Population Prescriptions: (Sanitary) Culture and Biomedical Authority in Contemporary Russia

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"The Demographic Problem" – A Short Introduction

Russia's population has been rapidly decreasing for several decades. Political fears over falling birthrates and growing mortality rates have recently reemerged as a staple in every conversation concerning the future of the Russian nation. In May 2006, in his annual address to the Federal Assembly, President Vladimir Putin identified Russia's decreasing population as the most acute issue facing the country. Later that year, the government launched a new, high-priority policy to address the "demographic problem," which was built around monetary incentives for women to have multiple children. As the state made an effort to revise and implement its new policy measures, different groups of experts took part in the debate about the demographic future of the nation. Alongside demographers and social scientists, medical and public health experts became visible as playing a crucial role in this debate.

To address the role of this community of experts in Russia's most heated debate, this paper examines how a group of obstetricians and gynecologists in the large provincial city of Yekaterinburg, Russia appropriate existing discourses of the "crisis of underpopulation" and demographic policies, and assign new cultural and social meanings to them in their clinical and research practices. An ethnographic study I conducted among these medical professionals demonstrates how they negotiate their power not only through individual patient care (Rivkin-Fish 2005), but also outside their clinics as they participate in the demographic debate and in the development of regional family planning programs.[1]

This paper reveals how a group of health providers in one of the largest maternity hospitals in the city, borrowing from their Soviet past as the de facto experts on population health and growth, pragmatically use population policies as an opportunity to establish their institutional identity and reaffirm their authority vis-à-vis the state. It demonstrates challenges to this objective, which include dramatic transformation in state support to medical institutions and the increasing competition for state support with experts in other fields of knowledge such as demography, social education, and private and/or non-government organizations. In response to these challenges, physicians appropriate terms like "culture," "emotions," and "values" from the social scientists and educators, and infuse these concepts into their analyses and recommendations. They strategically deploy particular understandings of "culture" as a way to reproduce biomedical authority over the matters of reproduction and population dynamics. By infusing a biomedical way of thinking with concepts borrowed from social sciences, they strive to redefine themselves as a vanguard in the state's efforts to promote demographic recovery. The paper demonstrates that in an era that seems like a complete rupture with the past, these medical

professionals' reassertion of biomedical authority over population predicaments involves significant continuity of Soviet institutional and social practices.

"The Demographic Problem" – A Short History of Social Policies in Postsocialist Era

Fears of under-population in contemporary Russia are hardly new or exceptional. Political leaders have voiced these concerns both in the socialist period and in the years following the dissolution of the Soviet Union. These fears are manifested most clearly in the nation's pronatalist laws, which, scholars have argued, have been and continue to be one of the defining features of these political regimes (Feshbach 1986; Nakachi 2006; Blum 2001; Rivkin-Fish 2003, 2010; Zakharov 2008). Taking a cue from its Soviet predecessor, in the years after the fall of the Soviet Union the Russian government has authorized several proposals that outline policies and programs aimed at intervening in population trends and especially at increasing Russia's birthrate.

Although throughout the postsocialist years, policymakers have framed the "demographic problem" as a security threat facing the Russian Federation, the Russian state re-interpreted the concept of population intervention in the most recent proposals of 2001 and 2006. In 1996 president Yeltsin attempted to update an older version of the state family policy by signing a document titled "Main Trajectories for the State Family Policies" (*osnovnye napravlenia gosudarstvennoi semeinoi politiki*), but this document was still formulated in the Soviet language of child allowances, maternity leaves, and other welfare measures[2] (Elizarov 2001). The program he proposed incorporated demographic concerns, such as decreasing fertility rates and rapidly increasing mortality rates, into the legacy of the Soviet family and welfare policies. Following Vladimir Putin's ascent to power in 2000, however, the scope of the population problem and the ways to overcome it have been reconsidered to meet the requirements of current political and economic concerns.

Following this shift, political leaders in Putin's cabinet issued statements that presented their concerns over demographic trends in ways distinctly different from their predecessors. Specifically, in both the 2001 report, "The Concept of Demographic Development for the Russian Federation through 2015" and the renowned, "Concept of Demographic Policy for the Russian Federation through 2025" issued in 2007, under-population was framed as a discrete problem requiring a departure from the legacy of the welfare state. Following Putin's address to the Federal Assembly in 2006 on the threat that population decline poses to the nation's development, the government launched a new population policy with a strong focus on fertility. The core of this policy is a one-time monetary payment to women who have a second child – maternal capital (*materinskii kapital*). Although it includes other forms of benefits, this monetary-oriented policy diverges from the solutions promoted by Yeltsin and his predecessors, who used population concerns to justify the expansion of state-sponsored welfare programs.[3]

The departure from the Soviet legacy of family and welfare policies coincided with a liberal shift in other social policies. This shift became one of the major objects of study for social

scientists in general, and anthropologists in particular. Scholars have examined the social consequences of new liberal economic policies and their effects on the lives of ordinary people in postsocialist states (Cook 2007; Dunn 2004; Phillips 2008; Haney 2002; Rivkin-Fish 2005). Anthropologists of postsocialism have demonstrated how the new regime of the "monitezation" of the wide net of welfare benefits coincides with "the overall trend of the personalization of social problems" in which long-term investments in social infrastructure (e.g., child-care system) are substituted with temporary and individual payouts (e.g., maternal capital) (Phillips 2008:16). This trend reveals a newly formed disruption between two realms of social activity, which, in socialist societies, were experienced as interconnected and mutually constitutive: a monetary domain and a domain of moral and social values (Oushakine 2009: 22-27; Haney 2002). This disruption, in turn, marginalized familiar social contexts, in which monetary exchanges were always visible and yet intertwined with moral and social values (Phillips 2008; Pine 2002; Humphrey 2002: 83; Lemon 1998; Verdery 1996: 168-203; Dunn 2004).[4]

Pronatalism and Postsocialism –Theoretical Background

In response to these larger political economic shifts and their manifestations in the everyday lives of people, anthropologists have begun to explore how the circulation of liberal discourses and economic reforms in postsocialist societies coincide with or relate to the (re)emergence of pronatalist discourses. Scholars have identified pronatalism as a powerful ideology influencing individuals' discursive constructions of citizenship and selfhood both in socialist and postsocialist periods (Nakachi 2008; Goldman 1993; Kligman 1998; Rivkin-Fish 2003). In the socialist period, they have shown, population planning had been an integral part of the centralized economic planning (Greenhalgh 2008; Nakachi 2008; Goldman 1993). Following Foucault's call to interrogate the science of population as an important form of a modern, and not uniquely socialist, governance (1991), anthropologists have demonstrated how these pronatalist discourses illuminate the role of the state and its capacity to shape (and constrain) life course trajectories (Greenhalgh 2003, 2008; Gal and Kligman 2000; Zhurzhenko 2004; Rivkin-Fish 2003, 2010; Kligman 1998).

By focusing on demography and its intersection with social policy, scholars of socialism and postsocialism have gained new insights into the state and its governing practices and methods (Blum 2001, 2004; Blum and Mespoulet 2006; Hirsh 2005; Kertzer and Arel 2002). They have demonstrated how public discussions about human reproduction, sexuality, and childcare have become sites where the negotiations between the state and its subjects are constituted and reconstituted (Gal and Kligman 2000; Verdery 1994, 1996: 39-57; Rivkin-Fish 2004, 2005, 2010). Invaluable in its contribution to the study of postsocialism, and especially to the ethnographic inquiry of the state (Verdery 1994, 1996), this research tends to focus predominantly on ideological aspects of pronatalism (i.e., public discussions and debates).

Rather than assuming the dominance of ideology over practices in the constitution of policies and political processes, this paper employs a social actor-oriented perspective to

understand the logics behind the production and enactment of demographic policies. This paper elaborates upon the "knowledge-centered approach" (Greenhalgh 2008: 9; Jasanoff 1990) of studying policy by investigating how the policy-relevant knowledge and narratives about "the demographic problem" are produced and advanced by a particular group of knowledge experts, namely biomedical professionals.

Paper Outline

Each of the following sections sheds light on the role of medicine and expert knowledge in the narratives concerning the problem of under-population and the ways to overcome the crisis. First, I introduce a group of medical professionals/public health specialists and their contribution to the demographic debate prominent in contemporary Russia. By focusing on their practices, such as programs surrounding childbirth and pregnancy education, I examine the concepts of knowledge expertise used by this particular group. Second, I provide necessary background to the historical development of the medical profession in the Soviet Union. This historical context illuminates the continuity of the institutional and social practices these physicians employ as they establish themselves as a community of experts and as a legitimate and powerful force of social change in postsocialist Russia. By revealing the ways in which these medical professionals use their relations with both Soviet and Post-Soviet states, this paper also complicates ethnographic accounts that have focused on the practices of post-Soviet physicians that were driven largely by their attempt to distinguish themselves from the fallout of the state (Rivkin-Fish 2005).

The last two sections demonstrate the complexity of the demographic debate revealing how medical professionals, in their attempt to institute themselves as a powerful source of knowledge regarding population intervention, must face other forces of social change in contemporary Russia. By introducing these forces, first, in the form of organized alternatives to biomedical knowledge and second, in the form of new state policies, I demonstrate how medical professionals transform their narratives and institutionalized practices in order to compete for resources and sustain their authority as a community of experts in the context of population crisis.

Sanitary Culture – How to Give Birth with a Smile

As an anthropologist conducting fieldwork in Yekaterinburg and interested in population policies in Russia, I was a frequent participant in a series of scientific-practical (*nauchno-prakticheskie*) conferences and meetings dedicated to the problem of population decline in the Ural region and Russia more generally. Over time, I became acquainted with the majority of these participants and learned their roles, strategies, and interests in the process of negotiating local demographic programs and initiatives. One of these meetings was a day-long conference entitled "Reproductive Behavior in the Age of Population Crisis,"[5] which brought together social

workers, city council members, civil servants from the regional government (*oblast'*), social scientists, religious anti-abortion activists, prenatal psychologists, and health providers from a number of the city's hospitals. This program was organized by the department of Social Work at one of the universities in Yekaterinburg.

At this conference, I met Galina B.,[6] a physician who represented one of the oldest and largest maternity hospitals in the Ural region. The hospital occupies an architecturally avant-garde constructivist building erected in the late 1920s. Both through its architecture and its historical reputation, it presents an image of a progressive and technologically advanced institution. The hospital was among the first in the region to invite fathers to be present at their wives' deliveries (*partnerskie rody*) – a practice that did not officially exist in the Soviet Union and is still not very popular in the majority of maternity wards.[7] Galina had come to the conference to present an educational program that she and her obstetrician colleagues at the hospital had developed to prepare women and their partners for childbirth. In her presentation, Galina stated:

> The goal of our course "Giving Birth with a Smile" (*Rozhai s Ulybkoi*) is to make families stronger. We have experts that can help partners overcome difficulties. We talk about family values, about family aspects of pregnancy, about family relations and about how children interact with other members of the family. Besides, we are all *mnogodetnye mamy* (we have large families) ourselves. I have three children; my colleague Elena K. has three. We, all of us, are family oriented (*semeino orientirovannye*)…

One recurrent theme at this conference, and many programs similar to it, was the problem of families and their role in population decline.[8] Speakers credited the "moral decay" of the society and the disappearance of family values as the reason for this social crisis. Their presentations resonated with a scope of public debates about "the crisis," in which family and family values became the main point of reference and the main object of necessary intervention (cf. Zhuzhenko 2004). Thus, for instance, addressing the declining population trends in Russia, the former deputy director for the State Statistics Service, said to a journalist: "Population will continue to decline if there are not going to be revolutionary changes in people's minds."[9] He then explained that the main change "in people's minds" should be in the way Russian families work and live.[10] Galina's reference to her program as "a family oriented enterprise," addressed popular and well-defined concerns over the future of the "Russian family." Moreover, because I had attended several conferences before this one, I thought Galina's introduction sounded very much like the presentations of other professionals from family centers, municipal clubs, and private "psychological centers."

After a short introduction, however, Galina's presentation took an unexpected turn. "Would you like a riddle?" she asked. "How do you both go into labor and keep smiling?" After a theatrical pause, Galina said boldly:

> Sanitary culture. If you are sanitary educated you can give birth and smile (*togda ty mozhesh rodit' s ulybkoi*). The goal of our program is to improve the state of a sanitary culture (*povyshenie sanitarnoi kultury*) among women and men alike. We nurture a responsible attitude toward pregnancy and we teach our patients the basics of mutually responsible reproductive behavior. By doing so we actually succeed in making our women give birth and smile at the same time.

Galina was referencing the critical importance of the traditional field of knowledge possessed by the Soviet medical community, namely, social hygiene. Soviet physicians in the 20th century played a powerful role in disciplining patient behavior through claims surrounding social hygiene, a topic that I will discuss later in this paper. In light of this history of the Soviet medical profession, I was eager to explore how "sanitary culture," biomedical knowledge, and the language of emotions and family values co-exist and operate as an educational tool in the context of childbirth. Moreover, because I was familiar with the fairly progressive practice of *partnerskie rody* (men's presence at birth) in Galina's hospital, I wanted to understand the relationship between this practice and sanitary culture. I also wanted to learn more about the institutional context in which Galina and her colleagues were able to institutionalize *partnerskie rody* at their hospital, given its lack of popularity at other medical institutions. After a series of short conversations, Galina granted me access to a course titled "Giving Birth with a Smile."

One Saturday morning, after I convinced a woman at the hospital reception desk that I was there for the pregnancy class – despite the fact that she could not see my belly – I joined eight other women and three men in the conference room of the maternity hospital. We listened to a lecture about pregnancy, delivery, and partners' presence during childbirth. One of the most important parts of the class, we were told by our lecturer, was to make ourselves familiar with the hospital environment. "This is what distinguishes us from other classes in the city." she said. Therefore, following forty or so minutes of attentive listening, twelve of us followed our lecturer through numerous hospital corridors. After familiarizing ourselves with various parts of the hospital, we reached our final destination – the maternity ward itself. As she showed us the ward with its predominantly white and metallic colors, she concluded: "As you can see, it's a very friendly environment and it's spacious so you and your husband can feel comfortable here." Faint giggling sounds coming from other members of the group, however, revealed the fact that many of us were less convinced by the friendliness of the medical environment.

After the lecture I spoke to Elena, another woman obstetrician and a public health researcher, who was one of the first organizers of this educational program and was very passionate about it. When I asked her to tell me the story behind the course, and consequently of *partnerskie rody* which all of her colleagues were so passionate about, she first emphasized the fact that, unlike other hospitals in the city, their institution did not charge partners for attending the birth. She then told me that the current reproductive cohort (i.e., reproductively active women of the last five or so years) is not a very healthy generation. "They give birth to unhealthy

children and the index of health is declining as we speak. Hence, the importance of sanitary education," she said. I asked her how the hospital officials reacted to the initiative to have partners present at birth, and she said "It was not easy, but it is the right of every father to take part in the birth of his child." She then returned to her point about the importance of sanitary and reproductive education:

> But what is important here is the microbiological aspect of having your partner around. Let's talk about the microbiological level of '*partnerskie rody.'* Babies have a very limited interaction with the environment. They receive all the important microorganisms from their mom and dad. Those babies who were born with both parents around have less intestinal diseases when they grow up. In terms of health, there is a clear difference between babies who were born in '*partnersie rody'* and those who were not. In addition, we offer a sanitation treatment for both parents during their stay in the hospital. We treat them for a specific kind of staphylococcus that exists in all the maternity wards. These moms and dads get healthier, too, when they get out.

From Elena's perspective, *parnterskie rody* is a "mature and responsible act," in which microbes are considered human immunological allies and are exchanged between men, women, and their newborn babies at the time of delivery (Latour 1993: 199). As with the link Galina established between sanitary culture and a woman's smile, Elena is convinced that *partnerskie rody* provides the optimal environment for the exchange of these protective microbes. This practice, in turn, makes women and their partners not only healthier, but also happier. In short, "sanitary culture" or sanitary knowledge shapes and enhances the microbiological level of human existence, which in turn improves reproductive health outcomes and makes the partner's presence a necessary emotional component of every partnership.

Emotions here become an object of governance (Petryna 2002, Rapp et al. 2001, Rivkin-Fish 2004).[11] *Partnerskie rody* and the course constitute a social practice aimed at remaking interpersonal relations and ways of thinking (Rivkin-Fish 2004, 2005). Anthropologists have documented how doctors in postsocialist societies deploy different practices to discipline patients and to claim their legitimacy in the context of unstable reality and perpetuate social change (ibid., Gabriel 2005, Bazylevych 2010). My ethnographic data further reveal how these medical professionals extend these "disciplining practices" outside their clinical practice to the current population debate. Here they infuse social categories of the demographic debate with biomedical knowledge, sanitary education and emotional aspects of interpersonal relations. In the following pages, I will demonstrate how, by drawing upon their traditional expertise from the Soviet past – social hygiene and its role in demographic policy interventions – the medical professionals at this particular hospital sought to reproduce their authority over the matters of reproduction and population dynamics. I will dwell upon the legacy of social hygiene and public health research used by medical experts in order to establish themselves as a community of policy experts.

Population Prescriptions – A History of Medical Demography and Social Hygiene

That cold December morning after the first meeting of the "Giving Birth with a Smile" class, when I introduced myself to Elena and began to tell her about my research interests, she interrupted:

> The OB/GYN community has important skills to improve demographic policy. We are able to strengthen the reproductive capital (*reproductivnyi potentsial*) of our country. We cannot influence social values; this should be the government's role. We have other resources. We can support demographic policy by offering sanitary education and by helping young people make right choices.

To understand Elena's adamancy, it is necessary to situate her response within the historical relationship between medicine and demographic policies in Russia. Historicizing Elena's statement, I believe, might shed light on the question of why she and her colleagues consider themselves experts in "medical demography," and consequently, demographic policies and interventions.

The history of the Soviet medical community is a turbulent one. Soviet physicians have been active in research on social hygiene since the early 1920s. Soviet social hygiene emerged as the science which studied "the influence of the economic and social conditions of life on the health of the population and the means to improve that health" shortly after the revolution (Solomon 1991: 175). Social hygienists enjoyed this leading position in public health research until their studies began revealing disturbing realities of the Soviet existence that could not co-exist with the regime's commitment to industrialization and progress. By the early 1930s, the majority of social research on health was discontinued and research departments were shut down (Solomon 1991).[12]

In the 1960s, medical demography, led by prominent social hygienists who survived the purges of the 1930s,[13] emerged in the Soviet Union. It was largely concerned with the problem of declining fertility rates. In their studies, social hygienists argued that health, and especially the mother's health, was an important determinant of family size and the reproductive decisions of Soviet families. The dominance of the biomedical approach to population issues and especially the focus on reproduction resulted in research that took as its main subject the influence of health conditions, infertility, and abortions on birth rates (Feshbach 1986: 69-78).[14]

The problem of declining fertility rates, as well as infant and maternal mortality rates, remained the major object of study among social hygienists throughout the 1980s. During this period, political leaders devoted the majority of the state's social hygiene and public health resources to the development of research and state programs in the field of obstetrical and gynecological health (Feshbach 1986: 76-77).[15] These developments helped establish social hygienists working in the field of Obstetrics and Gynecology as experts in population studies. In

the post-war Soviet Union they were the principal authorities consulted on the relationship between health factors and effective interventions in the realm of demographic policies. Elena and her colleagues were products of this history.

Nearly thirty years after the rise of social hygiene as a foundational discipline in the study of demography, "sanitary education" remains a vital body of knowledge among medical professionals. In fact, it is arguably becoming an even more important field for these individuals, as it consolidates their identity as a community of experts in the face of increasing numbers of other social actors, outside the field of Obstetrics and Gynecology, contributing to the population debate. When Galina presented her education program at the conference, she emphasized its distinction from other pregnancy classes offered in non-medical institutions. She did so by claiming that ultimately, women will return to medical settings, such as hers, to deliver their babies, and their lack of familiarity with this environment could not only jeopardize their health, but also their emotional state:

> There are a lot of other places out there for pregnant women. We, as an oldest district maternity hospital, accept all kinds of patients including some of those who go to these other classes for pregnant women. The problem with these places is that they are not part of the medical environment; they are isolated from the place where women actually give birth. Therefore, women are left with a very idealistic understanding of the process. They were told one thing and when they come to us they see a completely different situation. Women who come to us get adapted to the reality of the maternity ward and therefore they smile when they give birth (*rozhaiut s ulybkoi*).

Among other things, such as the rise of consumerism and new middle class values (Patico 2008), the explosion of new options for childbirth classes in Yekaterinburg reflects the increasingly diverse groups emerging as experts in different population interventions. While there are a few organizations that exclusively assist women in homebirths, they do not advertize it openly for legal reasons.[16] The majority of these classes prepare women for a hospital birth. They are fairly similar in structure and usually include a short series of informative lectures about different psychological and physiological aspects of pregnancy, labor, delivery, and breastfeeding. In addition, these classes offer couples psychological consultations throughout the pregnancy. Galina disdainfully referred to this emphasis as "an idealistic understanding of the process," where the functioning of the psyche is perhaps privileged over the tangible physical health risks that require the close monitoring of legitimate medical professionals. From Galina's perspective, it is not merely ignorant, but also irresponsible for women to lack "exposure" to the clinical environment – echoing Elena's concern for instructing parents on making "mature and responsible" decisions in their birth plans.

Galina used the concept of "sanitary culture" to underline the difference between her enterprise and other pregnancy courses in the city: "These [other] schools don't have any

medical or sanitary knowledge. They don't work with obstetricians, and they promote non-traditional[17] forms of medicine that inevitably lead to increasing infant and maternal mortality rates." When other participants asked her about the mortality statistics, she simply replied: "There is no statistical data on this. It is not revealed." Galina continued, "But surely, [our hospital] promotes the most modern and safe methods of medical assistance during pregnancy and our infant and maternal mortality rates are almost negligible. And we all know that these mortality rates are one of the main reasons for the 'reproductive drama' in our country." By referring to "sanitary education" and by highlighting her knowledge in promoting women's health, Galina called attention to the importance of her expertise in the context of population crisis.

Reproductive Drama – Doctors and Others

As the Russian state attempts to enact pronatalist policies through the system of fixed financial payments, the authority of the biomedical community as a leading force in the questions of population has begun to be challenged by an array of other social actors. Governing emotions, and especially the emotions of pregnant women, has become a popular enterprise. The "reproductive drama" of population decline Galina was referring to is also a social drama between different experts participating in the demographic debate. It is within this debate that professional identities and hierarchical relations are established and reconfigured. Natalya, the owner of a private family center that specializes in educational courses for pregnant women and their partners, was among this larger body of individuals making claims on the emotional wellbeing of pregnant women and questioning biomedical authority over matters of reproduction, childbirth, and the hospitalization of pregnant women. Natalya self identified in an interview as "a scapegoat of the medical OB/GYN community in the city." This position came as a surprise to me as I had heard repeatedly about her center's popularity from several women and even a man who had participated in the education course.

In between Natalya's breastfeeding class and a birthday party she had organized for her daughter in the daycare, I met with her for coffee and she told me her story. As a woman in her forties and a mother of four young children, Natalya has had an unusual career path. She worked as a pianist in a middle school for several years. She then received a degree in psychology and opened her first family center in 1999:

> I thought that I had something to share, I thought there is this niche and no one is interested in doing this but I have things I can share with people […] My own experience, my knowledge, for example. I did my final project in the university on prenatal psychology […] and I am a mom myself. I wanted people to be happy in the process of pregnancy. I wanted them to feel inspired instead of being fed scary stories.

Natalya, similarly to the obstetricians from the hospital, declared enhancing women's emotional state as one of her main goals. These "scary stories," she described, became evident in her interaction with her doctors during her first pregnancy. She described, "When I came to the clinic (*konsul'tatsia*) and said that I was pregnant and need to register with them, the answer I received was: 'Do you need an abortion or are you keeping it?' This is when I began looking for alternatives.'" [18] Natalya eventually decided to deliver her baby at home and received help from one of the two city centers that specialized in homebirth.

Natalya's decision to turn to alternative forms of childbirth as well as her future family center for pregnant women is part of a larger social movement that has its roots in late socialism. In the 1980s, a network of "family clubs" (*semeinye kluby*) all across the country began practicing alternative medicine and what has been labeled as "spiritual midwifery."[19] Rather than being a product of what is usually considered a one-directional movement of post-1991 New Age ideas coming from the West, Natalya's ideology and practice can be traced back to late socialism and the circulation of what an active member of such a club, Ludmila V., called "an ideology of traditional medicine" (*traditsionnaia meditsina*).[20] In my conversation with Ludmila, she identified the main goal of her family club activity in the 1980s as "fostering healthy, strong, and happy families" (*vospitanie zdorovoi, sil'noi i schastlivoi sem'i*). During the Soviet period these family clubs were accused of being religious sects, yet they continued to practice what Ludmila called "a holistic approach to body, soul and spirit" (*telo, dusha i duh*). Similarly to her medical counterparts, Ludmila spoke about the link between the emotional state of women and their health. Yet she articulated that her objective was to offer an alternative to what she considered an unnecessary medicalization of people and family relations.[21]

Natalya is Ludmila's younger colleague and her center is the third generation of the city "family clubs," dedicated to childbirth, families, and alternative medicine. Although there are other private family centers with a similar agenda of promoting a non-medical approach toward pregnancy, Natalya is among the most successful. When Natalya decided to devote her career to working with pregnant women and their partners, she enrolled in a nursing school and became certified as a nurse-obstetrician. Perhaps, this certification gives her the courage to openly confront physicians about their practices. When I asked Natalya to tell me why she considered herself to be a "scapegoat" of the medical community, she told me:

> I think I have some sort of a revolutionary spirit in me and that is how I paid for it… We always do a little survey in our courses when women first come to us. One of the questions is about how women prefer to give birth. And I had 100 surveys by then, it was in 2000, and 45 women said that they would prefer to give birth at home […] So I went to the city department of health with my surveys and I went straight to the head of the OB/GYN department and I said, "Here's my suggestion, let's use one of the city maternity hospitals and set up a maternity ward there that would resemble a home environment." She told me: "We don't need you, we have it all, because we have enough refrigerators and TV sets in our

> hospitals." I tried to say something about different poses that women would be allowed to choose. She began giggling: "Next you'll tell me about all the psychological help women need and all these things I am reading about on the internet. This is all very funny, because we obstetricians decide how women [give birth]. And in general, I like C-section, because C-section saves lives."[22]

The obstetrician dismissed Natalya's suggestions as irrelevant to women's health, insisting, rather, that reproduction was an inherently medical matter. Natalya was stunned by this response: "It was a revelation that this was an opinion of a woman and a doctor who is supposed to be progressive and to be the vanguard of the OB/GYN profession."[23] Appalled by Natalya's suggestion, this official then published an editorial in a medical journal casting Natalya as a "black midwife" who promotes dangerous and anti-scientific approaches to childbirth.

After this editorial was written, Natalya's practice was widely castigated by the medical community for jeopardizing women's health. She continued:

> Since then our center has been receiving very negative responses from medical officials. They conceive of us as if we are some sort of a cult that prepares women for unidentified, underground (*podpol'nye*) childbirth. I've heard from our women that even in the X hospital [where Galina works], which is considered to be progressive, when women ask doctors what kind of [medical] interventions they are going to do during delivery and if they can refuse these interventions – in our courses we actually train people how to build relations with doctors, how to talk to them – when [doctors] hear these questions they become very aggressive and they say: "Ah, you're coming from Natalya's center, we won't accept you here."

In my interviews with doctors and other medical officials in the city, I had often heard these negative views expressed about Natalya. It was clear that Natalya's definition of "progress" did not correspond to the way obstetricians and gynecologists understood progress, as they disagreed whether pregnancy was a normal physiological process or a medical condition. This competition for women's emotions clearly demonstrates different forces of social change at play in contemporary Russia and it also reveals different stakes these social actors have in this competition.

Childbirth Voucher (*rodovoi sertifikat*) – Medicalization from Above

Competing beliefs about maternal wellbeing are not the only issues at stake in this drama. The obstetrics and gynecology community's response to Natalya's enterprise and their competition for women's (and men's) emotions were also, in part, the outcome of an economic

competition created by the national health project, which pitted hospitals both against each other and against alternative birthing centers for state funding. In 2006, recognizing the deteriorating state of its reproductive and maternal healthcare system and its negative effect on population growth, the government issued a new form of monetized aid to pregnant women. This "childbirth voucher" (*rodovoi sertifikat*) came in the form of a voucher (11,000 rubles or $370) for a woman to attend maternity clinics (*zhenskaia konsultatsiia*) for routine exams and other medical expenses during her pregnancy (including delivery itself), and the first year of her child's healthcare needs.

Although issued to an individual pregnant woman, as part of the larger process of the "monetization" of social benefits, these "childbirth vouchers" are actually direct state investments in the healthcare system. Thus, for each visit a woman makes to a maternity clinic (*konsultatsia*) with her voucher, the government pays that clinic 3000 rubles. These vouchers guarantee that maternity hospitals (*roddom*) receive 6000 rubles per individual accepted for hospitalization there, and pediatric clinics receive 2000 rubles.[24] The resources received by a hospital through birth vouchers can be utilized to buy additional equipment or to increase staff salaries. If a woman decides to go to another hospital or to have a homebirth, however, a hospital loses a portion of its anticipated revenue. To secure this source of income, maternity clinics and hospitals employ various strategies to attract women to their institutions.

The "Giving birth with a smile" class that Galina advertised at the conference is a good example of one such strategy that is designed to attract pregnant women to a medical institution. The class is held at a medical center that operates both as a day clinic and as a maternity hospital.[25] As the major regional maternity hospital, it admits women from the region and is not accessible to the city dwellers. To overcome this obstacle a lot of formal and informal solutions have been developed by the hospital administration. Aside from mobilizing personal and kinship networks (*znakomstvo, blat*) to gain access to the hospital facilities (Ledeneva 1998, 2006; Rivkin-Fish 2005), Elena told me that in previous years the ministry of health has given the hospital a limited option to offer private services. The price for a private room and delivery ward was approximately 30,000-50,000 rubles ($1000-1500). When I was doing my fieldwork in Yekaterinburg, Elena was complaining to me that this option is not available to them anymore.

In this regard, offering the education course within the premises of the hospital could be seen as a substitution of the previously existing private practices through which administrators successfully attract women to deliver their babies there as well. An official price for the course is 8840 rubles for 10 class meetings. This price also guarantees that a woman could then give birth in this very hospital "free of charge." In lieu of payment for the hospitalization, the hospital would accept this woman's childbirth voucher. The hospital thus benefits from two sources of income simultaneously: the course itself and the federal assistance attached to these childbirth vouchers. Their investment in technologies and specialists, and their reputation as the leading institution in obstetrics, further support the hospital's institutional efforts to lure women to attend these programs and to deliver in their hospitals. The women who attended this course with me

indicated that they prefer this particular course to any other courses primarily because it gives them access to one of the best hospitals in the city with highly qualified doctors.[26]

Although I did my fieldwork in only one maternity hospital, I had heard throughout my fieldwork about other hospitals that employ very similar strategies to attract women to deliver there. More importantly, many of my interlocutors who got pregnant after the implementation of this policy testified that since then there is a growing pressure on them to attend clinics and hospitals numerous times even when they do not consider it necessary or desirable. This transformation illustrates the importance of mapping the institutional and political economic context in which medicalized approaches to reproduction emerge and develop. Rather than simply glossing over medicalization and calling it a "cultural" attitude toward pregnancy and reproduction, this example of the implementation of one healthcare policy illustrates how this medicalized approach was enhanced by economic necessity and competition created by the very same policy.

Conclusion

This paper has revealed the roles and strategies of biomedical experts as a lens into the complex webs of social practices that constitute forms and relations of power in contemporary Russia. It has demonstrated how, in the context of Russia's changing political conditions and in the context of changing economic and social policies, different social actors can use demographic knowledge and knowledge about human reproduction as "ideologically and politically charged acts of representation and intervention." (Szreter et al. 2004: 6).

A group of passionate health care providers I discussed in this paper uses the popular debate about the demographic fate of Russia to reinforce their authority as experts in the field of population policy interventions. To do so, they have adopted a language that emphasizes social and emotional aspects of pregnancy, which they have grounded in microbiological principles. Their normative standards of being "cultured" are infused with claims of superior value of biomedical knowledge. Their historically grounded reputation as leading experts on the issues of reproduction and social hygiene allowed these doctors to translate the presence of men during a woman's delivery (*partnerskie rody*) as a progressive practice because of the immunologically protective "microbes" passed by men to their partners and babies. These physicians shared with their colleagues from other fields the belief that restoring "family values" and putting emphasis on emotions is an important milestone is resolving the problem of under-population. The moral and emotionally responsible decisions they lauded, however, centered on the use of medical services, and not taking unnecessary risks, which are posed by "non-traditional" birthing techniques.

Furthermore, the practice of borrowing the concepts of "culture," "values," and "emotions" as important linguistic tropes reveals that in the current era, biomedicine not only creates but also capitulates to other powerful forces of social change. Natalya's "non-traditional" enterprise regarding childbirth and reproduction is such a force. She challenges biomedical approaches to

pregnancy and "competes" with OB/GYN doctors for women's emotions by introducing new psychologically and spiritually oriented practices to govern them. In light of this competition, while hospitals are indeed transforming their services to meet the new social reality and to accommodate new health and demographic policies by introducing "emotions" as part of their professional vocabulary, they are in effect institutionalizing a biomedical approach toward reproduction and population dynamics.

A medicalized approach to reproduction is hardly new, after so many generations of Soviet physicians have employed it for many years (Rivkin-Fish 2005). Yet market economies and the competition introduced by the national health projects have subjected Russian physicians to new constraints. Though I did not aim to reduce my analysis solely to the question of political economy, new economic competitions created by monetized and liberally oriented social policies play a crucial role in these biomedical experts' assessment of the situation and in their practices of establishing authority vis-à-vis the state and other social actors. In assessing the "problem" of low fertility and by offering their medicalized framing of it, medical experts simultaneously genuinely pursue the state concerns over falling birthrates, and try to protect their own professional interests and autonomy in securing state resources.

Given the current political prominence of the "demographic problem" as a policy priority in Russia, this paper has revealed only a fraction of two larger issues. The first issue is whose diagnosis of the underlying causes and prescriptions for treatment is viewed in contemporary Russia as authoritative and why? The second is how the question of what constitutes the problem of under-population in Russia is framed and defined by a seemingly scientific reasoning produced by the state experts.

Endnotes:

[1] In a larger project I investigate a variety of experts as they take part in the process of formation, reconceptualization, and enactment of the new population policy. Health providers, demographers, social psychologists, educators, government officials, and private and/or non-government organizations are playing an important role in this process. Throughout my research I observed how these social actors had appropriated the perceived crisis of underpopulation and policies designed to solve it as an opportunity to negotiate their institutional identities and to re-shape their social hierarchies. Although an important part of my argument, the length of this paper prevents me from doing an in-depth analysis of the social practices of all the actors.

[2] In November 1991, the report entitled "Family Policies in the USSR in the 1990s: The Future Government Program" was published by the collective of demographers under the supervision of the prominent Soviet and Russian demographer Anatoly Vishnevsky (Elizarov 2001). Given the timing of its publication, right before the dissolution of the USSR in December 1991, this project had never been ratified by the government. In my ethnographic interviews, both Valery Elizarov and Vladimir Archangelsky, two Moscow based demographers who have taken an important part in developing recommendations related to demographic and family policies since the early 1990s, indicated that the 1996 program mostly consisted of the diagnosis and recommendations published in the 1991 report.

[3] For the detailed analysis of post-WW II Soviet family policies and their effects on the Soviet politics of reproduction see Nakachi (2008).

[4] The main trope through which the students of postsocialism approached these changes is the transformation of *blat* practices. *Blat* is defined as "a 'favour of access' at the public expense" (Ledeneva 1998: 35), which is mediated by the rhetoric of friendship. Because the relationships, networks, and favors of access involved in *blat* were perceived as sharing access with friends, the nature of *blat* transactions made them inseparable from other social domains. Although the theme of money, exchange, and social networks is an incredibly popular topic among scholars of postsocialism, there are a variety of approaches and interpretations of the role money played during the Soviet period and after it. For instance, while Lemon (1998) and Pine (2002) demonstrate the social and symbolic importance of cash in the day-to-day lives of citizens in socialist countries, Verdery (1996) assumes the incommensurability of capitalist economic practices with socialist forms of exchange and articulates broken social relations as mediated by the transition from socialist to capitalist forms of exchange. Phillips (2008) has shown the continuity of *blat* practices in postsocialist Ukraine as a strategy utilized by Ukrainians in their attempt to navigate in the new market economy. Also see Rivkin-Fish (2005), Dunn (2004).

[5] All of the conferences I attended in the field were called "scientific-practical" conferences (*nauchno-prakticheskaia konferentsiia*). The idea behind this type of conference is to bring together both researchers and practitioners in this particular field of knowledge. Moreover, in the end of every such conference, its organizers formulate a document with policy recommendations and send it to the local authorities.

[6] All individual names are pseudonyms. I refer to my interlocutors using first names only although I have been using patronymics in my conversations with some of them. I indicate this by using the first letter of their patronymics (e.g., Galina B.).

[7] According to Galina B. and some of her colleagues, the Ministry of Health allows a relative (either a parent or a husband) to be present in the delivery ward if the physical conditions of the hospital allow it. A medical official I interviewed indicated that a many maternity hospitals simply couldn't afford men's presence because they might have as many as four different women giving birth simultaneously in the same delivery ward. Some of my other interlocutors (and medical professionals were among them) had a more cynical view of the issue at stake. Lidia, a nurse, told me that some hospitals take advantage of the physical conditions' clause in the law in order to create additional revenue for the hospital by institutionalizing paid services. One of the popular practices is to renovate and redecorate several hospital rooms and, for an additional charge of 30-50 thousand rubles ($1000-1500), offer these renovated rooms and a private delivery ward for couples striving to give birth with both partners present.

[8] Family occupied an ambiguous position in the Soviet politics. On one hand, Soviet leaders feared family as a place of potential challenge to the party, as a place of potential betrayal. On the other hand, they represented Soviet family as a necessary mechanism of Soviet politics, precisely the place where intimate loyalties to the state are formed and enacted (Hooper 2006). It is through this legacy of ambiguity that contemporary knowledge experts attempt to address the role of family in the current "crisis" of population.

[9] http://www.connews.ru/news/47

[10] Rivkin-Fish (2010) discusses discursive dimensions of such framing and argues that it is through this framing of the moral decay of families that "state power and citizenship are being created and transformed" (702). Oushakine (2009) considers the origins and effect of the ethnic framing of the demographic problem. He argues that through xenophobic discourses and through identifying naturalized distinctions between different ethnic groups, people in Russia articulate their search for meaningful social relations and solidarity within the context of an unstable past and an unpredictable present (79-129).

[11] On how other forms of governance direct emotions see also Lemon 2009; Shever 2008.

[12] More generally, Stalinist purges of the Academy of Medical Sciences in 1947-48, followed by personal denunciations, incarcerations and institutes' reorganizations, left medical professions shattered and fractured. In the post WW II period Soviet physicians, and obstetricians and gynecologists in particular, reemerged as social actors playing an active role in the state's attempt to recover from a steep population decline by fostering birthrate growth. Their roles included two major tasks: preventive care and policing non-clinical abortions, which were temporarily banned in 1936 (Nakachi 2008: 232-315).

[13] Susan Gross Solomon (1991) argues that unlike other social scientists, whose fate was much more tragic, the majority of prominent social hygienists of the 1920s continued to do public health research in the 1930s. However, many of them (e.g., Semashko, Frenkel, and Molkov) had to take refuge in other departments and institutions, working under the auspices of other disciplines, such as medical statistics, general hygiene, or the health care organization (192-193).

[14] The significance of studying hygienic processes and their effects on demographic processes was also translated into and reinforced through policy recommendations, outlined in the program entitled "Scientific Foundations of the Protection of the Health of Mother and Child for 1978-1990" prepared in 1978 by the Academy of Medical Sciences and the State Committee on Science and Technology (Feshbach 1986: 74).

[15] Special courses on social hygiene and its effects on population processes were re-established and taught at medical institutes, policy recommendations were formulated, and new research institutions were established (e.g. "Laboratory of the Hygiene of the Labor of Women") (Feshbach 1986:76-77).

[16] Homebirth is a relatively popular practice among many women I had contact with during my fieldwork. However, doulas operate in a somewhat legally murky environment. There are no certified doulas in Russia; however the practice of homebirth has existed in Yekaterinburg since at least the mid 1980s. One of the "doulas" told me: "Officially, I cannot do this but I do assist women at homebirth though I cannot take responsibility if something goes wrong." A woman I interviewed who gave birth to her two sons at home told me that when she had complications during her second delivery, her doula called an OB/GYN doctor she knew and apparently worked with constantly, and this doctor gave her medical assistance off-duty. Valentina Shirokova, the head of the department of child and maternity health at the Russian Ministry of Health said to a journalist: "Homebirth is not prohibited in Russia, not officially at least. However, there are no normative documents or rules dealing with this procedure." http://www.minzdravsoc.ru/health/child/82

[17] Counter-intuitively to English speakers, Galina refers to western medicine as a form of traditional medicine

[18]For a forceful and detailed analysis of doctors' clinical practices and attitudes towards pregnancy and reproduction and their embeddedness in the social and political context of postsocialist Russia, see Rivkin-Fish (2005).

[19] Doulas I met during my fieldwork had their first exposure to alternative medicine during this period and through this network of "family clubs."

[20] Western ideas and objects have spread across these countries exponentially and affected the ways people there imagine themselves and others (Berdahl 1999). However important these influences may be, ideas often circulate in different directions and empirical evidence often points to the different origins of these ideas. For example, Alaina Lemon (2008, 2009), in her recent work, explores the movement of ideas, values, and techniques in a different direction. Her study of the Russian Academy for the Theatrical Arts challenges the notion that influential ideologies and values are arriving only from the West or that these ideas and values have been blocked by the Cold War. Also see Rogers (2010).

[21] Ludmila successfully transformed her late Soviet experience as a family club activist into the organization of the first NGO in Yekaterinburg dedicated to family, health, and children. Today she operates as a successful expert on writing grant proposals for other NGOs in the city. The way she put it: "As our kids grew up, so we grew up as experts in this field." Hemment (2007) describes the world of NGOs in Russia as "a site of agency and creative compromise, where the global and local come together in dynamic improvisation" (16). She demonstrates how, in the era of market-oriented policies, involvement in the world of foundations and grants allowed women involved in the world of women NGOs to maintain integrity amidst harsh socio-economic conditions. In the new marketplace of NGOs, their activism became a part of the professional sector with little to no connection to local reality and with constant requirements to navigate bureaucracies, to master grant writing, and demonstrate "effectiveness." Also see Phillips (2008).

[22] Cynthia Gabriel (2005) documents doctors' decisions to make C-sections in one of the Saint Petersburg maternity hospitals. She describes women's struggles with doctors when they ask to have a vaginal delivery while doctors insist on C-sections for no explicit reasons (Gabriel 2005: 76-80).

[23] Rivkin-Fish (2005) has employed Bourdieu's concept of misrecognition in order to explain this apparent lack of solidarity among women obstetricians and women patients.

[24] For the official government issued information on birth certificates: http://www.rost.ru/projects/health/p04/p34/a35.shtml

[25] This is a rare combination in Russia. Usually, an obstetrician in a maternity ward is not the same specialist who followed a woman during her pregnancy.

[26] Because this maternity hospital operates under the authority of the Ural federal district, it accepts patients from an area much larger than the city. The high demand for their services makes it difficult for Yekaterinburg residents to be admitted and receive healthcare there. Because of its reputation, however, women and their partners often mobilize their personal and kinship networks (*znakomstvo, blat*) to gain access to its health providers (Ledeneva 1998, 2006; Rivkin-Fish 2005). In this respect, a childbirth class that would eventually ensure a woman's access to this hospital could also be seen as a measure that institutionalizes already existing practices of using informal methods of accessing and paying for a better healthcare, documented by Michele Rivkin-Fish (2005) in a fascinating ethnography on health and reproduction in post-Soviet Russia.

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