutrition, overwork and consequently to women suffering a nervous breakdown. All these factors contribute to the deterioration of the health of women. Therefore, solutions to these health problems must be sought not only in adequate provision of health care but also in the position of women in the family. Structural changes in gender roles could lead to expectations that the pattern of gender inequalities in relation to health will also change.

The effects of transition such as loss in the status of women and increase in workload could result from a shift in gender relations and unequal exchange between the sexes, in favour of men. Therefore, it would appear that patriarchy indeed has a detrimental effect on the health and well-being of women. During transition, women suffered a loss. This contributed to their dependence on economic authority and a loss in their general status for which still there is no solution or strategy to challenge the consequences of this. The generation of women studied had little chance to compete. Therefore, one survival strategy was to construct their life setting around the domestic domain, which meant retreating to patriarchy.

Women in this research found themselves particularly disadvantaged, not only compared to men, but also to younger generations, who due to their mobility could more easily adapt to an ongoing process. Therefore, as previously mentioned, patriarchy challenges not only the private but also the public domain as middle-aged women could be segregated within public not only by men, but also by younger women. It should be noted that the current study only discusses one specific group of women whose interests might significantly differ (though not to an extreme extent) from those of other groups of women. In many respects, the position of the study participants can be compared to those of other women in the region. The commonalities seem to exist concerning matters of legal stats, family relations and political participation (which is low among all representatives of different stratum). The group of participants are middle-class, urban, educated professionals. Although their situation differed from the majority of the rural population and the majority actively participating in public life, they were generally more liberal in their attitudes towards emancipation. The gender asymmetry in their families existed despite the fact that those women played an equal part in the outside production, although primarily through indirect production, as they usually worked as doctors, teachers, secretaries or other similar professions.

In relation to health, it is evident that the health issue of women occupies not only a private domain where women exercise choice and control over their health but also a public domain, where the state should exercise responsibility to maintain the good health of its citizens. The health status of the Uzbek population reflects obvious and hidden factors in its development. Health concepts and perceptions are constructed and shaped not only by state policy but also by ideological issues such as national and ethnic identity and religion. In the Soviet times, health represented a state responsibility. When the state was entirely responsible for provision of health services inequalities in access to health provision was minimised. When the role of the state in health provision was reduced inequalities increased. Thus, the changes that are now taking place in the country contribute to the division of rich and poor. The socio-economic inequalities in health result from uneven distribution of income and differences in living standards, which have particular implications on women's health (Graham, 2000:91). The government of Uzbekistan initiated many strategies to address women's health issues, such as the Programme of Save Motherhood. However, as it was seen from the interviews the health sector reforms negatively affected the access of women to health care. The respondents mentioned that they had to pay increasingly more for health services and medicine, while the health services were declining due to the heavy

financial strains in the health system. Women, especially those with children, have found themselves in a position where they must put their own needs second when distributing family expenditure. This study confirmed that the burden of official and unofficial payments were disproportionately high for poor respondents and even relatively well-off families could fall into poverty as a result of considerable expenses spent on medical care when sudden inflicted with chronic illnesses. The newly emerged paid services provided women with additional options, although most of the respondents indicated that the prices were unaffordable. Thus, women with a low income became less mobile and less capable than other women. Their choices of health care settings were constrained.

Women in poverty face challenges that deny them achieving any beneficial health care standards. In such cases, the likelihood of adverse outcomes will increase. During interviews, women stated the importance of being responsible for their own health could be undermined by unfavourable circumstances. The findings of Blaxter (1990:242) also confirms that women in troubled social circumstances with low income were very concerned about their health, but had a very fatalistic attitude because they were not in control of their socio-economic situation. Thus, the ability to adhere to a healthy lifestyle 'is restricted by living and working conditions' (Ibid:243). Bierman (2003:202) suggests that the challenge for society is to "translate scientific advances into measurable improvements in the health and well-being of all women, while concomitantly working to eliminate health inequalities".

In Uzbekistan, transition was a dramatic shock for most of the population. The new economic developments have not yet brought prosperity to any social stratum in the country. People have been suddenly deprived from the paternalistic state protection and have had to confront an enormous decline in living standards without any adequate strategies to adjust to the new conditions. The times when salaries of husbands and wives were the same and kindergartens and 'pioneer camps' (summer retreats for children under the Soviet system) were available to all have ended. The period of so-called 'equal opportunities' has finished, and women in this study had fewer chances to support themselves through paid work.

Women in this study showed an enormous ability to adapt to difficult circumstances in their lives, although the effect of coping with competing demands was, in most cases, stressful on their physical and emotional well-being. This study described conceptual strategies that women employed to create a sense of coherence, stability and

order in their life and in their family's life. Thus, if the cost of treatment was unaffordable to them they used self-treatment and folk medicine. If they did not get help and support from their spouses then they turned to their children for help. The respondents showed openness to new medical trends and information in order to update their own medical knowledge as well as the traditional heritage of folk medicine they used. Religion was also used by women to deal with the ill-health of themselves and their children and to deal with psychological difficulties that they faced. The majority of women showed their ability to employ a variety of means when they lacked professional medical help. Social support outside the family (relations with friends and colleagues) was seen as an important feature in maintaining a balance and well-being, and consequently optimal health. Women indicated that they derived emotional aid and assistance as well as receiving respect and empathy from close relationships with their friends. Thus, women tended to employ various forms of coping strategies to resolve the problems they faced.

Despite many women complaining about the deteriorated situation in all spheres of life during the last decade, including health care, they proved that they were able to reorganize and renegotiate their lives to adjust to the ongoing transformation process. In order to contribute further to their development, women must find a way to use opportunities and society must provide those opportunities equally among all its members.

7.3 An Evaluation of Concepts and Perceptions Shared by the Respondents

There is no perfect way to break through from the old to the new society, without carrying over patterns of thought and behaviour and values firmly fixed in people's consciousness that are especially deeply rooted in family behaviour. The explanations and perceptions for the cause of the disease developed by many participants were strongly influenced by cultural and traditional medical knowledge. The findings reveal that broader environmental, economical, social norms combined with an individual's knowledge and beliefs created the nature of Uzbek women's health seeking behaviour. Initially focusing on the individual, the study developed an insight of how immediate political, social, economic factors of women's environment affected their health, and how participants despite any hardships and adversities were, in many cases, able to control health-related requirements.

Cultural constraints of Uzbek tradition imposed on women a necessity to hide their health problems as unhealthy women could be considered as incapable of having healthy children and be a good labourer in the family. Although the possibility of being in perfect health among middle-aged women is practically impossible, several of the respondents declared themselves healthy, even if they were suffering from various diseases. Such contradictory responses arise from the inferior position of women and impose an extra pressure on them to maintain a healthy image, even if untrue. Thus, almost all the respondents see health and being healthy as an extremely important matter. The general acceptance of ill health as a stigma attached to women, leads to denial or hiding some diseases like in case of Gauhar and Shohista. At the time of the interviews most of the respondents suffered from moderate to serious health complaints, which they accepted and attempted to cope with as best as they could in their current situation by employing both conventional and unconventional treatments.

The results of the study show a profound medical knowledge among the respondents in relation to health treatment. Their knowledge encompasses biomedical perspectives as well as cultural and traditional experiences. The respondents emphasised that when seeking medical knowledge they relied not only on scientific medical information, but also on personal experience. Most women had a strong traditional belief that they used to explain concepts of health and illness. The majority of respondents expressed confidence in the fact that they were able to treat minor and major illnesses of their own and their family members using home and folk remedies. In the period of transition when access to medical utilization became less available due to the structural and financial changes in health care services, women showed the confidence and ability to handle health problems independently and successfully self-diagnose and manage their own and their family's health disorders.

Most of the respondents preferred to rely on conventional medical treatment when it concerned acute health problems. In cases of minor or common diseases women implemented a strong heritage of using herbal and home remedies. In the times when medical services become less available to the poor stratums of population, due to cost increases, traditional methods of care and self-medication, became more popular. Advances in modern technologies that make medical knowledge easy to access through the Internet, publications and advertisements, broadens women's medical comprehension further. Several respondents showed non-compliance to professional

medicine if they felt that the side effects outweighed the benefits (Oydin, Leila), especially when it concerned their children (Kamola, Mukaddas).

In relation to a healthy lifestyle, some women expressed the opinion that good health was related to behaviour. The common notion among the respondents was that if an individual looked after themselves, had a good diet, exercised, did not smoke and drank in moderation then they could maintain good health. Different types of diets and cleansing procedures were used by respondents not only to control their weight but also as healing practices to cure illnesses such as allergy, stomach upset, liver dysfunction and gall-bladder inflammation.

The respondents mentioned that social and economic circumstances played a major role in preventing disease and could significantly influence a person's health status. A lack of money can produce different types of stress and consequently can result in health risks. Women admitted that inequalities in accessing health care related to their income. Many women accepted the strong correlation between economic status and life style with their health status. Thus, economic hardships can work as an obstacle to improving and maintaining a healthy lifestyle, even if someone is prepared to lead a healthy life. Despite all the hardships that women had to face the study showed that Uzbek women had their own remarkable ways of surviving. The participants showed not only their daily capacities to cope, but also their spiritual skills and techniques for improving their well-being.

The findings from the interviews supported the generally accepted opinion that Uzbek women traditionally orient towards the family rather than employment. The statements of respondents reflect the traditional importance of the family and children in Uzbek society. Uzbek women perceive domestic and family problems as much more acute than any other problems. The main concerns for women interviewed during this study were family problems. Personal problems like health, professional status and own interests only had significance if it affected their family relations.

From the interviews it was recorded that women bear the major responsibilities for the health of their family, and are expected to look after the young, sick and elderly in their families. All the respondents accentuated the importance of carrying out their commitments to their family members, even if it was for expense of their own health. The findings from some interviews showed that when women took on paid jobs, some sharing of domestic tasks with household members often developed. Personal economic circumstances and the cultural patterning of relations between genders and between

generations shaped the domestic work of women. This study confirms that household work is distributed unequally with the bulk of the responsibility falling on the women. However, women used various social resources to help them carry out their difficult work.

Although the respondents of the study represented a homogenous group, in terms of age and ethnicity, they were divided into those who worked outside the home and those that were housewives. Employment among the working respondents was considered as a source of stress and as a cause of exhaustion and consequently ill health. However employment was also considered as an escape from the routine of monotonous and boring housework and a source of income, and therefore beneficial for health and well-being. For many employed and currently unemployed informants, work was considered an important part of life. The imminent threat of losing employment and the decreasing chance of obtaining a new job forced women to work overtime, neglect their own health and dedicate less time to their children. At various times in their lives women have different reasons for working or not working. Women reported that they considered their main responsibilities to be taking care of their children and maintaining healthy, psychological conditions in the family. On the other hand, contemporary socio-economic situations oriented on a market economy create unfavourable conditions for involving women who are mothers in employment outside the home.

Some respondents reported that they had chosen to work not only because of economic needs (although that was a crucial factor) but also from an internal conviction that they must work otherwise there was no point to having a formal education. Some women emphasised that in recent years they had become disillusioned by the usefulness of their work to society. However, the pride and independence which women gain from employment outweighed the negative consequences. Women who preferred to work, even if the financial situation in the family was good, reported that if they stayed at home they would be responsible for too much of the household work. When they worked outside, their husband and children were less demanding and helped around the house more than when they stayed at home. When they did stay at home they had to cook three meals a day, wash clothes and clean the house all by themselves. Therefore the respondents who are not currently working due to the personal reasons outlined in the chapter five, try not to lose hope of starting work in the future. The working women interviewed proved that it is possible to bring up children whilst working as successfully as women who devoted themselves solely to their family. However, economic hardship

can turn into increased health problems for women. In order to withstand economic hardship, women have to be more careful with their financial resource allocation in the family.

Several housewives emphasised their reluctance to work as they were occupied with housework and child-care responsibilities which took almost all of their time with no provision for getting bored (Adalat, Iroda, Yuliya, Shilrin).

Working respondents reported that employment had positive consequences on their health, whereas housewives mentioned that the lack of a second income for their households had negative consequences. The results showed that employment could have had both positive and negative affects on the health of women. The interview findings indicated that the effects of employment on the health of women depended on the type of job and the situation in the family.

The respondents complained that their ability to cope with stressful situations declined considerably because they had fewer opportunities to find a proper job. This inability to find a proper job, and therefore to be more economically independent, gave the women a low self-esteem. This low general self-esteem, in turn, reflected the hardships of social change taking place in Uzbekistan. Women reported that after independence the ability to control their lives decreased.

On the whole, the status of women in society and in the family is higher than in other Muslim countries (Droeber, 2003; Marcotte, 2003; Kandioyti, 1991). The findings showed that traditional and religious influences should not be overestimated. Some rituals have been retained and widely accepted and recognised by respondents as important (marriage, funerals and circumcision). With regards to religion, women showed the signs of gradual adaptation to an Islamic way of life either by their own will or under social pressure. The data reveal a growing tendency of the imposition of Islamic norms on women. This trend could lead to undermining the position of women due to the fact that it was men who set Islamic Law and standards. During the interviews, observations of religious practices or traditional social responsibilities in *mahhalas* (neighbourhood) were mentioned as the least important among women, if indeed they were mentioned at all. However, it is important to consider the reappraisal of cultural and religious traditions in terms of their possible impact on the status, and consequently health, of women.

Religious beliefs and rituals played an important role in the respondents' lives, with regards to physical health (unconventional forms of treatment, religious observations and restriction around new born babies and pregnant women, prohibition of food) and mental and emotional states (helping to cope with stress, explaining and accepting unavoidable misfortunes). Religion can have a beneficial effect on the physical and emotional health status of the respondents, as faith offers support and consolation to those who suffered from ill health (Nigora, Iroda, Asal). On the other hand, some of the religious regulations can restrain women when choosing to lead a healthy life style. Thus, Uzbek women are less prone to take sporting activities. Although physical activities were mentioned by most of the respondents as crucial to maintaining good health, a few, if any, were engaged in any sporting activities. Limited time, cultural upbringing and being overloaded by household responsibilities all contributed to the unpopularity of sports amongst Uzbek women. It is difficult to imagine that an Uzbek woman could leave her children with a baby sitter or her sick parents to a hired nurse in order to join an aerobic class. Public opinion will condemn her. Cycling, jogging and other outdoor activities are also very unpopular among Uzbek women, due to the fact that the appearance of a female in a sport suit in the street could provoke strong disapproval, especially in the parts of the neighbourhood with more traditionally minded inhabitants (Oydin).

Although the issues of depression and mental health did not get a merit attention in the current research opening the path for further investigation, the effects of women's worries and concerns discussed in chapter six have an enormous impact on the health of women. For many of the respondents the conditions of constant worry about the well-being of their children, parents and husband caused the most problems with health (Saida, Ruhsora). These worries were recognised by the respondents as the main causes of diseases like diabetes, heart disease and hypertension (Shirin, Saida). An excessive psychological and physical burden and aggregation of conditions of everyday life can be considered a main threat to the health of a woman. Most women when identifying the adverse effects on their health indicated the uncertainty of their future as a major factor contributing to the deterioration of the well-being of themselves and their children.

A solid ground of social support from relatives and friends helped women to cope with stress and depression especially during times of grief and mourning (Shirin, Gauhar). None of the respondents complained about loneliness or isolation. On the contrary, it was almost impossible to be alone, because of a traditional life of living in

an extended family, which was named as a difficult matter to deal with. Women with small children in particular, had few opportunities to have their own quality time. This time was usually reduced to one hour a day, if at all. Thus, a culturally predisposed way of communal life safeguards women from loneliness and from the possibility of being abandoned in their older years, which is a widespread problem in the developed counties. However, this also restricts the capacity of women to exercise more personal freedom and results in fewer opportunities to develop a healthy life style.

On the whole women appeared to be very adaptable in coping with their living conditions in a transitional society and showed evidence of inner strength as individuals. Economic and political changes that accompany the transition to a market economy in Uzbekistan will undoubtedly encourage the development of new social patterns in all spheres of human life. In periods of economic tension and rapid social and cultural transformations it is women who must play a more difficult and active role. It is obvious that contemporary women are subjected to constant stress and tensions that threaten their health and well-being. The results of this research clearly show that during the first ten years of independence women have faced increasing pressures from a socio-economic downturn, loss of state network support and cultural and ideological disorientation. The initial hypothesis that the health status of women has significantly deteriorated during the years of transition has been proved in this study. However, this study also provided examples of successful coping strategies and strong will among the respondents, despite their verbal complaints.

7.4 Methodological Implications

This study attempted to apply Western feminist theories to Uzbek contextual experiences. All the empirical and theoretical data from this research proved the validity of the Western feminist assumption that gender issues and patriarchy are paramount cross-culturally and that societies in transition are among the most susceptible to patriarchal manipulations. This is due to their unprecedented social and economic instability and uncertain political environment. The above discussion has demonstrated that the Uzbek as well as other societies are presently organised in a patriarchal way. Patriarchy has the ability to change its form and even intensify over time (Walby, 1990). Biological differences between men and women are conducive to political and ideological interpretations of gender order in society. Therefore, the reproductive abilities of women put them in a subordinate position, which has helped men to control

and exploit women in both public and private life (Annadale, 2000; Lee, 1998; Lober, 1997). The example of Uzbekistan's social development illustrates how society (be it socialist or market oriented) supports and uses patriarchy in accomplishing the process of development. Most of the current work, which was undertaken with the goal of contributing to a limited existing body of knowledge about middle-class Uzbek women, is explicitly interdisciplinary and essentially eclectic. It helped to place the research into wider discourse about gender in the nature of a transition process. This study produced evidence on how the situation of Uzbek middle-age women differed from that of women in other countries: a consequence of upbringing, the socio-economic environment and cultural peculiarities that all contributed to the development of specific features and distinctive characteristics of the position of women. The study accentuated the context of the women's situation, beliefs and attitudes, their judgment of the health care services and cultural arrangements and interconnections, which were not previously considered when examining the health status of Uzbek women. Taking into consideration the discourse of Western feminists on gender and health matters, an attempt has been made to summarise the research findings and put them in the context of the changes that have occurred as a result of a decade of independence. The study presented the individual experiences of Uzbek women and used these experiences for the social analysis to contribute to a broader picture of feminist discourse and provide data for the wider system of feminist theory.

The methodological approach of this study emphasises the importance of individual behaviour, perception and action in the social process. The study has attempted to raise questions about how women could adjust their lives to social and economic conditions. The implication of the research was to clarify the social affect of health, which in turn could enhance an understanding of health equalities and equitable health distribution. Focusing on health provided insights into a broader social reality and so contributed to further discussion on social theory. This study showed the importance of women's personal perception of their life in this context. In that sense it contributes to several trends of qualitative research on gender, health and the multiple roles of women. The findings from this study correlates with those of Western sociological discourse on the societal nature of health (Platt et al., 1993), the complex interdependence and integration of physical health with social, emotional and spiritual elements of women's life (Kasle et al., 2002), the difficulty of balancing work and personal responsibilities and its impact on women's health (Doyal, 1995; Lee, 1998),

and That the treatment of women as equals is essential in order to improve the health status of women.

The aim of this research was to explore the impact of the post-communist transition on the health status of women. Although health issues were central to the research in the course of talking about their health problems and those of their family members, it became evident that apart from the difficulties in health care system, social factors like patriarchal issues affected women's health and women's health seeking behaviour both directly and indirectly. Therefore, the health status of the respondents was viewed as a matter of social, political and economic relations in a wider system.

The study supports the proposition that the social status of women and gender relations within the family and public life remain a sensitive issue, and that the issue of health should be analysed within historical, cultural and social contexts. The research supports the Western feminist discourse to take into consideration the social environment when examining the health problems of women. Health status cannot be separated from the roles of women as "wives, mothers, employees, while they interact inside social structures such as work, education, health care services, religion, family structure, the economy and housing" (Bayne-Smith and McBarnette, 1996:174). "Economic resources, nutrition, family responsibilities and social support all are firmly fixed in a structure of social institutions – the economy, the family, the medical system and the gender order" (Lorber, 1997:94). Therefore, the discussion of the contemporary position of women includes the problems that confront women, the changes that occurred in gender relations during the transition and how these factors influence the health and well-being of women. An attempt was made to identify the general principles and concepts that have been found during this research in their historical perspective.

The study yielded insights on the validity of some major feminist theories in explaining the gender order and patriarchy in society. A qualitative character of the study of women's perceptions and experiences of health and health services utilisation draws upon both feminist and non-feminist traditions of interpretive sociology, ethnography and phenomenology.

Social scientific approach of using unstructured interviews helped to conduct the study in such a way that interpretations of the experiences and lives of individuals gained immediate attention. The study focused on individuals as the unit of analysis, so that their world could be seen through the prism of the women's perceptions and attitudes.

A fairly wide range of topics in the research contributed to the explanatory theories of the relationships between gender and various political and economic processes, and socio-cultural and psychological structure. These research topics then progressively narrowed into a more abstract theoretical discourse on the origins of patriarchy: a discourse that supported the idea that the status of women can only be understood in the context of an encompassing system of patriarchy (Walby, 1990; Fee, 1983).

The empirical evidence of the perceptions and behaviour of women calls for the utilisation of neo-Marxist feminists, culture theories and macrostructure social theories, which recognise the 'importance of religious and secular gender ideologies in buttressing a system of gender stratification' (Chafter, 1997). The interaction of gender, nature and women's individual choices and effects of social phenomenon on women's decisions, actions and attitudes can be also looked at from the perspective of the Rational Choice Theory (RCT) (Boundon, 2003; Hechter, 1997). The RCT is a sociological trend that strongly advocates the notion that social outcomes result from the relations of individuals with one another and with aspects of their non-social environment (Hechter, 2000). The study has benefited from and at the same time contributed to the RCT, since the work contributes to insights on general theoretical issues concerning the nature of individual values and socio-structural context. Women in the study were not only eager to share experiences from their lives, but also made an attempt to explain their behaviour, their choices and motives behind their actions. In particular, this was clearly seen during the second round of interviews. The women came prepared with considered answers in an attempt to not only explain their behaviour but also reveal the motives behind this behaviour in order to discuss and unravel the environment and its phenomena.

The ethnographical approach was especially conducive to investigating social structures and understanding the specific local and cultural ways of living. These in turn offered an avenue to enhance the possibilities of demonstrating the variety of social orders for global ethnography (see Gille and Orian, 2002).

7.5 Implications for Research

The study accentuated characteristics of the status of Uzbek women in society, which are markedly different from other cultures. The lack of feminist discourse in the

country and ethnic, environmental and religious settings that are structurally different from the rest of the world all contribute to the peculiarities of gender relations in Uzbekistan. However, there are many similarities regarding the nature of patriarchal revelations in Uzbek society and these have also been identified. With the exception of some specific regional problems, the status of Uzbek women generally does not deviate significantly from other societies. The findings on the specific nature of Uzbek patriarchy identified during this study could be used as an effective means in theoretical substantiation of patriarchy because it could provide Western feminist assumptions with new and unpredictable propositions. In this way, the research offers empirical information from which it may be possible to develop new insights into the complex subject of health, gender and society.

The current work provides a thorough description and explanation of Uzbek women's health and well-being through understanding the experiences of the women's daily lives. The work broadly defines the status of Uzbek women through an analysis of how women use health care services, their knowledge of health issues, their health seeking behaviour, their physical health and the impact of the environment in which they live. This includes socio-political, cultural and ideological transformations of the past decade, and their relationship with the health of women. The work put forward a firm base for the continuation of research into the health of women in Uzbekistan. In particular, issues such as women's awareness of their health needs, the lay attitude to the problems of health and the ability to resolve them with the minimum means of provision.

The work identified the necessity for a specific focus on the health issues of middle-aged women. However, such topics as violence in the family, women's mental and psychological problems and consequences of traumatic experiences on health, increasingly demand further attention from the researchers.

The introduction of reforms in the health sector does not yield quick benefits for the majority of the population. In such a situation, retaining and developing traditional healing beliefs and practices acquires a greater significance. The study pointed out the reasons for the retention or disregard of unconventional treatment by the respondents. However, more extensive research in this field could help to uncover not only economical causes for such practices but psychologically hidden motives and justifications for their use.

The study now enables a broad investigation into medical and public health problems and recognizes the entity of the problems of women, because it has brought to light the framework of general discussion of what the women consider to be the consequences of transition and its impact on their well-being. The confusion and disorientation of Uzbek women, following the collapse of the Soviet union, could eventually be resolved if scientific research continues and its results are then used to develop strategies for helping Uzbek women. The current research was undertaken at a moment in Uzbekistan's history when awareness and recognition of women's health problems could make a major contribution to the goals and missions of health care reform policy makers.

The practical implication of this study could be derived from the fact that the changes in the health care services witnessed by participants were one evident part of the social changes that women have experienced. In this respect the attitudes of women to health and health care systems may reflect a transformation in the changing nature of society. This could therefore provide the government bodies responsible for improving the position of women with substantial information in helping them envisage new policies and solutions.

Appendix 1: Interview Questions

These are the questions which were generally used as a guide in the interviews. The questions are grouped roughly because the order of the questions depended on the responses of the respondents.

Background:

What is your age?

What is your marital status? What is your education? What is your occupation?

Are you a religious person? To what faith do you adhere?

How many children do you have?

Who lives in your household or family now?

Health:

How would you describe your health at the moment?

Have you ever been seriously ill?

Have any of your family members been seriously ill?

Have you ever been to hospital?

Do you or your family members have chronic diseases?

Is there any disease prevalence in your family?

What are the symptoms? How do you treat the disease?

What medication do you have at home?

What health services do you prefer? Conventional, traditional, folk healers, or self-treatment? What kind of disease do you treat yourself? Why do you prefer self treatment to professional one?

Have you ever applied to private clinics?

What is your attitude towards doctors, traditional healers? What do you do if you are not satisfied with the doctors' decision?

What factors influence your decision to opt for one or another treatment?

How and where do you gather information about treatment, health, illness?

What are your health responsibilities in the family?

What do you do to maintain good health?

Is health important to you?

Do you take any preventive measures? Do you adhere to healthy life style? Do you smoke? Do you drink? Do you exercise? Whose food preference does your family follow? Who and what factors determine the family diet?

What is your initial action when you realise that you or someone in your family got ill?

What factors do you think play role in disease causation?

Many people believe that supernatural forces could influence people's lives, do you believe it? Have you ever tried religious healing? Did it help?

If you would compare the old Soviet health system with the contemporary one, how would you comment on the changes, if any?

In your opinion, have the conditions in the hospitals, policlinics, doctors attitudes, supply in drug stores, quality of treatment, been changed in the last decade?

Family responsibilities:

What are your health responsibilities in the family?

Do you have or had in the past any experience of looking after disabled and sick persons? How are the responsibilities shared in your family if someone becomes seriously sick?

Why did you choose to work/stay at home?

How do you manage to combine work and family responsibilities? Does your husband or your children help you around the house?

What do you think is the main cause of stress for you?

Do you have someone to rely on, or turn to in case of emergency?

What kind of social and emotional resources do you have to rely on? Could you count on support from your family? Friends?

What are your main concerns today? What worries you most?

How do you cope with the difficulties? What are your main strategies?

Religion:

Are you a religious person?

What is your attitude to religion, Islam, fundamentalism?

What do you think about the idea of revival of Islamic traditions in the country?

Do you or the members of your family observe religious rituals?

What is your attitude towards arranged marriages, circumcision, polygamy?

General:

What is your attitude to the current situation in the country? In the society?

What do you think could make women's lives easier? What kind of future do you think we have?

Appendix 2: Biographical Profiles

All names have been changed to protect people's identity.

Mariam: Age - 52, married, has higher education (Candidate in Science) – Tashkent State Institute of Foreign Languages. A University lecturer, also gives private lessons. Has two daughters – 29 (married with two children) and 26 years old, and son – 28 years old (married). Her husband, youngest daughter, son and her daughter in law, live together.

Nigora: 40 years old, married, has higher education (Candidate in Science) – Tashkent State University, the Faculty of Applied Mathematics. A University lecturer. Has two daughters –15 and 5 years old.

Ruhsora: 50 years old, married. Has secondary medical education. Housewife for the past ten years, previously worked as an assistant in a scientific laboratory at the Institute of Cardiology. Has three children, daughters 25 and 15, and son 21. All children live with her and her husband.

Munisa: Age-38, married, education higher, graduated from the State Institute of Physical Training. Worked as the physical education teacher in the Institute of Architecture. Currently a housewife. Has three kids, daughters – 14, and sons 13 and 7 years old.

Asal: Age –39, married, higher education. Works as a paediatrician in the Maternity Clinic No. 2. Has three children, daughter 16, and sons 14 and 5.

Saida: Age 51, husband went missing, education - medical secondary. She is not working because of serious health problems (invalid). Has a son of 32 years old, married, daughter - 28. One son died in a mysterious way. Lives with her two children, daughter-in-law and a grandson.

Mukaddas: Age-39. Married. Education higher, graduated from the Tashkent State Conservatoire. Currently works as an assistant in the NGO. Has two children son-15 and daughter 10 years old.

Yoqut: Age –39, married, education - higher, Tashkent State University, Faculty of Mathematics. Works as a Math teacher at secondary school. Has three children girls-11 and 13, a boy 8 years old. Lost a son of 11 month old. Lives with in-laws.

Gauhar: Age – 42, married, education higher, mathematician, temporary a housewife. Children – a son 15 years old. One son died 7 years old due to a heart disease.

Oidyn: Age 44, married, education - higher, Tashkent State University (Candidate of Science). Works as an analytical assistant in the Ministry of Education. Children – none.

Kamola: 39 years old. Separated from her husband. Education - higher juridical. Works as a head of human resources department. Has three children daughter 22, married, lives in the U.S. Daughter 20 years old married. Son - 13 years old. Lives together with her son.

Adalat: 38 years old, married, education - higher, graduated from the Tashkent Medical Institute. Became a housewife after she got married. Has three children, a boy of 8 years old and a girl of 5 years old.

Iroda: 42 years old, married, education - secondary technical. A housewife. Has a son of 15 years old.

Shirin: 50 years old, married, education special secondary. A housewife. Has a son of 23 years old and a grandson of 5 years old. A daughter of 25 (mother of the grand son) died after and operation on spine in 2000. Lives with a husband and a grandson.

Rano: 39 years old, married, education – higher, Tashkent State University, the Faculty of Foreign Languages. Works in the Institute of Arts and Theatre as a Rector's deputy. Has a son of 6 years old.

Shohista: Age –38, divorced, education - secondary special, choreographic school. Works as a ballet dancer in the Tashkent Theatre. Has a son of 15 years old.

Yuliya: 54 years old, married, education - higher, State Institute of Literature. A housewife. Has three daughters of 25, 23 and 17 years old, and a granddaughter of 5 years old from the oldest daughter. All live together.

Oliya: Age 51, divorced, education higher, Kiev State University, Faculty of Chemistry. Lives alone, children – none.

Sultanat: Age 54, married, education - higher, Tashkent state university, Faculty of Oriental Languages. Retired, used to work in the Ministry of Foreign Affaires. Has two children. A daughter of 25 years old, married with kids, and son of 19 years old. Lives with a husband and a son.

Leila: 46 years old, divorced, education secondary, retired due to disability, third grade invalid. Used to work as a clerical worker in different ministries. Children - none. Lives with father of 89 years old.

Appendix 3: *Mahalla*

Mahalla is a neighbourhood community in the urban residential area which have existed for centuries in Uzbek culture. *Mahalla* have promoted a traditional way of living among indigenous population. The main function of *mahalla* was and still remains to maintain traditional norms of community life and collective mutual assistance. During Soviet era *mahalla* preserved its traditional function but without official recognition, and 'as long as it maintained the ideological appearance of Soviet institution' (Koroteeva and Makarova; 1998:138)

Since independence of Uzbekistan, the role of the *mahallas* has increased considerably in regard to local self-management, and became one of the most significant regulators of people's lives at the local level (Yalcin, 2002:141). All social events and activities like wedding, funerals are held with the support and assistance from *mahalla*. In exchange for support which *mahalla* provides for its members it demands from them to take an active part in community activities, such as planting trees, cleaning streets, assisting poor families and even mediating day-to-day problems. Usually it was a group of elders (*aksakals* or *mahalla* committee) who play a role of mediators between the neighbours in solving any social problems. *Alsakals* monitor the behaviour of people living in *mahalla*, especially youngsters. They play a lead role in formulating public opinion on honour of the family, and control the behaviour of their members. Issues of honour are traditionally considered as paramount for the family. Thus, for example, divorce is not encouraged in the society, public opinion condemns divorce. In such cases *aksakals* will try to negotiate between families in order to prevent divorce. Before going to the Court the couple must put the issue in *mahalla* first. Today the head of *mahalla* is elected by the residents, but he must also be approved by local authorities, because he will receive a salary from the local budget. The status of the *mahallas* as legitimate bodies of local self-management has been affirmed by legislation (UNDP, 1996:44).

It is a tradition that a whole *mahalla* mobilises in assisting individual or their families in need. For example reconstruction of a house after the damage done by fire or

earthquake or other natural disaster. Usually *mahalla* members monitor each other's property in order to prevent any disorder and will collectively protect each individual, therefore the crime against people and property like theft, rape, occur seldom in *mahalla*. Due to the fact that *mahalla* committee posses a reliable information on its inhabitants, the government uses that ability when the state needs the assessment of financial standing of each household. Therefore *mahalla* is asked to identify the most vulnerable in their community and to decide on distribution of social benefits and aid to the local inhabitants, according to their needs. This system was ideally contemplated to discourage fraud, since every case supposed to be discussed at an open community meeting held by the *mahalla*. However, due to the occasional incidents of prejudice or bias from the *mahalla* committee, when deciding on applicants eligibility for assistance, 'many individuals in need of social protection do not always find easy to ask for it from the *mahalla*' (Yalsin, 2002:230). Thus, *mahalla* as a social institution plays an important role in lives of Uzbek people, and would be mentioned frequently during discussion.

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