RUDN Journal of Sociology. ISSN 2313-2272 (Print), ISSN 2408-8897 (Online) **2025 Vol. 25 No. 4 734–749**
Вестник РУДН. Серия: СОЦИОЛОГИЯ http://journals.rudn.ru/sociology

DOI: 10.22363/2313-2272-2025-25-4-734-749
EDN: KHVLXE

Social-economic determinants of women's reproductive health in Almaty (Kazakhstan)*

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Abstract. In the Almaty metropolitan area with the significant social-economic stratification, the relevance of the study is determined by the need to understand how household income affects women's reproductive strategies and identity. The article aims at identifying the relationship between subjective well-being, financial difficulties, family plans and reproductive health symptoms of 18–49-year-old women in Almaty. The authors conducted a cross-sectional quantitative survey on a multi-layered random sample with face-to-face interviews (N=320 women from eight districts of the city. Descriptive statistics, Spearman correlation analysis, regressions, factor and cluster analyses revealed a positive correlation between financial difficulties and postponing a childbirth in the next 3–5 years, a negative correlation between well-being and physical discomfort, and a positive correlation between family plans and seeking medical help. Women with children are significantly more likely to report reproductive symptoms, which indicates the need for a better postnatal care. Household income is a key determinant of both specific reproductive decisions (timing and planning of childbirth, seeking medical care) and reproductive identity formation. The study combined quantitative methods with an emphasis on subjective assessments of well-being and analysis of health symptoms, which allows for assessing the targeted support measures: development of free and mobile services for low-income women, postnatal monitoring programs and educational campaigns on reproductive health under the social inequality in Almaty.

Key words: reproductive determinants; reproductive behavior; social-economic inequality; household income; Almaty; economic sociology; women's reproductive health

For citation: Bakytzhanova A.A., Alimbekova G.T., T. Toikko. Social-economic determinants of women's reproductive health in Almaty (Kazakhstan). *RUDN Journal of Sociology.* 2025; 25 (4): 734–749. https://doi.org/10.22363/2313-2272-2025-25-4-734-749

The article was submitted on 27.05.2025. The article was accepted on 14.10.2025.

The article aims at explaining how urban social-economic conditions determine women's reproductive strategies. In megacities with pronounced stratification, such as Almaty, the contrast of well-being and vulnerability affects not only health but also life trajectories. Reproductive behavior is determined not only by biological and medical factors but also by social, economic and cultural conditions: inequality determines access to services, family plans and future horizons. Limited access to quality care, financial instability and social vulnerability affect timing of childbirth, use of contraception and access to medical care. The key determinant is the household economic situation: women with financial constraints are more likely to face pregnancy complications, unplanned pregnancies and barriers to contemporary methods of contraception; economic instability pushes for postponing childbirth. On the contrary, better-off groups have more opportunities for reproductive plans due to better access to medical services, educational programs and information. These contrasts explain the need to study the impact of economic inequality on reproductive decisions.

The selected data for Almaty is considered in the logic of how economic inequality in the large city affects access to services and strategies for seeking medical care, thereby, influencing reproductive decisions. In post-Soviet megacities, the higher the social status, the more often paid channels and personal connections are used, while low-status groups are limited in choice and postpone treatment, which increases health risks [21; 52]. However, reproductive intentions are not determined only by income: the "desired" and "expected" numbers of children differ due to the norms, education, marital and family trajectories, possibilities, and so on. Thus, educational status and values differently affect the desire to have more children. For the correct interpretation of Almaty data, we consider both — attitudes and expectations [6; 7].

To conceptualize well-being, we rely on the capabilities approach: what matters the most is not the formally "allowed" but real opportunities the woman has — to get advice, pay for examination, plan a childbirth without ruining one's career. Indicators of well-being beyond income (health, education, access to services, social support) have been adopted by the international studies of the quality of life as providing a more adequate operationalization in the urban context [27; 56].

We tested three nodal hypotheses on arrays in Almaty: (H1) lower household income leads to the later first child and less frequent use of contraception (given the same education and age); (H2) income connection with plans is mediated by access to medical services and information resources (including insurance); (H3) normative ideas of motherhood and marital statuses moderate the effect of income on expectations and behavior ("desired vs expected"). Thus, if it is not so much intentions that are decisive as bottlenecks in capabilities (time/cost of access, lack of information), then measures should address precisely the limited possibilities: mobile consultations and emergency check-up within walking distance, subsidies for contraception; for vulnerable groups — "navigation" services and educational

modules — in order to reduce the gap between desired and expected number of children. The post-Soviet urban studies show that such interventions reduce negative social-economic factors and increase the feasibility of reproductive plans [52; 62].

The key scientific approaches, which provide a deeper understanding of how economic status, social context and gender norms affect reproductive attitudes and decisions, consider institutional and biological conditions together with social experiences, including real-life scenarios: not all women with poor background seek to have children, and not all high-income women follow reproductive plans. Today, there is a growing number of people consciously rejecting motherhood and fatherhood, which means the need to study not only structure but also personal choice. Moreover, childbirth is often the result of unplanned circumstances rather than of a well-thought-out strategy, especially under social-economic instability. The chosen theoretical framework combines macro-level determinants with micro-social decisions in order to better understand how structural inequality transforms into individual experiences that shape reproductive identity. Thus, the demographic approach considers the influence of economic and institutional factors on fertility [18]. According to the economic theory of fertility, an increase in family income leads to a decrease in the number of children due to the high cost of their upbringing [10; 11]. The gender approach emphasizes the influence of patriarchal norms, and gender inequality influences women's reproductive decisions [41]. The life course approach considers the impact of social, economic and biological factors on reproductive health life [12; 35; 37] from childhood to adulthood (the impact of income, educational level, social environment and access to medical services).

Household income has a significant impact on women's reproductive strategies: women from low-income households are more likely to postpone childbirth due to economic instability [39]; in high-income countries, women are more likely to use contraception and plan a smaller family [26]; economic instability increases the likelihood of early pregnancies in poor households [34] due to the lack of a financial safety net and career opportunities, and limited access to medical services. Social-economic conditions in childhood, such as family income and social support, have a significant impact on women's reproductive characteristics, including the age of menarche and menopause [13; 40; 47; 49; 61; 63]. A high level of economic stress in childhood can lead to an early onset of menarche, which is associated with a higher probability of early pregnancy and social-economic vulnerability in adulthood [14; 20]. Such difficulties in childhood as poverty, family conflicts and parental divorce are also associated with an earlier start of reproductive life [15; 16; 51]. Women from low-income families are more likely to face a lack of quality medical care, which increases the risk of complications during pregnancy and childbirth, including unsafe abortions [2; 19; 25], and the likelihood of prematurity, perinatal mortality, and developmental delays [30; 42]. In addition, social-economic inequality affects access to methods of contraception:

low-income women are less likely to use contraceptive methods, which leads to an increase in unplanned pregnancies and abortions [1; 8; 9]. Limited access to reproductive health education programs also contributes to an increase in the number of unwanted pregnancies among women from vulnerable groups.

In societies with a high level of economic stratification, women's reproductive attitudes vary depending on class [17]: women from lower social groups more often consider motherhood a central element of identity [22], while in the middle class, there is a tendency towards conscious parenting and delayed childbirth [28]. In societies with pronounced social inequality, women from lower social strata may perceive early motherhood as a strategy of social adaptation that provides a certain status and support [47]; on the contrary, middle-class women tend to focus on professional career and financial independence before having children [31]. Reproductive identity is also associated with social norms and stigmatization: poor women are more likely to face public condemnation if abandon traditional reproductive approaches, which limits their choice in childbearing [36]. At the same time, limited resources and lack of economic support reduce their ability to control reproductive decisions.

We define reproductive identity not only as a set of values and expectations shaped by social-economic and cultural norms, but also as a vital and dynamic experience limited by material conditions. In Almaty, reproductive identity as a continuum reflecting how women perceive their maternal role, reproductive activity and bodily experiences in response to economic pressure. This conceptualization combines subjective assessments of financial well-being, family planning intentions and self-reported health symptoms as indicators of how reproductive identity is formed and how it is negotiated in conditions of inequality.

Life approach to the study of reproductive health emphasizes the importance of critical periods when economic factors can have the greatest impact on future reproductive strategies [36; 37]. Thus, economic conditions in early childhood can form the risk of undesirable reproductive outcomes through the mechanism of accumulating risks or risk chains [37]. Factors influencing the age of menarche and menopause are also a part of the life approach. Social-economic conditions in childhood, such as nutrition, medical care and education of parents, influence the age of the beginning of reproductive life [43; 63]: women with economic difficulties in childhood are more likely to face reproductive health problems in adulthood, including early menopause, pregnancy complications and chronic diseases [49; 50; 53].

Women's reproductive behavior is determined by a combination of social-cultural norms, economic factors, and family traditions. In Central Asia and Kazakhstan, women's reproductive decisions are significantly influenced by traditional family foundations, social expectations, religious norms, and economic development of households [3]. Reproductive values of women in Central Asia differ from Western models of fertility due to patriarchal norms, according

to which motherhood is a key element of female identity [32]. In traditional societies, childbearing remains the main indicator of women's success, which affects the number of children, the age of marriage, and the use of contraception [24].

In Central Asia, there are significant changes in women's reproductive behavior under urbanization [3; 4; 5; 55]: women with a higher level of education and financially independent are less likely to adhere to traditional norms of having many children and more often use family planning methods. However, despite the transformation of family models, traditional values of family stability and high importance of childbearing remain in Kazakhstan [38]: women in rural areas are more likely to follow traditions of early marriage and having many children, while in urban areas there is an increase in the age of marriage and a decrease in the birthrate [23; 24]. The family still plays a key role in women's reproductive decisions, especially in traditional households, since the older generation influences the number of children and the interval between births [65]. In the Kazakh culture, multigenerational families contribute to the preservation of collective reproductive decisions [33]. Moreover, in patriarchal societies, women experience social pressure, which limits their autonomy in choosing contraception and family planning [29]. However, urbanization and growing economic independence of women weaken the influence of family norms, contributing to the development of conscious parenting [48].

Islam has a significant impact on reproductive values of women in Kazakhstan and Central Asia, supporting the traditional role of women as mothers and guardians of the family [4]. At the same time, religious norms vary depending on the region: more conservative reproductive models are common for southern regions of Kazakhstan and Uzbekistan, while in cities, there is a decrease in religious influence on birthrate [54]. Historically, there have been traditions aimed at strengthening family values, for example, the Kazakh institution of *amanat* (a child was given to relatives) and polygamous marriages, which regulated the distribution of reproductive roles in the family [65]. Although these practices are rare today, their influence persists in the family hierarchy and reproductive expectations.

Despite many studies of women's reproductive behavior in Central Asia, unresolved issues remain. First, the influence of economic factors on reproductive strategies, especially of urban and rural women [23; 24]. Second, intergenerational differences in reproductive attitudes as young women are increasingly refusing the traditional norms of childbearing [38; 47]. In Almaty, women's reproductive values are shaped by urbanization, modernization of family relations, and economic mobility. However, elements of the traditional family structure remain, which creates a unique mix of conservative and contemporary reproductive strategies.

The research confirms that economic inequality is one of the key factors of women's reproductive strategies. Lack of financial resources, limited access to education and medical care, social norms increase women's vulnerability

to early and unplanned pregnancies, which ultimately affects their social-economic status and identity. In Almaty, these factors manifest themselves in inequal access to health services, educational resources and employment opportunities, which requires further study and policy development to reduce the existing gap.

Women's reproductive behavior is influenced by a variety of factors, among which the household economic status, income, access to health services and social-cultural norms play a key role [48]. In conditions of economic inequality, these factors determine the strategy of childbearing, availability of contraceptives and high-quality medical care. Kazakhstan as a country with active urbanization and significant social-economic imbalances present a unique case to study the interrelationship of demographic, economic and cultural factors that determine reproductive patterns. Almaty, the country's largest metropolis, combines high population density with pronounced social stratification: with 2,3 million inhabitants the city is the leading economic and demographic center of Kazakhstan and the main attractor of internal migration, which unites groups that differ in income, education and cultural traditions, forming a complex social environment for making reproductive decisions. Despite the fact that the sample of 320 respondents is not representative for the country (the error is more than 6%), the structural heterogeneity of the city allows to identify key patterns of urbanized contexts and stratification as affecting reproductive decisions and values.

Almaty shows significant differences in income: the average monthly nominal salary in the third quarter of 2024 amounted to 471,264 tenge, which is 15.2% higher than in 2023, but many face economic difficulties — the unemployment rate was 4.6%, and the number of registered unemployed reached 12,625. Despite the high average income, social contrasts remain significant: in the first quarter of 2024, the average per capita monetary income in Almaty amounted to 287,213 tenge, which is 47% higher than the national average, but there are still limitations in access of low-income groups to medical care, which may affect the frequency of medical examinations during pregnancy, the use of contraceptives, and family planning.

Almaty is the leading medical center in Kazakhstan, with a well-developed healthcare system of more than 250 public and private medical institutions, specialized reproductive centers and leading medical universities. However, urbanization does not always lead to improved reproductive health: low-income women face barriers in access to health services due to economic constraints, lack of time and awareness. According to the Multi-Indicator Cluster Survey (MICS, 2015) [2], the coverage of prenatal care by qualified medical personnel in Kazakhstan is 99.3%; however, in rural areas, 10.8% of pregnant women are under the supervision of nurses or midwives, which shows certain barriers for low-income families and migrants.

The concept of reproductive identity considers childbearing as a result of the interaction of structural conditions (economic inequality, access to resources, cultural norms) and individual attitudes. We rely on the theory of rational choice

in reproductive behavior and the "well-being as an opportunity" to evaluate not only formal rights but also the real opportunities of women in the field of reproductive health. We conducted a survey of women aged 18–49 from households with different income. The stratified sampling with elements of targeted selection allowed to take into account the diversity of social-economic conditions in the city (family plans, experience of seeking medical help, frequency of specialist consultations, availability of services and a subjective assessment of the financial situation). Data was collected with face-to-face interviews and online questionnaires, which allowed to reach respondents with different participation opportunities. First, descriptive statistics (frequencies, averages, medians, standard deviations) were used, next — correlation analysis (Spearman, Pearson) and regression modeling (linear and logistic) — to assess the impact of social-economic factors on the use of contraception, seeking medical help and choosing a family planning strategy. Variance analysis (ANOVA) showed differences between social-economic groups, factor analysis revealed latent determinants of reproductive decisions, and cluster analysis provided a typology of respondents based on behavioral patterns.

51% of the respondents were aged 18–25 years, 17% — 26–35 years, 25% — 36–45 years, which allows for the analysis of reproductive behavior in different age groups. Most respondents were Kazakh by nationality and Muslim; about half were single, about 22% — married, less than 2% — divorced or widowed, which allows for considering marital status as a factor of reproductive attitudes and practices. Only 8% had no financial difficulties and could purchase such expensive goods as a car or apartment. 54% considered their income sufficient for basic needs except for expensive purchases. 34% had difficulty purchasing durable goods, but their income was enough for buying food and clothing. Only 2% of women experienced serious financial difficulties, including lack of funds for food. Such data indicates a pronounced social-economic stratification among women in Almaty and the importance of the material factor for reproductive decisions.

Spearman's rank correlation coefficients were calculated: for meaningful interpretation, coefficients with a value of at least 0.3 were considered (a moderate relationship of practical importance) [52]. However, some weaker but statistically significant coefficients (0.13–0.19) were also identified as indicating trends that deserve attention when interpreting the social-economic determinants of reproductive behavior. For instance, a positive, albeit weak, correlation between the frequency of financial difficulties and plans for family expansion in 3–5 years ($r = 0.138$, $p = 0.014$) shows that women with financial difficulties are more likely to postpone childbirth. This trend is consistent with the hypothesis that economic instability is one of the key factors hindering the implementation of reproductive plans. Some respondents directly explained the refusal to have a second child by inability to pay for basic medical services or by the lack of a stable income from one's partner. Thus, the initial positions of women in relation to reproductive rights vary significantly: economic instability determines the strategy of "careful

parenting", in which priority is given to ensuring a minimum level of social and medical well-being of existing children. This weak but stable correlation reflects the logic of adaptation, despite the formally low values of coefficients.

The revealed positive correlation between financial difficulties and the postponement of family expansion indicates such structural feature of low-income households as the fate of women, whose reproductive decisions are limited not so much by choice as by external circumstances. Financial instability is not just a risk factor but a systemic obstacle to the realization of reproductive rights. Low-income women are more likely to find themselves in a position, in which having a child is associated with further impoverishment, and access to medical services and contraceptives is perceived as a privilege rather than a basic right. Thus, there is a paradoxical situation: despite the biological ability to motherhood, economic barriers make it socially unacceptable or impossible at a certain point in life, which indicates the need to rethink the role of the state and society in supporting vulnerable groups and to create a sustainable social protection infrastructure that can offset the impact of economic inequality on reproductive health.

The second significant relationship was found between financial difficulties and the subjective assessment of family material well-being ($r = –0.189$, $p = 0.001$). A moderate negative correlation indicates that the lower the subjective well-being, the more often women report financial difficulties. This connection is logical and confirms that the subjective perception of financial situation reflects the real impact of material constraints on everyday life and affects women's confidence in their ability to start a family and to provide for the basic needs of future children. There was also a moderate positive correlation between family expansion plan and the frequency of seeking medical help for reproductive health-related symptoms ($r = 0.176$, $p = 0.002$), i.e., women planning family expansion more actively seek medical help, probably to prepare for pregnancy which may indicate high responsibility and awareness among women who consider medical support a necessary condition for safe motherhood. A moderate negative correlation was found between family expansion plan and assessments of family material well-being ($r = –0.164$, $p = 0.003$), which suggests that women, who assess their financial situation as less stable, are more likely to abandon plans to expand their family in the nearest future. There was no significant correlation between financial aspects and the frequency of medical care requests ($r = –0.051$, $p = 0.360$), which may be due to the accessibility of medical services in Almaty (many are free of charge or at minimal cost), which negates the impact of income on the ability to get medical help.

Considering how the subjective perception of women's financial situation and difficulties affect reproductive behavior and decision-making related to childbirth, we found a moderate negative correlation between financial difficulties and subjective well-being ($r = –0.189$, $p = 0.001$): women who feel financial pressure are more likely to report a low level of financial security, i.e., subjective assessment of social-economic status adequately reflects the impact of material constraints

on daily life, sense of confidence and control over the future. There is a moderate positive correlation between family expansion plans and the frequency of medical care requests ($r = 0.176$, $p = 0.002$), which may indicate active reproductive strategies of some women: the desire for motherhood is accompanied by a conscious approach to reproductive health, which manifests high responsibility and awareness, especially given the general unavailability of specialized medical services for vulnerable groups. A significant negative relationship was found between family planning and subjective assessment of financial situation ($r = –0.164$, $p = 0.003$): women with unstable well-being are less likely to plan childbirth in the nearest future. This trend is consistent with the well-known model of "socially conditioned postponed parenthood" — until an acceptable level of economic sustainability is achieved.

However, there are observations with no significant statistical relationships: between financial difficulties and the decision to procreate ($r = 0.093$, $p = 0.097$), between financial aspects and the frequency of medical treatment ($r = 0.051$, $p = 0.360$). Such observations highlight the complexity of social reality: decisions about having a child are determined not only by economic factors, but also by cultural norms, family traditions, interpersonal relationships, religious beliefs and institutional contexts, including the public health care system. For instance, in Almaty, where reproductive services are provided partially free of charge, women get access to basic medical care even with limited incomes. Moreover, traditionalist communities consider motherhood as a social obligation, which reduces the influence of financial arguments on reproductive decisions.

Such an "indirect" structure of behavior determination, when decisions about parenthood are affected by multiple factors, confirms the need for an integrated approach, taking into account economic, cultural, emotional, psychological and institutional aspects that affect women's reproductive attitudes and behavior in conditions of social-economic inequality. Therefore, the term "reproductive discomfort" refers to a set of subjectively significant symptoms that women report: pelvic and abdominal pain, menstrual irregularities, urination discomfort, and pain during sexual activity. Although these symptoms may not always reflect clinically diagnosed conditions, they are important indicators of women's reproductive well-being, especially when access to professional medical care is limited or stigmatized. Such variables allow to analyze how bodily experience interacts with economic conditions and reproductive plans. The data in Table 1 confirms the hypothesis about the impact of financial constraints on the timely detection and treatment of urogenital diseases, while no significant correlation between subjective well-being and pain during sexual activity may indicate that the latter is determined by other factors than economic status — individual health characteristics, psycho-emotional state or the quality of intimate relationships. However, low-income women may have visited doctors less frequently and, consequently, had less awareness of possible health problems. Moreover, most of the reproductive health symptoms have significant positive correlations with each other.

Correlations between material well-being and reproductive health symptoms (only statistically significant relationships — $p < 0.05$)

Variable 1	Variable 2	r	Interpretation
Abdominal/pelvic pain or discomfort	Changes in pain during menstruation	0.506	Moderate positive correlation
Abdominal/pelvic pain or discomfort	Discomfort during urination/defecation	0.439	Moderate positive correlation
Abdominal/pelvic pain or discomfort	Discomfort in the ovaries/uterus	0.351	Moderate positive correlation
Abdominal/pelvic pain or discomfort	Menstrual cycle disorders	0.504	Moderate positive correlation
Changes in pain during menstruation	Discomfort in the ovaries/uterus	0.415	Moderate positive correlation
Changes in pain during menstruation	Menstrual cycle disorders	0.3	Moderate positive correlation
Pain during sexual activity	Discomfort in the ovaries/uterus	0.591	Strong positive correlation
Pain during sexual activity	Menstrual cycle disorders	0.4	Moderate positive correlation
Discomfort in the ovaries/uterus	Menstrual cycle disorders	0.517	Strong positive correlation

Correlation analysis revealed statistically significant correlations between age, having children, and symptoms related to women's reproductive health. Thus, the age of respondents showed a significant negative correlation with having children ($r = –0.419$, $p = 0.000$), which is explained by the age distribution of the sample (younger respondents have fewer children), and a negative correlation with pain during sexual activity ($r = –0.184$, $p = 0.001$), which may indicate that as women age, they are less likely to experience pain during sexual activity, possibly due to physiological changes or a decrease in the frequency of sexual intercourse. However, the relationship between age and other symptoms was statistically insignificant ($p > 0.05$), perhaps, since reproductive symptoms do not depend on age, especially if women regularly visit medical institutions.

Having children showed a positive correlation with most symptoms (frequency of abdominal and pelvic pain, changes in pain during menstruation or sexual activity, discomfort during urination, bowel movement or in the ovaries or uterus, menstrual cycle abnormalities), i.e., women with children are more likely to experience symptoms of reproductive discomfort, probably due to physiological changes after childbirth, which means the need for enhanced medical monitoring of women after childbirth. Additionally, strong intra-symptomatic correlations were identified, confirming their physiological relationship.

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The results of the study allowed to identify several areas for further scientific research. First, we need to conduct a deeper qualitative analysis of the impact of social-cultural factors on women's reproductive behavior, including their perception of medical services, the role of the family and intergenerational differences. Second, the study sample needs to be expanded to include women with other social-economic backgrounds, from rural and urban areas, in order to identify possible differences in reproductive strategies. Third, we need longitudinal research — long-term monitoring of women from different social groups will allow for a more accurate assessment of the impact of economic factors on reproductive behavior and health, changes in family planning strategies, and long-term effects of economic inequality on reproductive health.

The research findings also raise the question of the role of subjective perception of well-being and health. Women in the same objective conditions may interpret their situation differently depending on cultural norms, educational level, religious beliefs, and intergenerational experience. Therefore, reproductive behavior cannot be understood solely as a result of economic indicators — it should be considered as part of a broader social practice that includes semantic, symbolic, and bodily aspects. These results suggest the following directions for further research: first, it is necessary to strengthen the qualitative component of analysis — conduct interviews and focus groups to identify the logic by which women interpret their reproductive health; combine approaches from sociology, medicine, anthropology, and psychology to gain more complete knowledge about women's reproductive strategies in conditions of economic inequality, thus, developing more effective government support programs, increasing the availability of medical services, and implementing educational programs for improving women's reproductive health and reducing social inequality.

The results obtained are not only consistent with the available empirical data but also contribute to the development of theoretical approaches to the study of reproductive behavior, including the concept of reproductive identity and the theory of the life path, which allows for a deeper understanding of how social-economic inequality, cultural norms, and individual life experiences shape reproductive strategies in large cities with pronounced social stratification. First, it is necessary to strengthen measures ensuring access to health services for low-income women (specialized programs for free or discounted medical examinations, mobile medical teams that can provide services in remote or socially disadvantaged areas). Second, it is necessary to develop postnatal support programs for women with children based on regular monitoring of reproductive health, preventive examinations, psychological support and guaranteed access to educational programs about health, which would reduce the risk of complications and improve the quality of life of women in the postnatal period. Third, special campaigns should raise women's awareness of reproductive

health symptoms and the need for regular medical checkups, especially for women of younger age (digital platforms, social networks, and communities can be an effective tool in informing and reducing barriers to receiving qualified medical care). Fourth, it is necessary to introduce a sustainable system of long-term social support for women with children, which would go beyond one-time benefits in relation to self-care, psychological well-being and social adaptation (network of social workers and advisory services that would accompany women after childbirth, advise in critical circumstances, provide legal, psychological and social support to strengthen parental competencies, self-esteem and access to social infrastructure). Fifth, it is necessary to create an accessible network of developmental, medical and temporary social services for women with children (state counseling centers on early childhood development, organization of leisure and educational programs for both children and mothers, temporary centers or short-term stay facilities for children). Such a flexible support system based on the principles of humanity, safety and adaptability to women's needs would significantly improve the quality of life, reduce the risks of emotional burnout and strengthen the social integration of mothers in vulnerable situations.

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DOI: 10.22363/2313-2272-2025-25-4-734-749
EDN: KHVLXE

Социально-экономические детерминанты репродуктивного здоровья женщин в Алматы (Казахстан)*

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Аннотация. В Алматы, где ярко выражено социально-экономическое неравенство, актуальность исследования обусловлена необходимостью понять, как доход домохозяйства влияет на репродуктивные стратегии женщин и их репродуктивную идентичность. Цель ис-

Статья поступила в редакцию 27.05.2025. Статья принята к публикации 14.10.2025.

следования — выявить взаимосвязь между субъективной оценкой благополучия, частотой возникновения финансовых трудностей, планами по расширению семьи и проявлением симптомов репродуктивного здоровья у женщин 18–49 лет, проживающих в Алматы. Был применен перекрестный количественный анализ на данных, полученных с помощью метода личного опроса на многослойной случайной выборке (N=320 женщин из восьми районов Алматы). Описательная статистика, корреляционный анализ Спирмена, регрессии, факторный и кластерный анализы выявили положительную корреляцию между финансовыми трудностями и откладыванием планов деторождения на ближайшие 3–5 лет, отрицательную корреляцию между благополучием и физиологическим дискомфортом, положительную корреляциюмежду планами по расширению семьи и обращением за медицинской помощью. Женщины с детьми значительно чаще жалуются на репродуктивные симптомы, что указывает на необходимость улучшения послеродового ухода. Доход домохозяйств — ключевой фактор как конкретных репродуктивных решений (выбор времени и планирование деторождения, обращение за медицинской помощью), так и формирования репродуктивной идентичности. Особенность представленного в статье исследования — сочетание количественных методов с акцентом на субъективных оценках благополучия и анализом симптомов здоровья, что позволяет обоснованно предложить следующие меры целевой поддержки женщин: развитие бесплатных и мобильных услуг для женщин с низким уровнем дохода, программы постнатального мониторинга и информационно-просветительские кампании по вопросам репродуктивного здоровья в условиях социального неравенства в Алматы.

Ключевые слова: репродуктивные детерминанты; репродуктивное поведение; социально-экономическое неравенство; доходы домохозяйств; Алматы; экономическая социология; репродуктивное здоровье женщин

Для цитирования: *Бакытжанова А.А., Алимбекова Г.Т., Тойкко Т.* Социально-экономические детерминанты репродуктивного здоровья женщин в Алматы // Вестник Российского университета дружбы народов. Серия: Социология. 2025. Т. 25. № 4. С. 734–749. https://doi.org/10.22363/2313-2272-2025-25-4-734-749