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MIDWIFERY PROFESSION IN RUSSIA: INSTITUTIONAL CONTEXT AND EVERYDAY PROFESSIONAL PRACTICES

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SUMMARY

Development of caring professions in post-Socialist context rarely becomes subject of sociological research. Presented article addresses this issue by considering development of midwifery occupation in contemporary Russia. We study how social and political changes have influenced professional project of midwives after the dissolution of the Soviet Union. Particular emphasis is put on the impact of recent institutional changes on daily work on midwives and renegotiation of doctor-midwife professional border at the level of everyday interactions. Findings of the research are based on analysis of secondary data on development of midwifery in Russia and on interviews with midwifes from three Russian cities.

Healthcare occupations constitute a privileged subject of analysis for the sociology of professions. Since initial stages of the development of the discipline institutional arrangements and work practices characteristic to medicine have been seen as a model for a heterogeneous group of knowledge-based professions (teachers, accountants, IT specialists etc). Academic interest in caring professions has resulted in particular attention to paramedical specialists. In a number of researches midwives and nurses have exemplified a set of underestimated feminized occupations that are involved in routine care work and subordinated to the "classical" professions, which derive their

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authority from possession of abstract scientific expertise[1]. Studies of doctor-nurse and doctor-midwife relations are used by sociologists to address diverse issues associated with constitutive features of caring professions, professional hierarchies and struggle of less prestigious occupations for professional autonomy[2].

Ability of some selected occupations (like medicine and law) to represent a whole variety of modern professions, all of whom are in very different employment situations, has been already questioned by sociologists[3]. Another line of critique, to which this article aims to contribute, is concerned with almost exclusive focus on paths that professional projects take in the US and Western Europe[4].

Ways in which occupations are formed in other social and political circumstances bring a challenge to the Anglo-American concept of professionalism. Studies of Soviet and post-Soviet medicine have shown that doctors who work in this context do not fully comply with the image of autonomous professionals, capable to define the scope and conditions of their professional duties[5]. Development of caring professions in the region also significantly differs from the "Western" model. However, professional affairs of post-Soviet nurses, midwifes and social workers remain a marginal research topic for social scientists[6].

This article contributes to the corpus of studies on caring professions by analyzing professional project of Russian midwives. Most of sociological and anthropological works are focused on midwifery in North America and Western Europe. Considerably less attention is paid to position of midwives in the volatile political and institutional contexts of Central and Eastern European states.

How midwifery is constituted as an occupation in coexistence with rather weak medical profession and high level of reproductive healthcare politization? What impact do ongoing neo-liberal reforms of post-Socialist healthcare have on professionalization of midwives? These are the questions addressed in the article.

The article consists of three parts. In the first one theoretical framework of the research is discussed. The second part provides description of institutional organization of Russian midwifery and state socio-political interventions in the sphere. In the third section we refer to the micro-level of midwifery practice and examine how it is influenced by liberalization and merketization of post-Soviet healthcare. The concluding remarks summarize research findings.

Research framework

Theoretical framework of the article rests on concepts drawn from two areas of social analysis: the sociology of professions and social policy studies. Following the approach employed in researches on midwifery in developed "Western" countries[7], we will draw attention both to institutional level of organization of Russian healthcare system, and to micro-level conflicts and negotiations between actors in the maternity care domain.

Sociology of professions

In this article we approach a category "profession" from the viewpoint of neo-Weberians and identify it as an "exclusionary social closure in the marketplace sanctioned by the state"[8]. Such understanding rests on a picture of competitive world, where relations between different occupational groups are unequal (in terms of income, status and prestige) and where each of these groups struggles for professional autonomy and jurisdiction. Researchers consider modern doctors (mostly Northern American and British) to be an emblematic example of a group successful both in gaining monopoly over particular field of expertise, and in securing their dominance over less advantageous paramedical occupations[9]. Midwifery, which is central to this article, is typically portrayed as subordinate to medical profession. It is identified as an occupation complementary to obstetrics, with a rather limited range of professional tasks and lack of professional authority[10].

Feminist scholars have challenged this view of the professions and professional hierarchies. On the one hand, it has been argued that at the level of everyday work boundaries between knowledge-based and caring professions can be contested and negotiated[11]. On the other hand, comparative studies of maternity healthcare systems have shown that midwives can successfully mobilize parental groups and sometimes make alliances with the state in order to enhance their professional status[12]. Thus, midwifery is not necessarily second to obstetrics. Relations between these two occupations are more nuanced and dependent on political, social and economic contexts.

It is worth noting that apart from developing professional projects occupational groups are responsive to organizational demands. According to recent scholarly revision of "professionalism", even in the us the logic of professional conduct is no longer indipendent from the logics of the organization and the market. Emerging as well as established occupations face financial constraints and bureaucratic limitations[13].

Social Policy Studies

As it has been mentioned above professional groups are not sealed in vacuum. Trends of their transformations are conditioned by cultural assumptions, scientific advancements, interplay of market forces, and state policy. The later becomes especially important in case of occupations related to maternity healthcare, which is one of the most politicized branches of medical care.

State social policy determines if births will be centralized in large hospitals or will preferably occur in settings of private homes; if costs of treatment will be fully covered by mandatory insurance or from the client's pocket. Basing on data from developed countries, scholars have demonstrated that welfare regime influences design of maternity healthcare, and that different regimes have different consequences for occupational groups involved in healthcare provision.

Liberal welfare states (like UK and Canada) put an emphasis on cost-effectiveness of healthcare services and may support midwives as an occupational group that suits this principle better than doctors. Such states also frame the issue of maternity care in a more individualistic way, making women important as consumers. In socio-democratic welfare regimes (like Finland), on the contrary, government is concerned with equality between citizens and intervenes in maternity care in ways that limit marketization[14].

Post-Socialist states fell beyond the scope of conventional classification of welfare regimes. They are believed to constitute a distinctive type of welfare regime[15], which is ambiguously defined by scholars as "transitional"[16]. Question about the ways, in which this kind of welfare organization influences maternity care provision and corresponds (or not) to professional interests of midwives and doctors, poses a scholarly challenge.

Maternity healthcare in post-Soviet Russia: institutional arrangements

Many distinctive features of contemporary Russian maternity healthcare are inherited from the model that Soviet medicine took by 1960's. That model can be described as a centralized and bureaucratically administered system, which provided universally available, but low-standard medical services[17]. Strong state dominated the whole sphere of welfare provision and acted as the main stakeholder in the area of maternity care. Childbirth was treated as a public event related to the upbringing of new citizens, and authorities that were pursuing pronatalist goals used healthcare institutions to control women's reproductive behavior[18].

Doctor-patient relations in this context took a form of triangle: doctor - patient - state[19]. Medical professionals, unlike their American counterparts, lacked control over conditions and content of their work. They acted more like bureaucrats deferred to public health authorities and

responsible for the transfer of state paternalistic care to the citizens. Furthermore, comparing to industrial production, work in health care was devalued in Soviet society. This resulted in 'feminization' of medical profession. Obstetrics and genecology (along with pediatrics) constituted the most indicative example of this trend. In early 1970's number of women in these fields reached 90%[20].

At the same time, the state which was allied with doctors guaranteed medical dominance through regulations that gave preference to obstetrical care. There was no higher education in midwifery in the country or any pronounced attempts to develop midwifery science. Midwives were restricted to auxiliary work and actually functioned as obstetrical nurses, who were not allowed to attend deliveries without doctor's supervision or to consult women during pregnancy and postpartum period. And that were doctors, not midwives, who bear legal responsibility for the quality and outcomes of medical interventions.

Structure of state maternity healthcare was presented by a two-tier system. Women's clinics (*zhenskaya konsul'tatsiya*) provided services for gynecological patients and pregnant women, while birthing hospitals (*rodil'niy dom*) took care of births. Usually women's clinics and birthing hospitals were structurally coordinated (some clinics were hospitals' subdivisions). However, most of such coupled institutions were staffed with different personnel. Thus, during pregnancy women were typically consulted at a local clinic by a team consisted of an obstetrician-gynecologist and a midwife, who acted as his/her technical assistant. Their deliveries were also attended by an obstetrician and a midwife, but these were other people completely unknown to the patients.

Feminist authors have criticized this system for utilitarian attitude to female reproductive experiences, as it prevented any kind of continuous relationship between a woman and a caregiver (or a group of caregivers)[21]. But such division also had a negative impact on

midwives as a professional group. Fragmentation of maternity services led to the fragmentation of midwives' skills and knowledge, and split the midwifery profession.

The system was designed exclusively for hospital approach to maternity care. However, in early 1980's a homebirth movement began in the country. It was a marginal underground initiative framed by its' members as an attempt to escape from extensive state intervention in private family experiences[22]. Ideology of the movement differed from ideology of 'Western' midwifery and patients' movements in two crucial ways. First, as the vast majority of Russian obstetricians were women, no opposition was constructed between a male-doctor and a female-midwife[23] Devalued position of medical profession in state healthcare actually made some obstetricians to join the movement along with midwives. Second, technologization of childbirth and extensive medical control over it were not the main targets of the critique articulated by Soviet homebirth proponents. Movement's agenda was grounded in parental discontent with low quality of medical services and state bureaucratic control over child bearing and childrearing.

After the dissolution of the Soviet Union in 1991 Russian healthcare experienced a chain of reforms aimed at reconstruction of its institutions according to neo-liberal and market principles. System of health insurance was introduced. State expenditures on healthcare were cut down, but the government allowed for private medical practice and for provision of commercial medical services in state hospitals and clinics.

Reforms proved to be rather inconsistent; the structure of healthcare system remained unchanged and the level of bureaucratic control over medical domain continued to be high. Along with official market of medical services briberies and informal payments thrived. Semi-legal practices became acceptable option both for low-paid professionals, and for patients who wanted to experience personalized approach and to receive care of better quality[24].

Commercialization and liberalization of healthcare created a window of opportunity for those midwives who aimed at gaining more professional autonomy. The system of state medicine, which put emphasis on obstetrical care, continued to be the main provider of maternity care services in the country. Midwives still were not officially allowed to attend deliveries independently. But in the changed situation healthcare institutions became interested in the development of commercial services that would answer to the demands of those wealthy clients, who wanted to make informed decisions about childbirth (including the choice of childbirth assistant).

One of such services introduced in hospitals was a so-called "individual delivery", in the frame of which a woman was able to choose an obstetrician and a midwife, who would help her during labour. In some hospitals women, who opted for "individual delivery", could decide to give birth with a midwife alone, with a doctor being nearby in case of emergency.

In 1997 in St. Petersburg a unique center for midwifery care was created as a commercial subdivision of the state hospital[25]. In the same decade a number of private "parenting schools" (mostly in Moscow and St. Petersburg) were set up. These schools shared "natural", demedicalized view on childbirth and promoted midwifery help. Officially, they were only allowed to teach courses to expectant parents. In fact, some state birthing hospitals had informal agreements with parenting schools; so midwives, who led the courses, were able to assist their clients' deliveries.

Another alternative to the conventional childbirth scenario was home birth attended by a midwife. In late 1990's it was steadily developing from a marginal practice into business[26] Homebirths were not literally prohibited in the country, but neither midwives, nor obstetricians could receive license for this kind of service. Professionals who had joined this practice did it at their own risk.

One can evidence that in the volatile context of post-Soviet healthcare transformations spots of growth of midwifery autonomy have emerged. This was possible because of the legalization of private business and interest of hospitals' administrations in offering new medical services that would attract solvent clients. Unsteady institutional context of the healthcare under reform, paradoxically, also has had a positive impact on strengthening the position of midwives. Changing and uncertain official rules contributed to widening the room for negotiations between clients, obstetricians and midwives; even some illegal practices (for e.g., homebirths, informal payments to hospital obstetricians for not attending the delivery) became acceptable.

These transformations have expanded the gap between hospital midwives and midwives who worked at women's clinics. For the former developing market of childbirth services brought new professional opportunities, while the later preserved their position of doctors' technical assistants. Another demarcation line has been drawn between hospital midwives, who strictly followed official prescriptions concerning their occupation, and those, who ventured to transgress the norms and to launch a center for midwifery care or to participate in home delivery. Work of the second group did not fully fit in the state regulations, but these midwives exercised more professional autonomy.

In mid 2000's another stage of the development of Russian maternity healthcare begun. It can be described in terms of restoration of extensive state control over the sphere and its subsequent politization. This trend reflected pronatalist policy orientation, when the authorities concerned with low birthrates searched for the solution for the "demographic crisis"[27]. Technological and assessable obstetrical and gynecological services were considered to be one of the answers to the problem. Thus, while the general trend in healthcare organization was characterized by the departure from affluent socialist social

provision to a means-tested model, pregnant women and mothers enjoyed introduction of new forms of state support. Authorities tried to make reproductive healthcare services available and free of charge for almost all categories of women, regardless their working and insurance status or place of residence.

In 2006 authorities started a priority national project "Healthcare". In the frame of this initiative maternity healthcare institutions received additional funding from the state, their technical facilities were ameliorated; more than 20 maternal hospitals equipped with the most advanced medical technique were built in the country. In the same year the birth certificate program was launched. It was aimed at introduction of competitive principle in maternity healthcare provision. Through the mechanism of financial stimulation hospitals, clinics and particular doctors should have become interested in attracting more clients and in providing care of better quality for each patient.

State campaign against informal payments in healthcare was initiated. Law enforcement authorities strengthened control over medical institutions in the frame of regular reviews[28]. In 2005 a campaign against home births was launched. It consisted of legal cases against those midwives, who attended home deliveries, and of media campaign that emphasized risks and dangers of this type of childbirth[29].

In the following section we focus on this later stage and consider the impact of socio-political changes on daily work of Russian hospital midwives and their professional perspectives.

Daily negotiations of Russian midwives

Research data and method

In this part of the article we concentrate on daily work of those Russian midwives, who attend deliveries, as this segment of midwifery service constitutes the main site of transformations of the profession. We

briefly consider micro-level of obstetrician-midwife interactions and trace influence of institutional reforms on professional hierarchies. Our attention is focused on 'ordinary' midwives, who work in state birthing hospitals, and 'alternative' midwives, who initiate independent commercial projects.

Empirical data for the study was collected in 2013-2014. Altogether 15 interviews with hospital midwives were conducted in the cities of Kazan, St. Petersburg and Volgograd. Nearly half of the interviews (N=7) were conducted with personnel of the centre of midwifery care in St. Petersburg, which is one of the most successful Russian examples of midwife-led birth being implemented within the settings of the a medical institution.

Alongside interviews we use data collected through participant observation at four Midwifery Today conferences that took place in Moscow in 2010, 2011, 2013 and in St. Petersburg in 2015. These conferences were devoted to discussion of "natural" childbirth issues and the legalization of midwifery.

Hospital midwives

According to the regulations of Russian Ministry of healthcare[30] a midwife is subordinated to a doctor, and scope of her professional duties is limited to auxiliary work. Her responsibilities are restricted: for instance, she is not allowed to perform vaginal examination, or to sew perinael tears. At the micro-level of routine day-to-day work, hierarchy of professional relations is less obvious, and boundaries between obstetricians and midwives are less refined. Members of both occupational groups have a pragmatic task before them; they are to help their patient at labour and to secure her and her child's health. Thus, similarly to other medical subdivisions that deal with emergency cases[31], in maternity care team-work is a crucial compound of efficient professional performance; a compound, which frequently becomes more important than boundary work.

In Russian birthing hospitals obstetricians and midwives, who work in delivery wards, normally are not combined into stable teams. They form temporary dyads depending on their work schedule. However, the situation is different in case of commercial 'individual delivery', when the patient can choose birth attendants in advance. Both midwives and doctors usually have particular preferences concerning possible members of the team. So if the woman-client chooses an obstetrician, the later recommends her to opt for a particular midwife, whom the doctor finds convenient to work with (and vice versa in rare cases when a woman wants to have a midwife-led birth).

Nowadays 'individual delivery' is a widespread service in Russian state hospitals in big cities and a substantial source of income for medical staff. Thus, ability to establish good relations and mutual understanding with a highly competent counterpart, who shares one's assumptions about childbirth, is valuable for both midwives and obstetricians. Midwives who have participated in the research describe this process in terms of 'finding contact' and 'attuning to each other'. This is a non-verbal tacit work. In the context of officially recognized medical dominance, success of this work highly depends on obstetrician's willingness to accept a midwife as a fellow colleague, and not just as a technical assistant.

The way in which routine work is organized in Russian birthing hospitals also contributes to the development of trust and cooperation between doctors and midwifes. An obstetrician typically is not presented at the delivery ward during all stages of labour. He/she comes from time to time to monitor the situation and attends only the final phase of the delivery. At all the other moments it is a midwife, who seats by the birthing woman, helps her to breathe through the contractions, offers different facilities to ease her condition etc[32]. And it is a midwife, who should call for an obstetrician, if some urgent intervention in labour process is required. One of the interviewees describes situation as follows.

> *It depends on his [doctor's] personality, if you will be his assistant or his counterpart […] However, judging from my own rather limited experience it is mostly a supportive cooperation. An obstetrician trusts a midwife, because his office is at another floor, and he comes to the delivery ward, checks if everything is alright and goes back to his office. And if something goes wrong while he is absent it is a midwife who should notice (midwife, 33 years old, St. Petersburg, 2014)*

However, situational configuration of doctor-midwife relation is determined not just by their common task to provide efficient help to a patient, but also by the bureaucratic requirements that limit midwife's autonomy. Obstetrician is the specialist legally accountable for the delivery: he/she is to fill in all the documentation regarding particular birth, he/she should also justify in a daily report actions accomplished by medical personnel during the delivery. This report should show that an obstetrician has fulfilled all the instructions and followed all the formalized schemes set by the Ministry of healthcare and adopted by the birthing hospital. Midwife's independent work is not presupposed by those regulations.

> *We don't have that many doctors, who can fully trust a midwife, like "you can do anything you want during the delivery". Such situation is almost impossible, because they have this persistent question in mind: "And how will I describe this delivery in my daily report?" (midwife, 37 years old, St. Petersburg, 2014)*

Midwives who have experience of work at late-Soviet period put an emphasis on the changes that were provoked in healthcare by liberal reforms. They consider that these changes contribute to the diminishing of the midwife's role in hospital labour. As we have already described above, authority of a midwife rests on negotiations with a doctor, on the situational balance of responsibilities that professionals have achieved. But in the context of healthcare liberalization and restoration of state control over the maternity care, adherence

to official rules and formal distribution of responsibilities becomes more and more prominent. Thus, relational logic of care[33] is being replaced at birthing hospitals by the logic of law, which is not in midwives' favor.

> *The chief obstetrician of our subdivision… in 1986 she provided midwives with more… well, I would say, she encouraged us to work with women […] And now we have this new trend that doctors have withdrawn patients from us, they have taken all the responsibility for themselves. But I understand why this is happening; not because they do not trust midwives, but because patients have become very competent. For every minor mistake, for every flow they complain to the authorities (midwife, 48 years old, Volgograd, 2014).*

According to midwives' accounts, recent institutional transformations have contributed not only to the shift towards formalization of professional responsibilities, but also to the increase of medical interventions in labour. From obstetricians' point of view (as it is re-translated by midwives), birth with extensive medical intervention is a more controlled one. So if an ambiguous and potentially hazardous situation occurs in labour, doctor would normally opt for C-section rather than rely on uncertain outcome of 'natural' birth. This trend indirectly weakens midwives' professional position. Deliveries become more medicalized and thus fall within the sphere of specific obstetrical competence.

> *This began five or six years ago. Women started to complain about maternity healthcare services […] And I do pity doctors. Most of them are for natural childbirth, yes, our whole maternity hospital is for natural childbirth. But, for example, we have a woman for whom Caesarian section is recommended, and she doesn't want to have a Caesarian. So a doctor has to decide between natural delivery and an operation. He would prefer to have a natural delivery and a healthy baby. But who knows what will happen? If anything will go wrong during labor, this very woman will sue him. So of course he chooses to perform an operation (midwife, 48 years old, Kazan, 2014).*

'Alternative' midwives

Feminist scholars have shown that in Western Europe and, especially, in the US midwifery movement originated from critique of medicalization of childbirth experience and excessive control of male-dominated medical profession over practices of both midwives and women-clients[34]. In Russia, as it has been described in previous part of the article, midwifery occupation has developed in a quite different context, where the main issue for healthcare professionals and for parents is extensive state intervention in the sphere of reproduction. Consequentially, in discourses on midwifery professionalization a critique of state healthcare system plays more prominent role than a critique of medical science and doctors as its representatives. This is particularly true for 'alternative' midwives, who are evading official regulations in their practice. They portray state birthing hospitals as "factories" and "assembly lines" that deprive childbirth experience of its genuine privacy and intimacy. Doctors, hospital midwives and their patients are represented as hostages of 'the system'. This aversive image is contrasted with the image of emotionally involved midwifery care. The midwife, who runs one of Moscow's parenting schools and assists at home deliveries, provides in her conference presentation a good example of this kind of judgment.

> *So you can have a birth that will be full of love and joy or a birth that will be full of pain and suffering. So you are to decide. However, our doctors rarely allow you to decide, because our maternity hospitals function as factories, like machines that just follow particular schemes (midwife35, Moscow, 2011).*

Correspondingly, hospital midwives, who have turned to a more autonomous professional practice (at midwifery care centers, parenting schools, or while attending home births), explain this decision by their unwillingness to work at an 'assembly line', where one have to attend up to 13 deliveries a day[36]. Present head of the Rainbow center for midwifery care describes how the organization was founded.

And people were coming and saying: "I also want to attend deliveries of those women whom I am acquainted with". And if to put it bluntly, that meant "I don't want to work at an assembly line anymore. I'm fed up with feeling myself an industrial worker. I want to take at least partial responsibility for what I'm doing". So that's the way the center was organized. There wasn't anyone, who would proclaim: "And now we will found a center, where mothers and babies will be treated with full respect". No, we were driven by a totally egoistic motif (midwife, 52 years old, St. Petersburg, 2013).

Midwives assume that those women who choose 'alternative' midwifery services want to escape typical childbirth scenario predefined for them at state birthing hospitals. These women-clients rarely see the difference between medical and midwifery professional responsibilities. They just want to avoid depersonalized attitude from hospital staff and to minimize effects of hospital 'machinery' that insists on following formal rules despite patients' actual wishes and needs.

Many women they are looking for a person, who will protect them from the system. And I think that some women choose home births for exactly the same reason, they just want to find someone who will protect them (midwife, 35 years old, St. Petersburg, 2014).

Recent strengthening of formal healthcare regulations coupled with state campaign against home births negatively influenced such midwives' initiatives as parenting schools and centers for midwifery care. Even those organizations, which were not related to illegal home birth practice, felt administrative pressure for being an 'alternative' to the official maternity care system. It became difficult for them to negotiate conditions of their work with obstetricians and hospital administration. For instance, in 2014 the center for midwifery care had to move from one hospital, with which it was associated for 17 years, to another. Here is a fragment from an interview with one of the center's midwives.

> *And we are losing all our achievements now, because it is so difficult to find a like-minded person among doctors… Our statistics shows that we have the best delivery outcomes in the city, but no one cares. I don't know why. It may sound harsh, but they think we are a gang of swindlers. Someone even calls as the Cradle37. By referring to "them" I mean our local public health authorities (midwife, 48 years old, St. Petersburg, 2014).*

To sum up in mid 2000's both groups of Russian midwives, who attend deliveries, have faced a sudden shrinking of their professional jurisdiction on the practical level. Merketization of healthcare services in 1990's and unsteady transforming context of medical practice contributed to the development of midwives' professional project. However, in a decade the state, which continued to be the main stakeholder at the sphere of healthcare provision, strengthened official control over maternity care and introduced socio-political measures to support medicalized obstetrical approach to childbirth. Midwives' professional initiatives that thrived on insecure ground of personal negotiations, semi-legal schemes of care provision and temporary lucrative interests of hospital administrations faced major obstacle on the way of their development.

Conclusion

Formation of welfare states and dramatic changes in gender order which occur in modern societies have led to institutionalization of care practices and have provided a basis for jurisdictional claims of caring professions. Midwives are one of the indicative professional groups, who ground their claims for professional authority by the reference to committed care that they provide to their clients. In this paper we have considered professional project of post-Soviet midwifery that rarely becomes a subject of the sociology of professions. The very nature of care conditions the specificity of professionalization of occupations related to this social phenomenon. Care practices and relations are situational, local, oriented toward wellbeing of particular others. They do not fully fit neither market logic nor the universalistic

logic of contract responsibilities[38], although being determined by both of them. Thus, it is crucial to consider two levels of development of caring profession - macro level of social and political arrangements, and micro level of routine daily work at maternity hospitals.

Dissolution of Socialist regime and its aftermath was associated with the reshaping of Russian healthcare system. The resulting model resembles Finnish model of maternity care provision, which is characterized by the strong state pursuing universalistic welfare policy and undermining autonomy of professional groups (both midwives and obstetricians) in favor of state authorities.[39] However, unlike the Finnish case, in Russia female reproductive experiences and maternity care services are heavily politicized, and there is less concern about women-friendly politics or feminist agenda. Another distinctive feature of the organization of Russian maternity care is incoherence of its regulations, as the government attempted to introduce neoliberal and market principles in the work of otherwise unchanged healthcare institutions.

On the micro level of healthcare provision these incoherencies and contradictions have developed into a number of semi-legal practices (briberies and other kinds of informal payments). However, these unsettled order provided the room for ground-level professional initiatives of midwives aimed at practical renegotiation of the border between obstetrical and midwifery duties.

Our data shows that in the satiation when the state supports medicalized approach to childbirth, the ability to achieve some extent of professional autonomy at micro-level is crucial for the development of the profession. This process can be facilitated or, on the contrary, restricted by wider socio-political context. During the first decade of liberalization of Russian healthcare, midwives had better position for negotiations with doctors and hospital administration. Restoration of extensive state control over the reproductive health in mid 2000's has weakened midwives' standpoint and limited further development of midwifery autonomy.

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28. CHIRIKOVA A., SHISHKIN S., *Neformalnie platezhi v meditsine: dinamika institutsionalnih izmemenij*. Presentation at a conference "Citizens' health

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29. In 2005 at St. Petersburg a child died during home delivery. The midwife who attended the delivery was sentenced to 5 years for malpractice. This case attracted significant public attention and led to a media campaign against home childbirths and independent midwifery practice (for e.g. see the following TV reports http://www.vesti.ru/videos?vid=201144; http://www.5-tv.ru/news/18243/).
30. Order of the Ministry of Health of the Russian Federation No. 572, 01.11.2012 "On Establishing a New Order in Providing Medical Help in the Sphere of Midwifery and Obstetrics".
31. See for e.g. CARMEL S., *Boundaries obscured and boundaries reinforced: incorporation as a strategy of occupational enhancement for intensive care*. Sociology of Health and Illness 2006; 28(2): 154-177.
32. Midwife can fully accomplish this role only in the frame of 'individual delivery', as she typically is responsible for several deliveries that happen almost simultaneously.
33. MOL A., *The logic of care: health and the problem of patient choice*. London, Routledge, 2008.
34. WITZ A., note 2.
35. As home births are illegal in Russia, age of the informant is not indicated to secure her anonymity.
36. Estimated number of births is derived from the data provided by midwives in their interviews.
37. "The Cradle" is infamous parenting school in St. Petersburg, whose founder in 2005 was sentenced to 5 years for attending home deliveries (see note 29).
38. MOL A., note 33.
39. BENOIT C., note 14, pp. 727-729.

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