

Activism and Patient Vulnerability: Resistance to Medical Authority and Regulation in Russia

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Abstract

The paper analyzes the opposition and adaptation of Russian patients, independent perinatal specialists, and professional human rights activists to normative regulation of obstetric care, medical authorities, and the practices of the Russian maternity hospital. During my ethnographic research, I have collected personal stories about the clashes of women in labor and their assistants (primarily doulas) with the medical system, stories of collective and individual appeals to authorities, and protest flash mobs. The article presents the history of the transformation of the Russian system of obstetrics and the development of grassroots movements by midwives and doulas. It outlines the features of human rights and perinatal protest discourses and identifies the tactics of legal and vernacular resistance and non-resistance to medical authorities encountered during fieldwork.

Introduction (1)

In the course of ethnographic research starting in 2017, I have collected contemporary birth narratives describing the decisions and interactions of women and their families with medical professionals and midwives, doulas, and other external perinatal specialists. In narratives from the Soviet and post-Soviet eras, there was practically no mention of independent choice and freedom of action in medical institutions and official discourses, or indeed of the involvement of family members or independent participants in medical care during childbirth [Belousova 2003, 2012; Olson and Adon'eva 2013; Rivkin-Fish 2005; Rouhier-Willoughby 2003, 2008: 66, 91]. However, in contemporary narratives, Russian women convey their agency in some detail and negotiate with the obstetric system for various options [Gramatchikova 2020; Kuksa 2020b, 2021a, 2021b; Kuksa and Shnyrova 2021; Temkina and Rivkin-Fish 2020]. Thus, my fieldwork shows that women now plan and shape the birth process much more than they did in first two decades after the fall of the USSR.

This more active patient position of Russian women is connected primarily with grassroots activities and training by independent perinatal specialists (midwives and doulas). As a rule, they have had several children, hold college and graduate degrees (often both), and had a different experience in childbirth, either at home or in the hospital, than the average woman. These midwives and doulas construct the boundaries of patient agency and teach tactics to overcome bodily and mental vulnerability. They also interact with doctors during labor and delivery

and provide variety of non-medical support for women at all stages of the birth process [Kuksa 2021a, 2021b].

My analysis of both discourse and narratives from independent specialists reveals how and why women have become more active in pregnancy and childbirth as well as demonstrates the role of grassroots activists in legal and vernacular protest to medical authorities. As Kleinman [1978] wrote, each group of “agents of care” (from popular, folk, and professional arenas of the health care system) has its own “explanatory models” of health/sickness with its specific idioms—abstract or concrete, technical or non-technical, impersonal, or highly personal—that they need to convey to each other. He has argued that there are conflicts “between professional medical (especially biomedical) explanatory models that construe sickness as disease and lay (popular culture) explanatory models that construe sickness as illness” [1978: 88]. Given the multiplicity of “agents of care” and actors during delivery and their divergent interests and expectations, I explore representations of birth (including popular, folk, and professional explanatory models) and the interpretations of experiences from different perspectives, including of the patient and her family, physicians, the law, and perinatal specialists. According to Bakhtin’s theory of speech genres [1986: 159], we must approach the analysis of speech utterances as a dialogical and interactive process that considers speaker and addressee goals and genres that they may choose and use in certain contexts. In this paper I will apply Bakhtin’s and Kleinman’s conceptual approaches to reveal the multiplicity, polyphony and heteroglossia of discourses by participants in childbirth. Participants’ models and discourses rely on speech genres with variable meanings and functions that are affected by legality, legitimacy, degree of stigma and contexts (or frames) [Bakhtin 1986].

The grassroots activism and legal or vernacular tactics of resistance to medical authority described in this article are only formally similar to American feminist and anthropological critiques of biomedical and technocratic childbirth in favor of individual “control over childbirths” [Davis-Floyd and Sargent 1997; Rapp 1999; Sargent and Gulbas 2011]. In this framework, we would be forced to classify tactics to counteract medical authorities as part of a contemporary feminist agenda and as a struggle for political and neoliberal rights and social control over reproduction. Any evaluation of grassroots activism and legal and vernacular protest in Russia must take into account the following essential factors, which the feminist approach ignores: 1) the variable meanings and functions of bureaucratic and vernacular texts (depending on genre, addressees and communicative contexts (or frames) [Bakhtin 1986; Kuksa 2020b]; 2) differences between collective and individual forms of legal prose; 3) obstetric policies at different regulative levels and in local contexts [Kuksa 2021b]; 4) illegal and stigmatized homebirth practices, which are difficult for ethnographers to observe [Kuksa 2018, 2021a]; 5) recent medicalization, financing, and technologization of Russian obstetric care; and 6) the majority of obstetricians and gynecologists, from the Soviet era to the present, are women, unlike in the United States [Kuksa 2018; Rivkin-Fish 2005; Rouhier-Willoughby 2003, 2008; Sargent and Gulbas

2011]. My approach highlights how informants reclaim agency in vulnerable situations and their oppositional and adaptive tactics when interacting with the obstetric system. A primary avenue is hiring independent midwives and doulas, and this paper will focus on how they have been able to resist and even transform the birth process, at least for some women.

This research is based primarily on a corpus of semi-structured in-depth interviews collected from doulas, midwives, physicians, and parents living in Moscow and Saint Petersburg (since 2017) or in cities located in the Central, Northwestern, Volga, the Urals, Siberian, and Far Eastern Federal Districts (since 2020). For this article, I have also relied on data from an online survey of Muscovite and regional perinatal specialists conducted during the COVID-19 lockdown in spring and summer of 2020 on the attitude toward medical interventions by women in labor. I have explored federal statutes regulating childbirth as well as materials from medical, midwife and doula conferences, lectures, and training sessions, which I attended as a participant or online listener.

I focus on documented digital and verbal opposition to the practices of Russian obstetric institutions. In particular, I study midwife, doula, and parental discourses and resistance tactics used by human rights activists, independent perinatal specialists, and laypeople. In this article, I present the most characteristic methods for legal and vernacular resistance to medical authorities as well as opting-out (e.g., home birth) encountered in my research. I analyze the dependence these types of resistance on the agency of parents and perinatal professionals in the contemporary maternity hospital.

The practice of written refusal of a woman in labor to routine medical interventions is a relatively non-confrontational and common form of the mobilization of law. It is guaranteed within a legally stipulated framework of informed consent to medical intervention. Private conflicts at the grassroots level are resolved through individual complaints, appeals and, less commonly, lawsuits initiated by patients to compensate for harm done to them, investigate medical misconduct, and hold medical professionals accountable for their actions. The use of petitions signed by citizens (usually unknown to one another) to protect women generally also mobilizes the law through a collective appeal to state authorities or as part of a class action lawsuit [Kuksa 2011; 2020a]. All three variants of routine law enforcement and legal conflict fall within the framework of the concepts of “everyday legality” [Ewick and Silbey 1998, 2003] and “law mobilization,” a term coined by Black [1973, 2010] to express that the law exists not on paper, but only when citizens use it to protect their rights. These legal tactics display overt women’s resistance to medical authorities in the maternity hospital.

While legal tactics are used by some, the more common approach to counter medical authorities is vernacular resistance. Vernacular articulation of the problems of patient rights and agency and the physical and mental vulnerability of pregnant women, women in labor, and mothers is seen in online protest flash mobs and accusatory discourses. In my view, they serve the same function—resistance to and protest of the system—as urban folklore about medicine. Urban lore about doctors, hospitals and diseases exists in a variety of genres, including

rumors, gossip, fakelore, and conspiracy legends, and expresses dissent with institutional medicine and treatment (for more on this topic, see Kitta 2019). I examine “victim” narratives and accusatory texts distributed by perinatal specialists and women who have experienced psychological and bodily trauma in a maternity hospital from three perspectives. First, these texts function as a “socially sanctioned outlet” for protest [Dundes 2003] and a modern ritualized form of behavior [Rouhier-Willoughby 2003, 2008; Kitta 2019]. They also help narrate and contextualize psychophysical experience [Kleinman 1978; Khristoforova 2020; Kuksa 2020b]. Finally, they allow for “symbolic resistance” (what Scott calls the “weapon of the weak” [Scott 1985]) by traumatized women and independent perinatal specialists not embedded in the medical and bureaucratic hierarchy.

A distinctive feature of grassroots perinatal movements in Russia are forms of female opting-out that express dissent, but that are invisible to bureaucratic institutions—by analogy with Yurchak’s concept of “outsideness/out-of-reach” [Yurchak 2014: 267-270, 563-571]. Yurchak applies this concept to the Soviet citizen, who discursively and performatively shifted authoritative ideological discourses towards their own interpretations. They include illegal practices of home and solo childbirth among Russian educated women, which are stigmatized in the institutional space and were especially popular in 1990s and 2000s [Belousova 2003, 2012; Kuksa 2018, 2021a, 2021b, Kuksa and Shnyrova 2021; Rouhier-Willoughby 2008]. I also have recorded a surge in home births since the spring of 2020, especially outside of Moscow. They resulted from the introduction of anti-COVID restrictions that reduce the agency of women in local hospitals, e.g., prohibition of partner- or doula-accompanied births and separation of mother and child (discussed in more detail below).

Transformation of the Russian System of Obstetrics

Russian women can exercise their agency and opt for a delivery in accordance with their expectations as a result of the transformation and financing of obstetric infrastructure over the past two decades. Some key historical events resulted in a shift in the system toward a focus on women’s needs and the development of grassroots movements dedicated to parenting and the training of midwives and doulas.

As a result of federal funding for the Delivery Certificates program in 2006, regardless of the mother’s place of residence (as recorded in the *propiska* [official place of residence indicated in the person’s passport and state accounting system]), a pregnant woman received the right to access any Russian maternity hospital within the framework of compulsory medical insurance (hereafter CMI). CMI was introduced in 1991 to ensure the constitutional right to free medical care and protection of the health of the citizenry. Patients thus present an insurance card and receive a Delivery Certificate (in electronic form as of July 2021) from a medical institution, which guarantees coverage for medical services (e.g., prenatal clinic, maternity hospital, or children’s clinic) from the Social Insurance

Fund or its regional branches. However, actual choice among obstetric organizations, according to the testimonies of interviewees, was primarily implemented only in large cities, where there are enough hospitals to create real competition for CMI and private deliveries.

At the initiative of the Moscow-based obstetrician-gynecologist Mark Kurtser, founder of the only network of private maternity hospitals in Russia (2), since 2006, midwives at the Moscow Center for Traditional Midwifery and Family Medicine (hereafter CTM (3)), could legally accompany women in labor only in one pilot program at the 6th Maternity Hospital (now closed). These trained professionals from CTM taught natural childbirth and promoted the popular approach of “soft childbirth.” Tamara Sadovaia, the founder of CTM and “traditional” midwife, defined this term as follows:

«Мягкие роды» — это организация условий для проведения естественных родов с максимальным использованием внутренних резервов женщины и минимальным медицинским вмешательством.

[“Soft childbirth” is the organization of conditions for natural childbirth with the maximum use of the woman's internal reserves and minimal medical intervention] [Tamara Sadovaia, 14 April 2018].

Today CTM works officially with some Moscow maternity hospitals and doctors with a unique program for personal obstetric services, which include non-invasive anesthesia and other “soft” treatment practices designed to benefit women and children, as Sadovaia discusses:

Мы абсолютно легитимно работаем. В нашей инструкции нет никаких нарушений отечественных стандартов практики [протоколов]. Может, это для кого-то звучит парадоксально. То, что мы называем торопить роды, то, что мы называем агрессией и насилием в родах — это не отображено в стандартах [протоколах], это просто стереотипы и дурные привычки нашего постсоветского акушерства, с которым мы стараемся как-то работать и их искоренять. Наша практика, которая говорит о том, что женщина имеет свое время, она может рожать долго и она может рожать в любых позах не только в первом, но и во втором периоде, что мы можем использовать воду.

[We are absolutely legal. There are no violations of domestic standards of practice [protocols] in our instructions. Maybe it sounds paradoxical to someone, what we call birth, what we call aggression and violence in childbirth—this is not reflected in the standards [protocols]. These are just stereotypes and bad habits of our post-Soviet obstetrics, with which we are trying to somehow work and eradicate them. Our practice, which says that a woman has her time, she can give birth for a long time, and

she can give birth in any position, not only in the first, but also in the second period, that we can use water.] [Tamara Sadovaia, 19 March 2018]

The 2011 federal law “On the basics of protecting the health of citizens in the Russian Federation” № 323 (hereafter 323-FZ) guarantees the option for partner-accompanied childbirth (with a husband or another family member) without a fee (using CMI). However, it is subject to the availability of a ward in a maternity hospital, and the partner must submit medical test results, the extent of which may vary in practice (due to the lack of an exhaustive list of required tests in the law and at the discretion of the hospital) [Kuksa 2018, 2021a, 2021b]. A freelance obstetrician-gynecologist at the Moscow Department of Health in 2019 reported on the positive impact of spousal participation in childbirth and said that a third of Muscovites have partners in the delivery room [Olenev 2019]. For the last ten years, two dozen Moscow maternity hospitals (with the exception of three specialized ones) have offered the option of partner-accompanied births, at least with the father of the child.

The situation with non-familial support is somewhat different. At first, doulas worked exclusively outside of medical institutions. After 2011 independent personal, non-medical support of childbirth was arranged through private (paid) contracts in some maternity hospitals [Kuksa and Shnyrova 2021]. Later, birth partners without a medical education were allowed (since 2015 in some Moscow maternity hospitals) without confirmation of a kinship relationship (effectively as quasi-relatives). Occasionally they have been admitted as unpaid volunteers since 2018. Doula services, especially in the case of informal admission as quasi-relatives to deliveries with CMI are much cheaper for clients than paying for two separate contracts with a maternity hospital and a medical center of midwifery. This fact allows doulas to compete for clients who do not have the financial means to hire an individual midwife for the delivery, as a Moscow doula describes below:

Сейчас независимым акушеркам, не работающим в центрах типа ЦТА или Акушерство клуб (у центров есть лицензия на медицинскую деятельность и официальные договоры с роддомами), нет нужды мимикрировать, они оформляются на кусочки ставки во все интересующие их роддома и таким образом имеют право работать как акушерки в роддоме. Прямо роды принимать. Роддомам это выгодно, чтобы купить контракт с такой акушеркой, необходимо купить контракт с самим роддомом. Мимо роддома нельзя. То есть 100–150 [тысяч рублей] роддому плюс 50–60 [тысяч рублей] за акушерку. Это вам не с доулой по ОМС пойти

[Now independent midwives who do not work in centers such as CTM or The Obstetrics Club (the centers have a license for medical activities and official contracts with maternity hospitals), there is no need to double up

[contracts], they are employed part time in all maternity hospitals of interest to them, and thus have the right to work as midwives in a maternity hospital. To attend a delivery directly. This is profitable for maternity hospitals, to contract with this kind of midwife, you need to contract with the maternity hospital itself. You can't avoid the hospital. That is, 100-150 [thousand rubles] to the maternity hospital plus 50-60 [thousand rubles] for a midwife. This is much more expensive than with a doula using CMI] [Doula 2, 15 January 2020].

The popularity of independent midwives from the initial grassroots wave of perinatal specialists and family birth partners has contributed to the admission of new participants, namely those with no family ties or medical education, into labor and delivery. Non-medical and emotional support for a woman has become attractive for mothers with many children who are on maternity leave, for psychologists, and for other perinatal specialists, who may benefit from additional earnings [Kuksa 2021a]. It has promoted demand for private doula educational programs (like the Institute of Perinatal Support (4)). The availability of remote learning also has led to the spread of this occupation outside of Moscow and to a second wave of the grassroots perinatal movement throughout Russia. Activists united in the Association of Professional Doulas (hereinafter APD (5)) are trying to legalize the profession and the admission of trained doulas to maternity facilities [Kuksa 2021a].

The interviews collected for this study also indicate that individual choice of relevant management of childbirth (e.g., vaginal birth without intervention or after a caesarean, a “soft” caesarean, delayed cord clamping) and a variety of psychophysical practices (e.g., non-medicalized pain relief, freedom of movement, skin-to-skin contact with newborn during the first “golden hour” after birth) are in demand among pregnant women. Therefore, they require personal assistance by midwives or doulas from attending doctors, at least in paid contracts. However, generally women with childbearing experience and of financial means articulate this kind of agency [Kuksa and Shnyrova 2021]. According to my interlocutors, the farther from the larger cities, the more conservative the staff are in maternity hospitals. As a result, fewer opportunities exist for independent choice by women in these areas. Thus, regional and local features of the obstetrics system also play a role in a woman’s options and degree of agency.

Therefore, diversity, competition, and interaction of providers and “explanatory models” of childbirth have contributed to the gradual transition from solo and home childbirth to “natural” and “soft” childbirth with a midwife in maternity hospitals (at least in Moscow, where independent midwives are legal) [Kuksa 2018, 2021a]. In addition, we see the rising popularity of spousal childbirth partners and professional doula support [Kuksa 2021a; Kuksa and Shnyrova 2021]. As a result, changes in obstetric infrastructure and policies have led to the “humanization” of Moscow maternity hospitals and competition among all the parties potentially involved in the process. Hospitals try to attract private clients of midwives and/or doulas, or patients with Delivery Certificates

requesting state-sponsored deliveries with partners or quasi-relatives (doulas). These social and legal changes have resulted in the introduction of more humane and patient-centered obstetric care (mainly in the private sector), the emergence of separate maternity wards and family wards in regional maternity hospitals, the development of medical “tourism” to Moscow for state-sponsored or private (for-pay) deliveries with non-familial or familial support. Despite slow implementation of updated protocols of obstetric care by medical personnel, the grassroots movements by perinatal activists have transformed maternity hospitals to meet women's needs. They have likewise encouraged the active involvement of women in the training of delivery and legal protection of her interests in the maternity hospital, as we will see below.

Protecting Patients: Official and Unofficial Approaches at the Individual Level

The first wave of independent midwives, who established the Russian home birth movement, call themselves “*materi-spetsnaz*” [mothers-special forces]. This term accentuates the difficulty of survival under post-Soviet conditions of information isolation and lack of material goods. They, like elite troops, overcame these difficulties through active training and self-help, as a Moscow doula explains:

Старая школа, 1990-2000-е годы, тогда был такой рассвет домашнего акушерства. Какой их основной посыл был? Женщина должна очень хорошо подготовиться физически к родам, взять на себя всю ответственность за роды и подготовиться. То есть обливание, баня, там закаливание, физические нагрузки. Вот физические. И тогда она хорошо выносит, хорошо родит. Взять на себя такую внутреннюю ответственность за этот процесс. И тогда было достаточно много самостоятельных родов, когда женщины всю ответственность брали и рожали без акушерки. Потом сами становились акушерками — вне медицинского подхода. Потом они заканчивали всякие медицинские, но потом. Сначала начали практиковать просто от посыла «мы взяли на себя эту ответственность». «Взять ответственность» — это первый посыл

[Old school, 1990-2000s, then was the dawn of home midwifery. What was their main message? A woman should be very well prepared physically for childbirth, take full responsibility for childbirth and prepare. That is, washing with cold water, the bathhouse, hardening, physical activity. Those are the physical ones. And then she endures well, gives birth well. To take on such internal responsibility for this process. And then there were quite a lot of independent deliveries, when women took all the responsibility and gave birth without a midwife. Then they themselves became midwives—outside of the medical approach. Then they finished all sorts of medical [courses], but later on. At first, they

started practicing simply from the message “We took this responsibility upon ourselves.” “Taking responsibility” is the first message] [Svetlana Shnyrova, 17 February 2018].

As we see, the explanatory model of the first perinatal wave endorses psychophysical and informational preparation for the process and recommends that women take responsibility for decisions about financing and care. However, they regretfully note the tendency of Russian women to perceive themselves as passive subjects, rather than independent actors, as a Moscow midwife told me:

Очень маленький процент женщин готовится к родам. [...] Когда предлагаешь поработать в родах с ощущениями (поменять положение, подвигаться), отказываются, предпочитают анальгезию. Персоналу роддома на потоке невозможно работать иначе, чем стандартный протокол, так как только такой протокол обеспечивает безопасность мамы и ребенка в отсутствии возможности реализовать индивидуальный подход из-за нехватки персонала. Для женщины, идущей на роды осознанно, как субъект процесса, реализовать свой план родов возможно только либо по контракту с индивидуальными специалистами, либо активно отстаивая свою позицию, что в родах не всегда реализуемо, так как процесс родов достаточно яркий и требует несколько другого состояния, чем активное отстаивание своих прав

[A very small percentage of women prepare for childbirth. [...] When you offer to work a delivery based on bodily sensation (change of position, moving), they refuse, preferring analgesia. It is impossible for the staff of the maternity hospital to work differently than from the standard protocol, since only this protocol ensures the safety of mother and child in the absence of an option to implement an individual approach due to the lack of staff. For a woman who goes into childbirth deliberately, as the subject of the process, to realize her birth plan is possible only either through a contract with individual specialists or by actively defending her position, which is not always feasible during delivery, since the birth process is quite vivid and requires slightly different conditions than active defense of one's rights] [Midwife 1, 7 April 2020].

Doulas are ascribed illegal status at maternity hospitals, except when hired through private contracts or serving as official volunteers. Referring to the boundaries of competence and the concept of respect for patient choice, they support any decisions the woman makes, including requesting or refusing forms of (non)-medical care. This right lies at the core of the explanatory model of the second perinatal wave. Therefore, for ideological, practical, and ethical reasons, they rarely complain about the passivity of their clients. As a rule, doulas, like

midwives, blame the “conveyor” system in labor and delivery, e.g., the use of standard protocols to the detriment of a patient-centered approach, excessive medicalization to speed up labor, high burnout in the medical environment, and outdated practices that are convenient for doctors and bureaucrats, as we see in this excerpt from an interview with a Moscow doula:

И всё до потужного периода более-менее естественно выглядело (они как бы встали на путь гуманизации). Но, когда женщина раскрылась в полное раскрытие, её, как обычно, посадили на кресло, собралась вся бригада, и её стали жёстко растуживать. [...] А детский врач подошла и начала командным голосом: «Так, ребёнку очень плохо, он сейчас страдает, ты должна постараться, давай, делай вдох и тужься изо всех сил». Ну как обычно вот эта вот история, выпучив глаза, да? Акушерка ей показывает так пальцем: «Ну что ты ещё, дай ей спокойно войти как бы в процесс», а та показывает на часы: «Время, мне идти пора, давайте уже родим, и я пойду». То есть здесь включаются не интересы женщины, а интересы персонала — собрались около родильного стола: «ну давайте уже побыстрее её родим». И тогда всё в ход идёт эпизиотомия, потому что она ускоряет — расширили просто проход. А то, что у женщины потом будет на самом деле шов, там будет у неё достаточно глубокий рубец, там будут затянуты ткани. И это будет долго заживать — это целый месяц восстановительного периода. Потому что это шов, он болит, он как бы там стягивается, его надо обрабатывать, его нужно там, за ним ухаживать всяко. Сидеть нельзя. Ну, куча всяких неудобств

[And everything before the active period looked more or less natural (they seemed to have embarked on the path of humanization). But when the woman was fully dilated, she was, as usual, put on a chair, the whole team gathered, and they began to heave her around roughly. [...] And the pediatrician came up and began with a commanding voice: “So, the child is very bad, he is suffering now, you have to try, come on, take a breath and push with all your might.” Well, it’s the usual story, with bulging eyes, yes? The midwife points her finger at her, like this: “Well, what more do you want, let her calmly enter in the process,” and the pediatrician points to the clock: “It’s time, time for me to go, let’s give birth, and I’ll go.” That is, it is not the interests of the woman, but the interests of the staff—they gathered around the delivery table: “Well, let’s deliver her as soon as possible.” And then the episiotomy comes into play because it speeds it up—they just widened the passage. And the fact that the woman will then actually have a suture, there will be a fairly deep scar there, the tissues will be tightened there. And it will take a long time to heal—this is a whole month of recovery. Because this is a suture, it hurts, it kind of shrinks there, it needs to be treated, it needs to be cared

for in every way. You can't sit. Well, a lot of inconveniences] [Svetlana Shnyrova, 17 February 2018].

This doula emphasizes the medical personnel's responsibility, not the woman's, unlike the midwife above. They approach the situation from two different perspectives and explanatory models, given their roles in the process, it appears. Importantly, while preparing for childbirth, women can choose personal assistants suitable for them and plan the degree of medical intervention that is acceptable to them. Thus, despite their difference in status, roles, and explanatory models, personal midwives and doulas provide "empathic witnessing of the existential experience of suffering" [Kleinman 1988: 10].

Based on interviews and my observations in maternity hospitals, I have found that women striving for "natural" childbirth in hospitals (according to a popular explanatory model held by parents) refuse a number of medical interventions. For example, they sign an informed consent waiver for oxytocin stimulation (typically prescribed for an anhydrous period or for weak or irregular labor, according to delivery protocols, but in deliveries with CMI, it is administered in most cases to speed up the process), anesthesia or pain relievers, amniotomy, episiotomy, and infant vaccinations. As a Moscow doula told me [Doula 4, 1 April 2020], "идеальная практика невмешательства в роды — без навязывания сценариев протокола — редко, но случается" [the ideal practice of non-interventive childbirth—without imposing protocol scripts—is rare, but it does happen]. In order to minimize the risks of excessive intervention, some resilient Russian women calculate arrival time at the hospital to avoid the routine use of invasive procedures and drugs, but to ensure adequate medical care during the active phase of labor. They may also prepare an oral or written plan and, less often, properly executed refusal of these treatments, if they are trained in legal genres [Bakhtin 1986; Hull 2012]. The practice of written informed consent forms or the refusal of routine medicalization (for certain forms of medical intervention) was established by federal law 323-FZ and is one of the most common ways to mobilize the law in the everyday context of contemporary obstetrics system [Black 1973, 2010; Ewick and Silbey 1998, 2003]. However, as the preceding and next interviews both show, it is difficult for women to ensure the implementation of their plans due to the nature of the communicative situation and the specifics of medical speech practices (see also Belousova 2003; 2012 and Kuksa 2020b for further discussion).

Но вы знаете, врачебная какая штука есть. Что, если женщина начинает отказываться, они начинают объяснять так, что женщине становится страшно. Ну, то есть «если ты не подпишешь, ты, конечно, можешь не подписывать, но, если ты не подпишешь, все умрут». Типа такого, да? Ну, так везде, мне кажется. ... мне кажется, врачи некоторые говорить так учат врачей, в общем, немножко запугать, потому что они всё-таки отвечают, там, за жизнь, да? И им

тоже наверно немножко тревожно, если женщина от чего-то отказывается, что они считают абсолютно необходимым

[But do you know this medical thing. That if a woman starts to refuse, they begin to explain in such a way that the woman becomes scared. Well, that is, “if you don’t sign, you certainly cannot sign, but if you don’t sign, everyone will die.” Like that, right? Well, it’s everywhere, it seems to me... it seems to me that some doctors teach doctors to speak like that, in general, to intimidate a little, because they are still responsible for life, right? And they, too, are probably a little anxious if a woman refuses something that they consider absolutely necessary] [Doula 8, 10 April 2020].

As Kleinman has argued, the meanings of illness (and, I would add, its treatment) are “polysemic and multivocal” [Kleinman 1988: 8], which we can see in patient and family stories. Even though some women reject certain medical interventions, my interviews reveal that other women have different expectations and ideas about childbirth. They do not refuse early or prolonged hospitalization, medical intervention, or analgesia. Women describe worries about having an experienced anesthesiologist on staff (or on the delivery team) and the availability, sufficient quantity, and quality of analgesics during labor with CMI. Therefore, these interlocutors arranged for an early arrival at the hospital to have time for procedures prescribed by standard protocols or entered into informal relationships with the anesthesiologist and other personnel in order to provide quality care [Kuksa 2020b].

It should be noted that, in some metropolitan and most regional maternity hospitals, doctors generally oppose the right to refusal by patients within the framework of deliveries with CMI.

И у нас точно нет в Петербурге такого, что при подписании этих бумаг (информированных согласий) как-то это обсуждалось на потоке, скажем так, да. То есть, как правило, пожелание, какой-то план родов, может обсуждаться клиенткой, если это контрактные роды с выбранным врачом. Или если это домашние роды с акушеркой

[And we certainly do not have this in Saint Petersburg that, when these papers (informed consent) were signed, it was somehow discussed on the fly, let’s say. That is, as a rule, a wish, some kind of delivery plan, can be discussed by the client if it is a contract delivery with a chosen doctor. Or if it’s a home birth with a midwife] [Doula 10, 16 May 2021].

If the refusal of interventions as provided by 323-FZ produce conflict, or the parties encounter violations in medical care and interactions, there are cases of formalized confrontation and medical and patient litigation, when midwives,

doulas, or birth partners can strengthen the position and agency of a woman. Medical staff also fear prosecutorial and judicial investigations as a result of adverse consequences after childbirth (especially if it did not conform to the established protocol). As a consequence of this concern, according to my interviewees, the practice of defensive medical litigation has spread recently in Russia. Attending doctors at maternity hospitals use expedited court procedures to file claims against “unreliable” patients, as a Petersburg doula explained,

Однажды на женщину, которую я готовила к родам, 10 роддом Санкт-Петербурга подал иск в суд с формулировкой «угроза жизни и здоровью ребёнка» в 2017 году. Причина — женщина ушла до выписки и написала отказ от госпитализации. Благодаря хорошему юристу суд был выигран. Я оказывала помощь в поиске адвоката

[Once the 10th Maternity Hospital of Saint Petersburg filed a lawsuit against a woman whom I was preparing for childbirth with the wording “a threat to the life and health of the child” in 2017. The reason—the woman left before she was discharged and wrote a refusal to be hospitalized. Thanks to a good lawyer, the case was won. I helped find a lawyer] [Doula 6, 4 April 2020].

At the same time, the stories tell of courageous women who, in the face of intimidation and disregard for their wishes, take advantage of their right to change doctors, break contractual agreements, or submit pre-trial complaints to higher authorities while in labor or after childbirth, as we see in the quotation below:

Это как раз было там, где врач отказался меня пускать на роды, он стал потом давить на женщину, что роды надо возбуждать. В итоге она разорвала контракт, потому что, когда она отказывалась, он давил на нее психологически, пугал

[This was exactly where the doctor refused to let me into the delivery, he then began to put pressure on the woman to stimulate labor. As a result, she broke the contract because, when she refused, he put pressure on her psychologically, frightened her] [Doula 3, 1 April 2020].

Written records produced by women about ignoring their wishes in situations of legally guaranteed patient choice force physicians to respond quickly and resolve conflicts *in situ* to avoid a formal legal appeal. Therefore, the stories sometimes tell of cases when electronic appeals and pre-trial complaints have the desired effect on the staff, as in this citation:

Была направлена жалоба с сайта Минздрава Саратовской области в 2017 году: женщине угрожали — не выписать ее из роддома без внутреннего осмотра дежурным гинекологом. Через полчаса

пришла заместитель главного врача, мило улыбалась, спросила в чем суть претензии — не нашла повода не выписывать. И они ушли домой

[A complaint was sent from the website of the Ministry of Health of the Saratov Region in 2017: they threatened not to discharge a woman from the hospital without an internal examination by the on-call gynecologist. Half an hour later, the deputy chief physician arrived, smiled sweetly, asked what the essence of the claim was — she found no reason not to discharge. And they went home] [Doula 5, 2 April 2020].

Sometimes doulas take part in individual complaints and claims to protect the injured woman, as we see below, or testify in defense of the client if a claim is filed by a medical organization. However, the illegal status of non-medical assistants in the maternity hospital and informal participation as quasi-relatives does not allow them to be in targeted opposition to the system without potentially negative consequences for their career, except in rare cases. One doula told me “Медики плохо относятся к доулам, на одну жалобы даже подавали в прокуратуру” [Medical providers have a bad attitude towards doulas, one complaint was even filed with the prosecutor’s office] [Doula 9, 20 September 2021]. Another outlined a similar situation based on her experience.

Я написала жалобу на врача в 2013 году, который непотребно себя вел с моей клиенткой, писала в Департамент. Это спустили главному врачу. В итоге этот заведующий отделением мне потом отомстил — в следующий раз он отказался меня пускать в 18 роддом Москвы (сейчас закрыт)

[In 2013, I wrote a complaint against a doctor who had behaved improperly with my client, I wrote to the Department. This was kicked down to the head physician. As a result, this department head later took revenge on me—the next time he refused to let me into the 18th maternity hospital in Moscow (now closed)] [Doula 3, 1 April 2020].

The controversies they describe, which had reached the stage of filing official complaints and lawsuits, are a variant of civil and criminal law mobilization [Black 1973, 2010; Kuksa 2011]. They are initiated to compensate for harm, investigate the improper provision of medical services (medical misconduct or legal infractions), and to hold medical professionals accountable.

Despite these descriptions of clashes between participants in obstetric care, litigation mechanisms to resolve conflict are rarely used by patients or doctors in Russia. Nevertheless, criminal prosecution of doctors has an enormous perlocutionary effect and is actively discussed in conversations and in thematic perinatal social media groups. They emphasize women’s powerlessness and vulnerability, obstetric aggression and medical neglect and harm, and the

inhumanity of the system. At the same time, the medical community in the media space condemns patient litigation (calling it “patient extremism”) and laments the lack of protection for doctors in the face of legal prosecution and by the Prosecutor General's Office in particular [Kuksa 2020a]. The activism on the part of perinatal specialists led to a range of network and vernacular strategies to protect women, particularly since individual legal remedies are so rarely an option, because of ignorance of legal genres. Such cases, as we see below, demonstrate how midwives and doulas have mobilized women to take a more active role in childbirth.

Protecting Patients: Vernacular Resistance Strategies

In 2016, two regional representatives of the doula community with degrees in psychology launched the flash mob #violence_in_childbirth. They have collected more than 1000 digital anonymized stories of Russian women, written mainly in the genre of abuse narratives on a single social network [Goriacheva and Ushankova 2016]. The organizers of the network action believe that “тема акушерской агрессии табуируется обществом, ведь главное в родах — это живая мама, живой ребенок. А роды — ну да, больно, страшно, грязно, следует потерпеть, а потом попытаться все забыть” [the topic of obstetric aggression is taboo in society, after all, the main thing in childbirth is ‘a living mother, a living child,’ and childbirth—well, yes, it hurts, is scary, dirty, you should be patient, and then try to forget everything] [Goriacheva and Ushankova 2016]. Separate hashtags were proposed to classify the types of violence in childbirth, namely psychological abuse (insults, blackmail, gaslighting) and physical violence (face slaps, forcing out a child, cutting the perineum and other interventions without the woman’s consent). Using these classifiers and the stereotypical narrative model for describing childbirth [see Kuksa 2018 for a discussion], women negatively described their experience of being in a modern maternity hospital, obstetric aggression, medical neglect and harm, and psychological and physical abuse during childbirth. The following quotation displays typical invectives and accusations from medical personnel, as described by an anonymous woman on the digital flash mob:

...каждый раз мне говорили, что так я угроблю ребёнку. Сил от этого не прибавлялось, прибавлялся дикий страх и истерика от собственного бессилия. Через 2 часа такого “тужения”, у меня начались настоящие потуги и меня заставили лезть на стол высокий (это с обездвиженной одной ногой), хорошо муж был и затащил меня туда. И тут мне сказали, что ребёнок застрял в родовых путях и в этом виновата я. Ко мне в палату в ближайшие 1,5 часа человек 15 врачей заходило, все взволнованные бегали. Моего ужаса не передать. Сил тужиться не было совсем, все ругали меня и пугали ещё больше. В итоге сделали мне эпизио, но и оно не помогло и

тогда 3 человека локтями начали давить ребёнка. Достали дочь всю фиолетовую, с обвтием

[...every time they told me that I would ruin the child this way. Strength did not increase from this, added wild fear and hysteria from my own impotence. After two hours of such “pulling,” real contractions began, and they forced me to climb onto a high table (this is with one leg immobilized), it was good that my husband was there and dragged me up there. And then they told me that the child was stuck in the birth canal, and I was to blame. In the next 1.5 hours, about 15 doctors came to my ward, everyone ran excitedly. My horror is indescribable. I didn’t have the strength to push at all, everyone scolded me and frightened me even more. As a result, they did an episio[tomy] to me, but it didn’t help either and then three people began to crush the child with their elbows. We got our daughter all purple, with entanglement [from the umbilical cord] [Anonymous, 20 October 2020].

On the one hand, the narratives presented are anonymous and not directly addressed to actants that are assigned the role of rapists and abusers. According to Bakhtin, every statement has an addressee, “the reciprocal understanding of which the author seeks and anticipates” [Bakhtin 1986: 322-323]. The actual readers of the network flash mob (addressees of the message) are an indefinite circle of people involved in a single emotional experience, most likely the initiators and authors of stories, as well as journalists and researchers. Functionally, network narratives about medical abuse reproduce the pragmatics of the widespread ritual practices of “closing labor” [Kuksa 2020b], which are actively used by individual perinatal specialists for a woman’s postpartum recovery. The continued revitalization of traditional rituals in modern urban culture testifies to the continuity with the “post-Soviet maternity ritual complex” [Rouhier-Willoughby 2008]. On the other hand, despite changes in infrastructure and a new context for labor and delivery, some of the motifs in childbirth narratives testify to the partial continuity of invective speech genres [Belousova 2003] used by physicians along with the “conveyor” practices of obstetrics.

The confessional narratives of the flash mob (as well as the modern rituals of closing childbirth) allow women to voice their traumas, suffer, and let go of unjustified expectations and resentments. They strengthen and transform negative emotions through narration, gain support from similar stories, and express solidarity with other victims. Such texts rather quickly “infect” the network communicative spaces and become explanatory folk models [Garro and Mattingly 2000; Kleinman 1978, 1988]. Vernacular discourse and narratives thus describe psychophysical experience and contextualize the interaction between women in labor and medical personnel [Bakhtin 1986; Garro and Mattingly 2000; Khristoforova 2020; Kitta 2019; Kleinman 1978, 1988; Mattingly 1998], becoming an acceptable and formulaic “socially sanctioned outlet” [Dundes 2003], with which one can try to express an uncomfortable traumatic experience

of childbirth and designate a guilty or responsible actor. As Rouhier-Willoughby has argued, an essential feature of the (post-) Soviet ritual complex is simultaneous resistance and acceptance [Rouhier-Willoughby 2008: 112].

If the model of a network flash mob implies personal articulation of traumatic experiences and collisions with suffering, emotional solidarity with the victims of “obstetric aggression” and “psychological” and “physical” violence presupposes the use of appropriate psychoanalytic terminology and a stereotypical narrative model that mandates a suffering victim and an abuser. In comparison with formulaic folk models of narratives, online petitions require participants (petitioners and signatories) to have a different, bureaucratic conversation and require people to arm themselves with human rights terminology, so that the format and content of the appeal is accessible and understandable to the addressee, as we will see below.

Protecting Patients: Collective Network Strategies

Russian perinatal specialists and human rights activists commonly organize online (or, less commonly, hard-copy) petitions to protect the rights and free CMI of pregnant women and their families. Online activism mobilizes the law through collective appeal to public authorities within the framework of pre-trial feedback or class action legal proceedings [Kuksa 2011, 2020a]. Two cases from my fieldwork, one from 2017 and another from 2019, will illustrate this process.

On 29 March 2017, perinatal rights activists Olga Arutiunian and Nadezhda Anan'eva from Krasnoirsksk and Ekaterina Mariposa from Moscow, with the assistance of the lawyer Arina Pokrovskaia, launched a network campaign to protect pregnant women, regardless of their place of residence, material resources and marital status, and ensure their right to free childbirth accompanied by a partner of their choice [Arutiunian et al 2017]. The authors of the petition hoped to amend Article 51 of 323-FZ to expand support for patients in state-sponsored wards during labor and delivery. They argued that the current interpretation of the law by medical organizations was too narrow. Hospital personnel sometimes demand documented proof from relatives and allow only a husband, mother, or an adult daughter into the delivery room. Therefore, from the point of view of the authors of the petition, they discriminate against those that do not meet these criteria, e.g., widows, unmarried women, and military wives, to name a few (for a complete list, see (6)).

The authors of the petition also wanted to eliminate the requirement for medical testing for certain diseases (by analogy with visits to an intensive care unit). They also demanded birth-partner access to the operating room, as is customary elsewhere in the world. They also pushed for removal of the right of physicians to set restrictions on partner deliveries “at their own discretion,” because the wording (“taking into account the state of the woman in labor”) is vague and can justify barring birth partners for no actual medical reason.

The petition was posted on the Change.org portal under the title: “Supported childbirth should be available to all Russian women.” A year later, on 12 March

2018, Pokrovskaia announced that she had sent a collective appeal by registered mail to the authorities of the Russian Federation. The departments promised her to take into account the proposed “legislative initiative.” Over the last five years, the petition has garnered 13,861 signatures (as of 10 June 2022). Despite significant numbers of supporters, not a single legislative initiative about these proposed changes has been introduced.

Two years later, in 2019, the founder, director, and lead educator at the Doula Link Institute of Perinatal Support (the largest educational doula project in Russia) Ekaterina Jitomirskaia-Schechtman also began an online appeal directed at regulators. She is also a renowned doula, a former midwife, and a member of APD. On 26 February 2019, Jitomirskaia-Schechtman initiated a campaign on Facebook to send appeals to the Russian Ministry of Health and regional health departments in protest of restrictions on doulas’ volunteer initiatives and professional support for mothers [Jitomirskaia-Schechtman 2019]. A template with blanks for a woman to complete was developed for this purpose. Their testimonies confirm discriminatory situations when using CMI: if denied the opportunity to call a spouse or mother, other birth partners were refused admittance. Doulas also pointed to the closure of volunteer projects based at maternity hospitals, which has led to the elimination of free professional support from doulas during delivery.

In informal conversations, officials explained to the doulas that there was no significant demand for professional support from patients. However, in response to numerous individual appeals from women that responded to Jitomirskaia-Schechtman’s initiative, regulators provided the standard response that the law does not guarantee the right to a “non-family” partner during delivery when using CMI. As one Moscow doula reported, despite patient and doula support for an amendment to the law, they would not succeed without *blat* [pull, connections] [Doula 1, 29 August 2021]. To date, the Ministry of Health of Russia continues to ignore requests by the Institute of Perinatal Support and APD, despite the implementation of a state program to support volunteerism and unpaid assistance by civic activists in medical institutions since 2018-2019.

Therefore, unlike the vernacular narrative model discussed above, these statements are produced by legally competent senders trained in this genre and directed toward regulators of the Russian obstetric care system. Network statements functionally reproduce the legal pragmatics of individual and collective appeals to public authorities with a request, proposal, complaint, or claim within the framework of the methods of pre-trial feedback or legal proceedings [Kuksa 2011, 2020a].

Protecting Patients: Collective Strategies in the COVID-19 Pandemic

The COVID-19 pandemic only exacerbated the situation for perinatal specialists and patients. Spring 2020 regulatory restrictions to prevent the spread of COVID-19, digital surveillance, and sanctions (in the form of fines for violations) have temporarily suspended daily physical communication and non-

medical assistance in medical institutions (at least in the Moscow region and Tatarstan). At the same time, interdependence has increased, while patient choice and the usual pre-COVID volume of medical care for patients have been reduced [Kuksa 2020a, 2021a, 2021b]. Pregnant women and women in labor found themselves in a forced medicalized “COVID-19 reality” while in an extremely vulnerable state, feeling insecure, fearful, and even guilty about making decisions about care.

My informants have intensified their protests since March 2020. Moscow doulas and human rights activists released strident statements in the media, on social networks, at conferences, and in interviews about the illegality of the prohibition on partner births and the forced separation of mothers and babies in Moscow and regional maternity hospitals [Kuksa 2021b].

Restrictive decisions by the Moscow *Rospotrebnadzor* [the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Well-Being] and the Moscow Department of Health on 12 and 13 March 2020 that “prohibit the admission of visitors to hospitals” led to an absolute ban of family-oriented births in the wake of the general lockdown [Kuksa 2021b]. Appealing either to the “quarantine” regimen or to the “ban on the admission of visitors to hospitals,” by the end of March 2020 (and through August of that year), all Moscow maternity hospitals, except for one private hospital, had suspended birth partners of any kind from both CMI and paid deliveries. A Moscow doula describes her reaction to these restrictions as follows:

Но вот именно попытки запрета партнерских родов я переживала тяжелее, чем то, что сейчас. Потому что ощущалось, что все, что мы выстроили (мы это обсуждали в доульском сообществе), все, что мы строили столько лет — эти доверительные отношения с роддомами, которые немножко откатились назад после ситуации [уголовного дела на перинатального специалиста]. И вот сейчас все стало вроде исправляться. И началось опять волонтерство потихоньку. И опять все схлопнулось! И опять черте что, извините

[But I have experienced more difficult attempts to ban partner childbirth than there are now. Because it felt like everything that we built (we discussed this in the doula community), everything that we built for so many years—these trusting relationships with maternity hospitals, which had rolled back a little after the situation [of the criminal case against a perinatal specialist]. And now everything seems to be getting better. And once again, volunteering had begun slowly. And again, everything collapsed! And again, all to hell, sorry] [Doula 2, 31 March 2020].

By default, as with partner births, support by doulas was prohibited. As a rule, due to their illegal status, doulas were viewed not as perinatal professionals, but as quasi-relatives of any woman in labor relying on CMI, as this doula went on to explain:

До этой недели, которую Путин объявил типа выходной/нерабочей насильственно, пускали в 70-й роддом. Потом с обеда субботы, последней субботы, доул перестали пускать. И пап стараются не пускать в 70-й роддом. Под прикрытием того, что: «Да, главный санитарный врач, конечно, не может запретить партнерские роды, но Путин сказал: «Все обязаны сидеть дома». Значит, папы должны сидеть дома и доулы должны сидеть дома». Понятно, доулы бороться не могут, папы бороться могут. А до этого было очень дружелюбно к доулам и можно было по ОМС пройти доуле с папой вместе в 70-м, да

[Until this week, which Putin declared forcibly as a day off/non-workday, we were allowed to enter the 70th Maternity Hospital. Then from Saturday afternoon, last Saturday, doulas were no longer allowed. And they try not to let dads into the 70th Maternity Hospital either. Using the excuse that “Yes, the Chief Sanitary Doctor [the head of *Rospotrebnadzor*], of course, cannot prohibit partner childbirth, but Putin said: “Everyone is obliged to stay at home.” So, dads should stay at home and doulas should stay at home. It is clear that doulas cannot fight, dads can fight. And before that it was very friendly to doulas and it was possible for a dad and a doula together to get into the 70th using CMI, yes] [Doula 2, 31 March 2020].

Moscow doulas pointed out the injustice and discrimination against women, who were prohibited from having birth partners during state-sponsored childbirth, while the private perinatal hospital MD Group provided for partners at a cost few could afford despite the pandemic regulations to reduce the spread of coronavirus infection. Since pregnant women were denied the presence of their spouses, even in deliveries when paying themselves, women urgently sought out new doctors and maternity hospitals where birth partners were allowed or drew up private contracts with midwives who worked in maternity hospitals that welcome a “soft birth” approach in “commercial” departments.

In interviews and on social media, professional doulas with a legal education complained frequently about the limits of the anti-epidemic regulation and the fact that the edict issued by *Rospotrebnadzor* should not abridge the rights of pregnant women guaranteed by 323-FZ [Kuksa 2020a]. For example, the same Moscow doula mentioned it in her interview as well:

Да, в этом постановлении нет ни слова о партнерских родах — там только о посещении стационаров. Посещение стационаров законом не гарантировано. А партнерские роды — с отцом, по крайней мере, с членом семьи, — законом гарантированно. И под это дело мы тушкой и чулком — папы с моим заявлением, которое я для них разработала, — пролезали в роддома до последних дней. Я сама проходила — вот последний раз я была 27 марта в роддоме — в 70-

м, в Новогиреево. Сейчас Москву зарубили на эту тему полностью. Сказали: «Все, все мы боимся — не будем пускать никого, может только самых настойчивых пап». И партнерские роды у нас остались только в Московской области. [...] Я надеюсь со своей девочкой съездить, потому что у нее сломана спина и первые роды, ей не нужна эпидуральная анестезия, ей нужны естественные методики помощи. Мы очень уповаем на возможность все-таки родить «партнерски»

[Yes, in this resolution there is not a word about partner childbirth—there is only about visiting hospitals. Hospital visits are not guaranteed by law. And partner childbirth—with the father at least, with a family member—is guaranteed by law. And in this case, by hook or by crook, the dads with my application, which I developed for them, got into the maternity hospital until the last few days. I myself got through—the last time I was in the hospital on March 27—in the 70th, in Novogireevo. Now this topic has been completely shut down in Moscow. They said, “Everyone, we are all afraid—we will not let anyone in, maybe only the most persistent dads.” And delivery with partners remained possible only in the Moscow region. [...] I hope to go with my girl [a client], because she has a broken back and it’s her first birth, she does not need an epidural, she needs natural methods of help. We hope very much for the opportunity to attend partner births] [Doula 2, 31 March 2020].

From the point of view of Russian human rights activists, if a “state of emergency” had not been introduced, it is only through legislative means that federal laws (namely Article 51 of 323-FZ) may be suspended [Kuksa 2020a]. Lawyers and professional doulas with a legal education, as one discusses below, also wrote to the administration of maternity hospitals, *Rospotrebnadzor*, and to prosecutors of Moscow and the Moscow region asking for an explanation of the legal grounds for limitations on the rights of patients as guaranteed by 323-FZ.

Мы с Марией [...] написали обращения в Роспотребнадзор и прокуратуру. Но пришла отбивка, что ответят в течение месяца. Это было 18-19 марта. Когда роддома стали захлопывать для партнеров массово. И некоторые мои женщины написали жалобы. Но некоторые и смирились

[Maria [a lawyer] and I [...] wrote appeals to *Rospotrebnadzor* and the prosecutor’s office. But they wrote that they would answer within a month. That was March 18-19. When maternity hospitals began to close en masse for partners. And some of my women have written complaints. But some have resigned themselves] [Doula 2, 31 March 2020].

A similar situation unfolded in other regions, but not as quickly as in Moscow. Perinatal specialists in those areas relied on human rights activists and their support initiatives, including with money transfers for legal costs. One regional doula told me that she hoped that “чтобы нашлась отважная роженица с мужем, которые бы отстаивали свое конституционное право на партнерские роды в условиях ограничений в связи с коронавирусом” [a brave woman with a husband could be found who could defend their constitutional right to partner delivery despite COVID restrictions]” [Doula 5, 2 April 2020]. In rare cases, married couples outside of the Moscow region tried to defend the rights guaranteed by federal law 323-FZ in the courts, as a Pskov doula told me:

И вот [одна] из последних побед — в наше ковидное время мы добились. Была такая пара, они работали с юристом. [...]. Благодаря ей эта пара прошла в роды сейчас, вот буквально неделю назад прошел муж на роды. [А во время ковида и до сих пор нельзя [было]]? Нет, закрыто, закрыто. Ковид и все. Роспотребнадзор, главврач Роспотребнадзора запретил. Дальше был суд. И были выставлены требования — при каких условиях можно пройти. Они эти требования соблюли. И все — они родили вместе... вот неделя, 10 дней назад

[And here is [one] of the last victories that we have achieved in COVID time. There was this couple, they worked with a lawyer. [...]. Thanks to her, this couple went to the delivery now, just a week ago, the husband went into delivery. [And during COVID and up to now [was] it not allowed]? No, closed, closed. COVID and all. *Rospotrebnadzor*, the head physician of *Rospotrebnadzor* forbade it. Next was the trial. And the requirements were set—under what conditions you could get in. They met these requirements. And that's it—they were at the delivery together... a week, 10 days ago] [Doula 14, 18 September 2021].

After the subsequent official relaxation of restrictions (for a vote on a constitutional referendum) and changes in the March decree by the mayor of Moscow on 8 June 2020, partner birth did not return to Moscow maternity hospitals. On 11 June 2020, human rights activist and member of the APD Maria Molodtsova posted a proposal for the return of partner deliveries entitled “Supported childbirth should be available even in an epidemic” on the “Russian Public Initiative” website [Molodtsova 2020]. This Internet resource was created to accommodate public initiatives by citizens pursuant to presidential decree №183 (4 March 2013). Such initiatives mobilize the law through a collective appeal to public authorities. A proposal will be considered by federal authorities if signed by more than 100,000 citizens. Voting on Molodtsova’s initiative ended on 21 December 2021; only 528 votes supported the idea, 95 votes were against. The low number of supporters can be partially explained by the fact that partnered

births in Moscow were once again allowed in August 2020, so that the proposal had become moot for in the Moscow region.

Meanwhile, perinatal specialists from other regions complained that, unlike in Moscow, partner- and doula-accompanied births were still not possible in most cities. One doula said “сейчас только в платном можно. [...] Да, а родовспоможение лет на десять в прошлом в сравнении с Москвой” [Now you can only [have a doula] in a for-pay [ward]. [...] Yes, but, compared to Moscow, obstetric care is ten years in the past] [Doula 11, 15 September 2021]. Another expressed the same opinion: “Ну и вообще доступ в роддома ограниченный. Иногда мужей пускают, но доул, кроме мужей, не пускают. И то мужей пускают только в два роддома из семи, вот, и то по контракту только” [Well, in general, access to the maternity hospital is limited. Sometimes husbands are allowed, but doulas, other than husbands, are not allowed in. And then husbands are allowed only in two out of seven maternity hospitals, there, and then only under a contract] [Doula 12, 17 September 2021].

Since the beginning of COVID-19, perinatal activists have been mobilizing all available forms of civic and human rights activism—from volunteer projects and network protests calling people to fight for partner birth, support by a doula, and patient rights, to complaints to the prosecutor’s office and the organization of collective appeals and petitions to federal government bodies.

Doulas note with regret that some Russian women show aggression towards rights activists, and the overwhelming majority display inaction and non-resistance, even if they can improve the situation through bureaucratic means. A Moscow doula describes this situation:

Просто люди же разные: не все хотят бороться. Меня в том же инстаграме в нескольких местах просто помоями облили. Мы делали общий прямой эфир [...] про партнерские роды. [...] И очень многие сказали, что «я враг, что я враг всех врачей, хочу, чтобы мужья заразили врачей. И вообще меня нужно распыть, убить и так далее». Люди у нас, к сожалению, в отличие от Нью-Йорка, где мамы выбили себе партнерские роды, написав губернатору, и у них все это восстановили и возобновили. У нас, к сожалению, очень многие люди сами не хотят, хотят сильную руку и все вот это печальное, что меня вгоняет в около депрессивное состояние, скажу вам честно. Ну что ж? Будем держаться

[It’s just that people are different: not everyone wants to fight. In the same Instagram in several places, they just trashed me. We made a general live broadcast [...] about partner childbirth. [...] And many people said that I was the enemy, that I was the enemy of all doctors, that I want their husbands to infect doctors. In general, I needed to be crucified, killed and so on. Unfortunately, our people are unlike New York, where mothers knocked themselves out for partner childbirth by writing to the governor, and they have it all restored and resumed.

Unfortunately, many people here do not want to do for themselves, they want a strong hand, and all this is sad that it drives me into a depressive state, to be honest. Well, we'll be hold on] [Doula 2, 31 March 2020].

In pandemic conversations, other pessimistic doulas describe the manifestation of “learned” helplessness and inertia in Russian women, especially in comparison with the victories of Western perinatal specialists, which, from afar, seem much more impressive than their own Russian successes.

Сейчас у них ограничение — один человек. И женщины вынуждены думать, кто это будет - или муж, или доула, да, например. Это то, с чем я сталкиваюсь в разговорах с коллегами из Израйля. Некоторые больницы у них запретили вообще. Вообще запрет касается женщин, которые поступают в роды с признаками инфекции, да, респираторной. Но это как бы, мне кажется, это нормально и понятно, да, почему это происходит. Но тем не менее какие-то ограничения ввели сразу. В том же Нью-Йорке наши коллеги говорят, что... Ну, вы знаете эту историю, да? [Читала.] Что женщины просто отстояли. И поэтому им разрешили. У нас, к сожалению, женщина очень инертна. И добиться вот такой массовой инициативы, мне кажется, это очень сложно. Не думаю, что это вообще нереально, но это должно быть какое-то прямо движение, движение. У нас еще сидит такое, что, ну, сказали: «Нет». Значит, нет. Или вот еще: «Ну, все же рожали без поддержки, ну и я как-нибудь рожу». То есть, женщины сами себя...

[Now they have a limitation of one person. And women are forced to think who it will be—either the husband or the doula, for example. This is what I come across in conversations with colleagues from Israel. Some hospitals have been forbidden to them altogether. In general, the ban applies to women who enter childbirth with signs of infection, yes, respiratory. But it seems to me that this is normal and understandable, yes, why this is happening. But nevertheless, some restrictions were introduced immediately. In New York, our colleagues say that... Well, you know this story, right? [I read it.] The women defended it. And so, they were allowed. Unfortunately, our woman is very inert. And to achieve such a massive initiative, it seems to me, is very difficult. I don't think it's unreal at all, but it must be some kind of movement, movement. We still have such a thing like, well, they said: “No.” So, no. Or here's another: “Well, everyone used to give birth without support, well, I'll give birth somehow”. That is, women do it to themselves...] [Doula 7, 5 April 2020].

Some perinatal specialists nevertheless reacted with understanding to quarantine bans and isolation of women in labor from families, as in the quotation below,

since they are familiar with similar restrictive policies in other countries and, in principle, consider them reasonable and permissible.

Сопровождения запрещены. Это карантинная мера. И они запрещены по всем роддомам Москвы. [...] [А запрещены и папам тоже, да?] Да. Всем. Партнерские роды вообще. Ну, это карантинная мера. Это форс-мажорные обстоятельства. Да, то есть мы должны понимать, что это не потому, что врачам захотелось перестать пускать партнеров на роды. Это именно для того, чтобы избежать распространение инфекции. Как бы, понятно, что к этому есть вопросы. Но тем не менее... как бы Главный санитарный врач выпустил такое распоряжение. Все роддома прикрыли до особого распоряжения. В принципе это нормальная мера. Это то же самое, как сезонный карантин по гриппу, да, когда каждый роддом сам принимает решение

[Partner support is prohibited. This is a quarantine measure. And they are banned in all maternity hospitals in Moscow. [...] [And dads are also forbidden, right?] Yes. Everyone. Delivery with partners in general. Well, this is a quarantine measure. These are extreme circumstances. Yes, that is we must understand that this is not because the doctors wanted to stop letting partners into delivery. This is precisely to avoid the spread of infection. As it were, it is clear that there are questions about this. But nevertheless... the Chief Sanitary Doctor [the head of *Rospotrebnadzor*] issued this order. All maternity hospitals have been closed until further notice. In principle, this is a normal measure. This is the same as seasonal flu quarantine, yes, when each maternity hospital makes its own decision] [Doula 7, 5 April 2020].

Since the very first days of the pandemic, the freedom of choice for the location and the team for the delivery, which provided for competition between maternity hospitals and doctors, has been restricted in larger cities. Both individuals providing and receiving medical aid have lost their pre-COVID agency and have been turned into objects of medicalization and budgeting (of the Ministry of Health of Russia) and are subject of public health and epidemiological controls (of *Rospotrebnadzor*). This situation has led, once again, to a rise in opt-out strategies for some women.

Opting-out during the COVID-19 Pandemic

During the pandemic, some Russian women made choice for home birth with the support of a midwife and doula out of fear. They worried about the risk of infection during childbirth, increased medical interventions, and separation from the newborn in a maternity hospital. Pregnant women, women in labor, and their relatives, who, pre-COVID, have legally guaranteed statuses of patients,

partners, legal representatives, or visitors, became “coronavirus threat sources” while on the premises of healthcare facilities, for doctors and for their own babies. The suspension of partners and doulas, and restrictions on the baby remaining with the mother, according to informants, contributed to a significant increase in illegal home births in the regions.

Вроде как партнерские роды из-за ковида стали невозможны — у нас жесткий карантин был в роддомах. [...] Женщины все чаще решают рожать дома, как вижу так — издалека. Но это очень в диковинку. И родные потом очень плохо это воспринимают. Индивидуальных акушерок с медицинским образованием нет. Я знаю трех доул, одну домашнюю акушерку. Только если договор с врачом заключать, но это совсем не гарантия мягких родов

[It seems like partner-accompanied births became impossible because of COVID—we had a strict quarantine in maternity hospitals. [...] Women increasingly were deciding to give birth at home, as I see it—from afar. But this is very unusual. And then the relatives perceive it very badly. There are no individual midwives with a medical education. I know three doulas, one homebirth midwife. Only if you conclude an agreement with a doctor, but this is not at all a guarantee of a soft birth] [Doula 9, 20 September 2021].

[А большой процент женщин, которые на это [домашние роды] идут? И в связи с чем? Вам это известно?] Да, большой процент и он увеличивается с каждым разом. Потому что, во-первых, в условиях пандемии сейчас, когда закрепилась практика разлучения мамы и ребенка до анализа ПЦР на коронавирус, стали очень бояться вот этого момента и больше стало домашних родов. [...] Потому что женщины стали бояться роддомов, перестали перекладывать ответственность на врача, стали сами изучать физиологию беременности и родов. [...] И негатива, конечно, много по этому поводу. [...] [Да, это я знаю, стигматизация до сих пор очень сильная. [...] 20–30% по вашему региону?] [...] Больше, конечно, от домашних акушерок эту статистику мы слышим. У них очень много. Они вообще не сидят без свободного времени. У них прямо вообще все под завязку. [А вы не знаете, они имеют официальное образование или сами учились?] Да, конечно, это женщины, как правило, с большим опытом работы в государственных роддомах, и в частных, и всяких. Они в итоге просто уходят в домашнее акушерство

[And the large percentage of women who go for this [home birth]? And in connection with what? Do you know?] Yes, a large percentage and it increases every time. Because, firstly, now it’s pandemic conditions,

when the practice of separating a mother and child before the PCR test for coronavirus had become established, they have become very afraid of this moment and there are more home births. [...] Because women began to be afraid of maternity hospitals, they stopped shifting responsibility to the doctor, they began to study the physiology of pregnancy and childbirth themselves. [...] And, of course, there is a lot of negativity about this. [...] [Yes, I know that, the stigmatization is still very strong. [...] However, 20-30%?] [...] More, of course, we hear these statistics from homebirth midwives. They have a lot. They are constantly busy. [Do you know if they have a formal education or did they study by themselves?] Yes, of course, these are women, as a rule, with extensive experience working in state maternity hospitals, and in private ones, and all kinds. They end up just going into home obstetrics] [Doula 13, 17 September 2021].

Unlike in Moscow, in other regions, epidemic-control restrictions banned partner and doula accompaniment for an extended period of time. Opportunities to choose the location and team for childbirth were reduced—thus, patient and parental rights were limited. Under authoritarian restrictions of patient agency, women have turned to home births and perinatal specialists have shifted to interactions with women into a space uncontrolled by and invisible to the state as in the first two post-Soviet decades. Therefore, these self-same authorities have ironically undermined, to some extent, the objectives of preventing the spread of COVID-19 by excessively reducing family and patient agency in maternity hospitals. This decision by women in regions usually seen as more conservative or traditional is strong evidence for the influence of perinatal activists on the Russian obstetrics system as a whole.

Conclusion

We have seen that protest and resistance to the medical system during labor and delivery may take many forms and has been significantly influenced by the grassroots efforts of independent perinatal specialists. They have changed the view of childbirth significantly, leading to vernacular models that call for “humane and soft” approaches to the process. While medical personnel may hold to established medical protocols, patients and perinatal specialists have, at least in some cases, means to resist them. Individual legal strategies of resistance are used exclusively by women who are prepared for childbirth, with experience in childbirth and/or a familiarity with requisite linguistic skills to negotiate the legal system. In addition, professionals with legal and/or doula skills rely on collective legal strategies addressed to regulators. The only resistance strategy that involves two-way interaction is discussions the woman’s plan and expectations for labor and delivery with the staff within the context of informed consent forms. Opting-out to avoid the system is chosen by women who had a negative experience during

their first delivery or in situations where the usual or expected patient agency and freedoms have been prohibited.

If a woman is inexperienced in these areas or unaccustomed to confrontation to express their agency, they choose retroactive strategies to protest the medical system. For example, they may share their narratives in digital flash mobs. Most often, flash mob abuse narratives describe situations of obstetric care using CMI and employ the vernacular genre of victim narratives. Alternatively, they may cope with their trauma during postpartum rituals to “close the birth,” which have become widespread over the last ten years. In either case, we find active perinatal specialists who participate in protests and develop women’s interactive skills with medical staff or help to cope with birth trauma.

Signature collection on electronic and hard-copy petitions links patient, medical and bureaucratic discourses and frames. Whether based on a template or not, digital or on paper, individual or collective letters to the authorities allow activists to articulate problems and indicate solutions acceptable to women and perinatal specialists. They can be perceived by senders as a kind of digital resistance calling for human rights. In general, mobilization by perinatal human rights activists of various methods of direct and symbolic protest communication with powerful actors gives women a greater voice. It has allowed for the successful presentation of patient rights in the maternity hospital. They have laid the legal and scientific groundwork to challenge established medical protocols by teaching and promoting new ideas and values that have led to this new vernacular model of childbirth in Russia.

NOTES

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2 A contract delivery in private Moscow maternity hospitals of Mark Kurtser with an experienced obstetrician-gynecologist, according to independent midwives, costs more than 800,000 rubles. For more information on MD Medical Group, see <https://mamadeti.ru/about/rukovodstvo/>.

3 For more information on the Moscow Center for Traditional Midwifery and Family Medicine, see <https://center-akusherstva.ru/o-nas/>.

4 The Institute of Perinatal Support (<https://doula.link/>) has produced 24 cohorts, for a total of over 800 professional doulas in their six-year existence.

5 For more information on the Association of Professional Doulas, see <https://doularussia.ru/about>.

6 Women who: used IVF with donor sperm; live far from family; without close relatives, orphans; minors, residents of orphanages; whose husbands work on a rotational basis, are on long-term business trips, or are in detention; whose husbands or other family members do not want to attend the birth for personal or

health reasons; do not want the presence of their close relatives but want the support of another person.

BIBLIOGRAPHY

- Arutiunian, Olga, Nadezhda Anan'eva, Ekaterina Mariposa, and Arina Pokrovskaiia. 2017. Арутюнян, Ольга, Надежда Ананьева, Екатерина Марипоса, и Арина Покровская. “Роды с поддержкой должны быть доступны всем женщинам” [Supported childbirth should be available to all Russian women]. *Change.org*. Cited <https://www.change.org/p/роды-с-поддержкой-должны-быть-доступны-всем-российским-женщинам>. (consulted 10 June 2022).
- Bakhtin, Mikhail. 1986. Бахтин, Михаил. “Проблема речевых жанров” [The problem of speech genres]. *Эстетика словесного творчества* [Aesthetics of Verbal Creativity]. Москва: 250-296.
- Belousova, Ekaterina. 2003. Белоусова, Екатерина. “Родильный обряд” [The Childbirth Rite]. *Современный городской фольклор* [Contemporary Urban Folklore]. Москва: 339-369.
- Belousova, Ekaterina. 2012. *Waterbirth and Russian–American exchange: From the Iron Curtain to Facebook*. Doctoral Dissertation. Houston: Rice University.
- Black, Donald. 1973. “The Mobilization of Law,” *Journal of Legal Studies* 2: 125-149.
- Black, Donald. 2010. *The Behavior of Law*. Bingley: Emerald.
- Davis-Floyd, Robbie and Elizabeth Davis. 1996. “Intuition as Authoritative Knowledge in Midwifery and Homebirth,” *Medical Anthropology Quarterly* 10(2): 237-269.
- Davis-Floyd, Robbie. and Carolyn Sargent. (eds.) 1997. *Childbirth and Authoritative Knowledge: Cross-cultural Perspectives*. Berkeley: University of California Press.
- Dundes, Alan. 2003. *Фольклор: семиотика и/или психоанализ*. [Folklore: Semiotics and/or Psychoanalysis, Alexandra Arkhipova, ed. and transl.]. Москва: Восточная литература.
- Ewick, Patricia and Susan Silbey. 1998. *The Common Place of Law: Stories from Everyday Life*. Chicago: University of Chicago Press.
- Ewick, Patricia and Susan Silbey. 2003. “Narrating Social Structure: Stories of Resistance to Legal Authority,” *American Journal of Sociology* 108(6): 1328-1372.
- Gramatchikova, Natalia. 2020. “‘How I gave birth’ (and why I am writing about it): women’s narratives of first childbirth experiences from internet publications,” *Electronic Journal of Folklore* 80: 97-124.
- Garro, Linda and Cheryl Mattingly. 2000. “Narrative as Construct and Construction. Narrative Turns.” *Narrative and the Cultural Construction of Illness and Healing*. University of California Press.

- Goriacheva, Iulia and Maria Ushankova 2016. Горячева, Юлия и Мария Ушанкова. “Остановим насилие в родах” [Stop violence in childbirth]. *ВКонтакте*. Cited by: https://m.vk.com/humanize_birth. (consulted 20 February 2022) *Facebook*. Cited by: <https://www.facebook.com/humanizebirthrussia/>.
- Hull, Matthew. 2012. “Documents and Bureaucracy,” *Annual Review of Anthropology* 41: 251–267.
- Jitomirskaja-Schechtman, Ekaterina. 2019. Житомирская-Шехтман, Екатерина. “Кто не рожал с доулой, ибо отказали” [Who did not give birth with a doula, because they refused]. *Facebook*. (consulted 20 February 2022) Cited by: <https://www.facebook.com/groups/rodydouly/permalink/1945455245563653/>.
- Khristoforova, Olga. 2020. Христофорова, Ольга. “Гнетке — сонный паралич? Необычное между фольклористическими и медицинскими классификациями” [Is *gnetke* sleep paralysis? The unexpected between folkloristic and medical classifications], *Shagi* 6(4): 101-125.
- Kitta, Andrea. 2019. *The Kiss of Death: Contagion, Contamination, and Folklore*. Utah State University Press.
- Kleinman, Arthur. 1978. “Concepts and a Model for the Comparison of Medical Systems as Cultural Systems,” *Social Science and Medicine* 12 (1): 85–93.
- Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Kuksa, Tatiana. 2011. Кукса, Татьяна. “Роль и место процедур досудебного обжалования в контроле за сферой государственного управления, или перспективные направления административной и судебной реформ” [The role and place of pre-trial appeal procedures in the control of public administration, or promising areas of administrative and judicial reform], *Public Administration Issues* 1: 81-96.
- Kuksa, Tatiana. 2018. Кукса Татьяна. *Рассказы о родах и родовспоможении в современной городской культуре* [Stories about childbirth and obstetric care in contemporary urban culture]. Москва: Магистерская работа, РГГУ.
- Kuksa, Tatiana. 2020a. Кукса, Татьяна. “Биополитические решения и правозащитный активизм в период распространения COVID-2019 в России: ограничения субъектности и новые границы взаимозависимости” [Biopolitical Decisions and Human Rights Activism During the Spread of COVID--19 in Russia: Subjectivity Limitations and New Limits of Interdependency], *Medical Anthropology and Bioethics* 1(19): 67-99.
- Kuksa, Tatiana. 2020b. Кукса, Татьяна. “«Страшилки» для рожениц: конструирование и преодоление страха в родах” [“Horror Stories” for Women in Childbirth: Construction and Over-coming of Fear in Childbirth], *Urban Folklore & Anthropology* 3(1-2): 166-187.

- Kuksa, Tatiana. 2021a. Кукса Татьяна. “Доульское сопровождение родов: генезис, дискурсы и практики эмоциональной и физической немедицинской заботы” [Doula Support During Childbirth: Genesis, Discourses and Practices of Emotional and Physical Non-Medical Care], *Monitoring of Public Opinion: Economic and Social Changes* 3(163): 226-249.
- Kuksa, Tatiana and Svetlana Shnyrova. 2021. Кукса Татьяна и Светлана Шнырова. “Взгляд доулы на призвание и профессию: пребывать с женщиной в точке боли” [A Doula’s Perspective on Her Vocation and Profession: Being with the Woman at the Point of Pain], *Medical Anthropology and Bioethics* 1(21).
- Kuksa, Tatiana. 2021b. Кукса, Татьяна. “Партнерские роды и индивидуальные сопровождения в условиях COVID-19: властные решения, практики и дискурсы” [Partner-Accompanied and Individual Care Providers in the Setting of COVID-19 Pandemic: Power Decisions, Practices and Discourses], *Этнографическое Обозрение* 6: 294-313. DOI: 10.31857/S086954150017611-2.
- Mattingly, Cheryl. 1998. *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge: Cambridge University Press.
- Molodtsova, Maria. 2020. Молодцова, Мария. Роды с поддержкой должны быть доступны даже в условиях эпидемии [Supported childbirth should be available even in an epidemic]. Russian Public Initiative. Cited by: <https://www.roi.ru/74771/>. (consulted 20 February 2022).
- Olenev, Anton. 2019. Оленев, Антон. “Депздрав рассказал о росте популярности партнерских родов в Москве” [Depzdrav spoke about the growing popularity of partner births in Moscow]. *News of the Moscow City News Agency*. Cited by: <https://www.mskagency.ru/materials/2946293>. (consulted 20 February 2022).
- Olson, Laura and Svetlana Adon’eva. 2013. *The Worlds of Russian Village Women: Tradition, Transgression, Compromise*. Madison: University of Wisconsin.
- Rapp, Rayna. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. Routledge.
- Rivkin-Fish, Michele. 2005. *Women’s Health in Post-Soviet Russia: The Politics of Intervention*. Bloomington: Indiana University Press.
- Rouhier-Willoughby, Jeanmarie. 2003. “Russian Birth Customs: Ancient Traditions in Modern Guise,” *Slavic and East European Journal* 47(2): 227-250.
- Rouhier-Willoughby, Jeanmarie. 2008. *Village Values: Negotiating Identity, Gender, and Resistance in Urban Russian Life-Cycle Rituals*. Bloomington: Slavica Publishers.
- Sargent, Carolyn and Lauren Gulbas. 2011. “Situating Birth in the Anthropology of Reproduction,” *A Companion to Medical Anthropology* (Eds. M. Singer, P. Erickson) 289-303.

- Scott, James. 1985. *Weapons of the Weak: Everyday forms of Peasant Resistance*. New Haven: Yale University Press.
- Temkina, Anna and Michele Rivkin-Fish. 2020. "Creating Health Care Consumers: The Negotiation of Un/official Payments, Power and Trust in Russian Maternity Care." *Social Theory & Health*, 18(4): 340–357.
- Yurchak, Alexei. 2014. Юрчак, Алексей. *Это было навсегда, пока не кончилось. Последнее советское поколение*. [Everything was Forever, Until it Was No More: The Last Soviet Generation]. Москва: Новое Литературное Обозрение.

INTERVIEWS

- Doula 1. Moscow, Russia. Interviewed over Messenger. 21 February 2019, 29 August 2021.
- Doula 2. Moscow, Russia. Interviewed over Video Messenger. 15 January, 31 March 2020.
- Doula 3. Moscow, Russia. Responded to questionnaire. 1 April 2020.
- Doula 4. Moscow, Russia. Responded to questionnaire. 1 April 2020.
- Doula 5. Volga region, Russia. Responded to questionnaire. 2 April 2020.
- Doula 6. Saint Petersburg, Russia. Responded to questionnaire and interview. 4 April and 17 August 2020.
- Doula 7. Moscow region, Russia. Interviewed over Audio Messenger. 5 April 2020.
- Doula 8. Far Eastern region, Russia. Interviewed over Audio Messenger. 10 April 2020.
- Doula 9. Far Eastern region, Russia. Interviewed over Messenger. 8 May 2020 and 20 September 2021.
- Doula 10. Saint Petersburg, Russia. Perinatal Conference. 16 May 2021.
- Doula 11. Siberian region, Russia. Interviewed over Messenger. 15 September 2021.
- Doula 12. Volga region, Russia. Interviewed over Audio Messenger. 17 September 2021.
- Doula 13. Ural region. Interviewed over Audio Messenger. 17 September 2021.

Doula 14. Northwestern region, Russia. Interviewed over Audio Messenger. 18 September 2021.

Midwife 1. Moscow, Russia. Interviewed over Video Messenger. 7 April 2020.

Sadovaia Tamara, the founder of CTM and “traditional” midwife. Meeting with pregnant women. 19 March and 14 April 2018.

Shnyrova Svetlana, Moscow doula. North Goa, India. Interviews. 12 and 17 February 2018.