

Fertility in Transition in 21st-Century Russia

by

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Abstract

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This dissertation is a collection of three studies that, together, seek to characterize and explain immense changes in fertility – both its demographic patterns and the culture surrounding it – observed over the last thirty years in the Russian Federation.

The first study uses both descriptive analysis and modeling to examine Russia's fertility path in the Putin era. National and region-level demographic data and region-level economic covariates are used to assess the contribution of tempo and quantum factors to the deep fertility trough observed in the early post-Soviet era, the recovery from that period of low fertility, and a recent downturn in birth rates that has caused a great deal of concern for the Russian state, popular press, and some demographers. The main findings are: first, for first births, a relatively slow postponement transition caused and continues to cause moderate depression of period fertility; for higher-order births, a long period of delayed or forgone births ended only in 2007, after which compensation at relatively older maternal ages began. Second, a simple projection method indicates that completed cohort fertility was only moderately depressed by the fertility shocks of the 1990s, and has already begun to recover. Parity-specific data suggests that the timing and nature of the Putin administration's family policy reforms likely played a role in this. Finally, falling fertility in recent years is likely related to Russia's worsening economic situation, rather than the end of an incentive-driven boomlet; linear regression exploiting regional variation in fertility and the economy demonstrates procyclical fertility.

In the second study, I turn to the culture of fertility, using the Russian case to examine how ideas about the body interact with fertility intentions and experiences during a society-wide transition from early to later childbearing. I employ ethnographic and interview data, as well as internet forum posts, to explore contemporary Russia's bodily culture and its relationship to fertility. In brief, I argue that persistent beliefs about the fragility of good health; notions of bodily balance; and perceptions of the body as capable of learning and being trained have affected the shape of the postponement transition in Russia in several ways. First, they have contributed to the slow uptake of hormonal contraceptives and continued low rates of abortion of first pregnancies. Second, they contribute to Russia's low social

age deadline for first births; but they have also opened up space for new strategies that allow women to feel confident delaying births to older ages. Finally, I argue that this bodily culture interacts in unexpected ways with the changing doctor-patient relationship and the new availability of medical information to average Russians.

The third study departs from direct consideration of fertility rates and patterns to examine a major component of Russian society's broader dialogue on childbearing and reproductive health: the movement to limit abortion. Specifically, I examine more fully the functions of demographic and moral rhetoric in the contemporary Russian anti-abortion movement. I make three interrelated arguments. First, the use of demographic and moral schemas together serves an extremely important purpose: to expand the scope and type of resources that can be used for biopolitical aims, and thereby generate a robust, rapidly emergent and well-funded anti-abortion movement that enjoys a great deal of attention from both the church and the state. Second, I argue that the combination of these schemas is engendered by, and partially constitutive of, a larger anti-neoliberal, post-secular political project within Russian society, which positions Russia in opposition to the West and Europe. Third, I consider the demographic and cultural significance of these schemas, incorporating the ways ordinary women talk about abortion. I see this as an important step in developing a richer theory of how and why anti-abortion work, and other types of restrictive reproductive biopolitics, matter.

This dissertation is dedicated to the women of Taganrog.

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Chapter 1

Introduction

Introduction

Over the last thirty years, Russian fertility patterns have shifted dramatically. Unsurprising, perhaps – as the Soviet system collapsed and the Russian state, economy, and society itself were broken down and remade in the image of the neoliberal free market, the entire context of family life – from sex, to union formation and dissolution, to pregnancy, birth, and child-rearing – changed completely. This dissertation starts from a consideration of the changes in those patterns, and attempts to connect them to each other and to larger changes within Russian society, using both demographic data and field data collected during a semester of fieldwork in the small Russian city of Taganrog in the fall of 2017.

Thirty years of changing fertility patterns

At the end of the Soviet era, Russia was coming off of a pro-natalist campaign that had sought to remedy demographic troubles – specifically, below-replacement fertility among ethnic Slavs in the Soviet Union’s core regions of western Russia, Ukraine and Belarus – that had been of some concern to the Soviet leadership for decades (Attwood, 1990; Bridger, 2007; Desfosses, 1981). These pro-natalist measures, including better maternity benefits and housing assistance for young families – combined with the arrival of the “sexual revolution” in Russia without a concomitant increase in the availability of contraceptives – led to falling mean age at childbearing (MAC) and a period total fertility rate (TFR) that rose from slightly below replacement in the 1970s to a high of 2.23 in 1987, due largely to the tempo effect of earlier birth timing, which distorts the period TFR vis-à-vis cohort fertility (Zakharov, 2008).

However, as social and economic change swept the country with the arrival of perestroika, the TFR began to fall dramatically, beginning as early as 1987. The fall worsened as the Soviet Union collapsed in 1991, and the TFR continued to decrease nearly every year in the economically turbulent 1990s, bottoming out at 1.15 children per woman in 1999, the year

after a major Russian financial crisis and government debt default. While small gains began to be observed in 2000, the year Vladimir Putin took office as president, period rates stayed near or under 1.3, or “lowest-low,” until 2006. The period TFR then increased monotonically from 2007 to 2015.

What accounts for this pattern? For years, beginning with perestroika and continuing through the tumultuous 1990s and early 2000s, women delayed or avoided births, especially second and higher-order births. At almost the same time, the late-Soviet pattern of childbearing mentioned above, in which first births were completed at very young ages, began to shift toward a pattern more similar to that observed in Western Europe: the mean age of mothers at their first births slowly rose, and the age pattern of childbearing became more diverse.

At the same time, other changes that may have had more complex effects on the total fertility rate were afoot. The mix of contraceptives available and in wide use shifted dramatically, and Soviet “abortion culture,” in which unintended first pregnancies were both extremely common and generally carried to term, but unintended second and higher-order pregnancies were terminated rather than avoided, began to fade (V. Agadjanian, 2002). Changes in divorce patterns and increases in male death rates in the 1990s caused a rapid increase in the number of single mothers (Lokshin, Harris, & Popkin, 2000), further contributing to the decline in higher-order births, and ultimately leading to a new normalization of single motherhood (Utrata, 2015). The Soviet gender order, in which women received state protection in exchange for performing gender-specific duties to the state (namely, childbearing and child care, in addition to the non-gendered duty of labor force participation), disintegrated, as the state lost the “prescriptive capacities and ambitions” necessary to maintain this order (Ashwin, 2000, p.2). As a result, new gender ideologies proliferated (*ibid.*), and at the same time, motherhood took on new meanings, as pleasure rather than duty, a source of individual fulfillment and self-actualization (Issoupova, 2000).

Meanwhile, the collapse of the socialist welfare state was changing care patterns for infants and young children. From the 1950s to the 1970s, Soviet family policy had been oriented toward combining high fertility with high female labor force participation, and centered on an extensive system of municipal and state enterprise-affiliated nurseries and preschools. This system remained in place even as the pro-natalist policies of the 1980s allowed mothers to stay home with children for longer; the normative expectation was still that women would return to the labor force after their children’s infancies. In the 1990s, however, the nurseries and kindergartens foundered, forcing many families to rely on in-home care provided by the mother or another female relative. For the first time since before the Second World War, women were “allowed” to stay home permanently with children - a policy position supported by both liberal reformers (in service of individual choice) and nationalists (in service of demographic goals) – and in any case, the ideological underpinnings of requiring every citizen to work, like the rest of the contract between state and citizen, had collapsed (Teplova, 2007). This return to gender traditionalism also served as a pressure release on the extremely competitive labor market of the transition era (Avdeyeva, 2011). Indeed, over the course of the 1990s, working-age women – 90% of whom had been employed full-time in

the late Soviet era – became more likely than men to be out of the labor market or to work part-time or in informal sectors (Lokshin, 2004).

Later, as the state began to slowly recover from the collapse and to rebuild capacity and wealth under the rule of Vladimir Putin (president from 2000-2008, then prime minister, and president again from 2012 to the present), many of these trends reversed – not returning Russian fertility and family life to old Soviet norms, but moving it toward, perhaps, a new equilibrium. While the fall in fertility in the 1990s was driven to a large extent by birth postponement, the gradual rebound of the TFR that began in the early 2000s occurred even as the trend toward later childbearing continued – that is, in spite of, rather than because of, tempo effects. New family policies introduced in 2006 restored many late Soviet-era benefits that had not been adjusted for inflation since before the collapse of the ruble in 1998 (and had therefore been effectively symbolic for nearly a decade). They also signaled a renewed state commitment to pro-natalism – especially through a new “maternity capital” benefit designed to encourage larger families by offering a substantial one-time payment (roughly \$11,000 USD, adjusted annually for inflation until 2016) to mothers who gave birth to a second or higher-order child. These policies have remained in effect, largely unchanged, for the last twelve years. The maternity capital program was originally set to expire at the end of 2016, but has since been extended through 2021. In the new pro-natalist era, resurgent neotraditionalism, and a vociferous pro-family, anti-contraceptive, anti-abortion movement within the Russian Orthodox Church – and, to an extent, within the state – has begun to shape the discourse about family.

In the most recent four to five years, another drop in fertility has occurred. In 2014, with the internationally unrecognized annexation of the Crimean peninsula from Ukraine and the economic sanctions that ensued, Russia began to experience a serious economic contraction. The economy stabilized and began to expand again by 2016, but the drop in fertility that coincided with this new period of economic challenges has not reversed.

Thirty years of demographic crisis

In popular discourse, the entire pattern of fertility change described above is often subsumed under the heading of “demographic crisis,” used as shorthand for the collapse in birth rates and sharp rise in death rates that accompanied the final years of Soviet rule and the early post-Soviet period; the long-term effects of this period of negative natural increase; and perceived ongoing problems of fertility, mortality, and looming “depopulation.”

Indeed, when I tell people I study Russian demography, the two most common questions I receive are whether Russia’s demographic situation will improve in the near future, and whether Putin’s pro-natalist policies really had an effect on the birth rate. Neither question is especially easy to answer, but they are interesting questions to be asked. The former, which is posed by Russians and non-Russians, specialists and laypeople alike, shows how effectively the discourse on Russian population, both within and outside Russia, has been “crisisized.” Everybody understands – this question says – that the Russian population is in

a state of (perpetual) crisis. The specifics of this understanding vary: to a non-Russianist non-demographer, it is often a nebulous idea that Russians are drinking themselves to death, while specialists often pair this question with a conjecture that any recent improvements in fertility and mortality will soon unravel because of whatever political or economic challenges Russia is currently facing. But in both cases, the question itself signals a shared vocabulary of crisis around Russian population issues.

This relates also to the latter question, which is somewhat less common, since fewer people are familiar with Russian pro-natalism. The framing – has pro-natalism really helped? – signals a skepticism about Russian political and social reality. Things can never get better, for reasons that are only implied by the question itself but that may include the commitments and intentions of “Putinism,” the perceived deep roots of destructive cultural patterns, or the magnitude of the social and economic shockwave produced by the collapse of the Soviet Union. Certainly, skepticism over the administration’s commitment to improving the lives of Russian citizens is not unfounded; nor is hesitation over whether specific policies are effective at doing so. But again, the question itself expresses a shared narrative of Russian population as an intractable problem.

Demographic crisis as schema

It was this narrative of crisis that first got me interested in studying Russian population. It is compelling not in its explanatory power – “crisis” is a descriptor of birth rates, not an explanation for them – but its power and flexibility as a rhetorical category, and its ubiquity as an interpretive tool. It permeated my discussions with native Russians when I lived in the Russian regions after college, in 2006-2008. Indeed, it has been omnipresent both in everyday discourse and in the Russian media for decades, applied not only to the narrow phenomena of birth and death rates, but to a wide range of the other changes in Russian family and fertility patterns described above. In her dissertation, Leykin (2013, p. 10) characterizes demographic crisis as “metonymically stand[ing] for the moral dilemmas and quandaries that preoccupy Russian citizens caught up in the process of social change and political and economic transformation.” In this sense, I argue, demographic crisis functions as what sociologists call a schema (see, e.g., Johnson-Hanks, Bachrach, Morgan, and Kohler (2011b)). A schema is an underspecified, transposable cultural script – a “[way] of perceiving and acting through which we make sense of the world and motivate our actions” (ibid., p. 2). As a schema, demographic crisis offers a heuristic for making sense of social change, useful to actors within the state, to activists, and to ordinary people. It presents a moral framework within which life choices can be assessed or motivated. It may be relevant in encounters with a variety of institutions and structures, from the state primary education system to a missed menstrual period. Not least of all, it has motivated and/or buttressed key policy changes that have reshaped the Russian welfare state in the post-Soviet transition period. The uses of this schema in the transition era and the Putin era, and the “crisisization” of Russian population more broadly, are a major theme of this dissertation.

Other schemas

But of course, fertility is a micro-phenomenon as well, and at the individual level, changes in childbearing patterns are not necessarily informed by or experienced as crisis. In my fieldwork interviews, crisis seldom came up as people narrated their own fertility experiences, more commonly arising when we discussed the social or the political. My interlocutors were much more likely to discuss other, more mundane matters – age, health, relationships, finances, housing, personal development – when explaining how and when they had become or hoped to become parents. And indeed, these matters also relate to schemas, some much deeper and more powerful than the notion of demographic crisis. In particular, Russia has historically had very strong schemas attached to youthful motherhood, to the relationship between healthy fertility and the aging female body.

As Cynthia Gabriel (2003a) notes in her dissertation on childbirth practice in early post-Soviet Russia, “Russians view human health as constantly threatened by nature” (p. 71). Gabriel specifically explores the ways cold temperatures and sudden changes in temperature are seen to harm the body, but this way of viewing the body also means that the passage of time itself is a risk. Damages accrue; the body soon becomes less perfect than it was. As one of my interviewees expressed about her first child, “Probably his health was stronger because my body was newer [when I bore him].” This is certainly similar to the American concept of the “biological clock,” but the biological clock often implies a binary state – a woman is fertile until time runs out and she suddenly finds herself infertile – while the Russian perception involves moving inexorably, from a young age, along a continuum from good health to degraded health.

This, like the notion of demographic crisis, was something I encountered a great deal in Russia. Indeed, the experience of being on the receiving end of concern about reproductive function seems nearly ubiquitous among young American women in Russia. Young foreign women encounter this schema frequently and overtly, simply because we don’t understand the rules; nearly every woman I spoke to about this immediately recalled stories of times when she inadvertently horrified her Russian friends, study-abroad host mother, or even complete strangers, because of seemingly mundane choices she had made about her body.

As an example, in 2007, as I was waiting outside the U.S. consulate in Vladivostok for my passport to be checked so I could go in for a cultural event, a young Russian security guard approached me and nervously pointed out that the concrete barrier I was sitting on was cold. However, this was not my first encounter with the idea that sitting on something cold was harmful; I shifted slightly to show him that I was in fact sitting on a plastic bag, not directly on the cold concrete, which proved satisfactory.

A year later, in Irkutsk, a group of us – all young women, some Russian and some foreign – were sitting on the ground outside the office of the NGO Great Baikal Trail, waiting for it to be unlocked so that we could return sleeping bags we had borrowed for a trail-building trek. An older man approached and admonished us that we were risking our childbearing capacity by sitting on the sidewalk. We all laughed, thinking of all the ground-sitting we had done over the last two weeks in the mountains (although to be fair, the Russians all

carried stadium cushions in their hiking packs for this purpose), and remarked that since it was late July and nearly 30 degrees Celsius on the street, there was no way the concrete could harm us. The following week, as I stood waiting for a bus to the airport in Moscow with my hiking backpack on, another older man approached me and said exactly the same thing as the man in Irkutsk – *vam ješče detej rožat*, you still have children to bear – in an offer to relieve me of the burden of the heavy pack.

Other friends have shared stories of horrified reactions as they attempted to sit on the floor to watch televisions, of receiving remarks from every older woman who walked by that the bench they were sitting on was too cold, and of admonishments that they were going to freeze their innards. Nearly all of us had at least one conversation in which someone expressed concern that we were spending our childbearing years abroad. I remember my English students, seventeen-year-old college first-years, earnestly debating:

-If you don't have a child by the time you're thirty, you'll go out of your mind! Your hormones... -No, what are you talking about – Maria Ivanovna doesn't have any children and she's fine, a "normal auntie!"

Understandably, these experiences were at the front of my mind when, in graduate school, I began to study Russia's changing fertility patterns. In the demographic literature, fertility postponement is treated as a normal phenomenon in advanced societies (see, e.g., Bongaarts and Sobotka (2012); Goldstein, Sobotka, and Jasilioniene (2009); H.-P. Kohler, Billari, and Ortega (2002); H.-P. Kohler and Ortega (2002); Lesthaeghe (2010); Sobotka (2004)), but I could hardly believe that the mean age of childbearing was rising in Russia. It seemed to me that the culture of the body that I had experienced so acutely and relentlessly must prevent it.

Of course, this was a bit naïve, but disbelief is not necessarily a bad way to motivate further study. This disconnect between my experience and the literature points, perhaps, to a gap in demographic research. Much of the demographic literature on fertility postponement treats fertility timing as relatively neutral, or acknowledges that there is some age pattern that is "too late" (for instance, a mean age at first birth in the late 30s); but, understandably, does not take on the task of considering the cultural determinants of what counts as too late (see, e.g., Kohler et al., 2002). A more careful consideration of bodily culture increases our understanding of the cultural underpinnings of demographic facts, and thus of variation in those facts in post-demographic transition societies. This is the major aim of the second paper that comprises this dissertation.

Field site

I conducted three months of ethnographic and interview-based research in Taganrog, a mid-sized city in southern Russia. I chose my field site partly based on previous experience there; for the 2007-2008 academic year, I was placed as an English teaching assistant at the Taganrog Management and Economics Institute (TMEI) through the U.S. Fulbright Student program. Most of my students were then first- and second-year college students, aged 17-19,

and returning ten years later to a community where I was acquainted with a fair number of people now in their late twenties seemed like a natural choice. Taganrog was also attractive because the experiences of Russians outside St. Petersburg, Moscow, and the central Russian heartland remain understudied, particularly in the qualitative social science literature.

Taganrog is a city of about 250,000 people; about 40% of Russians – including the 25% who live in cities of a million or more – live in larger cities. Another 20% live in mid-sized cities like Taganrog, from 100,000 to 500,000 people. The city is an important commercial port and manufacturing center for the Russian South. While there is, of course, no such thing as an “average” city, these features make Taganrog a decent example of a certain kind of Russian daily life. In fact, Taganrog has for this reason been the site for an ongoing set of Russian sociological and economic field studies spanning the 1960s to the present day (Rimashevskaja, 2009).

Taganrog is located in the southwest corner of Rostov Oblast, a highly populated, relatively wealthy federal subject located in the European south of Russia, on the border with southern Ukraine and directly to the north of the Caucasus mountains. The oblast is about 500 miles south of Moscow. It is mostly steppe, and one of Russia’s major rivers, the Don, flows through it to the Sea of Azov. Rostov-on-Don, the oblast capital and Russia’s tenth-largest city (population 1.1 million), is about 40 miles to the east of Taganrog, and the two cities are well connected by commuter trains, private buses, and a major highway that was recently renovated for the 2018 World Cup.¹ Traveling to Rostov for better maternity care or consultation with specialists was a common experience among my interlocutors.

In the national historical imagination, the Rostov region is a former frontier of empire (Kislitsyn & Kislitsyna, 2008). The southern Ukrainian and Russian steppe was an area of contact between Russian-speaking Cossacks and “Tatars,” or various groups of Turkic-speaking steppe nomads, from the 15th century. It was seized for Russia from the Ottomans during the Russo-Turkish War of 1686-1700 by Peter I, re-ceded in the early 18th century, and finally decisively incorporated into the empire in the late 18th century, during the reign of Catherine the Great. The current oblast largely overlaps the homeland of the Don Cossacks, an ethno-military caste of free peasants who were the subject of the Nobel Prize-winning novel *And Quiet Flows the Don*. Cossack culture is still important in the region – many of my friends and acquaintances attended summer camps as children to study traditional Cossack culture, music, and martial arts, and on the very first day of my fieldwork, at the behest of the institute’s rector, I was whisked away on a boat tour to Starocherkassk, the old Cossack capital. The steppe around the Don River was also the staging area for the empire’s incursions into the Caucasus mountains in the 19th century.

Culturally, Taganrog is known as the birthplace and childhood home of the writer and playwright Anton Chekhov and the early Soviet comedic actress Faina Ranevskaja, as well as the summer retreats of Tsar Alexander I and the Tchaikovsky brothers. The city’s self-image is that of a historically cosmopolitan port with a rich literary history. Streets in the

¹Rostov-on-Don is named for the ancient town of Rostov northwest of Moscow; as it is now many times larger than its namesake, it is usually just called “Rostov,” and the older Rostov “Rostov the Great.”

historic downtown are named “Italian”, “Ukrainian”, and “Greek”; “Chekhov”, “Turgenev”, “Lermontov”, and “Gogol”, as well as many of the standard Soviet street names (Red Street, Komsomol Street, October street). The many late 19th-century buildings in the historic downtown are hung with plaques commemorating Chekhoviana and early Soviet history. The downtown’s ambiance has begun to attract the Russian television and movie industries to Taganrog as a location for period dramas, one of which was filming while I was conducting fieldwork.

All names used in this work are pseudonyms. I use the modified Library of Congress transliteration system without diacritics in translating Russian words and names, except when there is a different popularly-accepted transliteration (e.g., Tchaikovsky). I include terminology in the original Russian only when it provides added context, or denotes a concept that is awkward to translate concisely into English - most notably, the adjective describing a woman giving birth for the first time at an older age, *starorodiashchaia* (see Chapter 3).

Outline

This dissertation is composed of three related papers that examine different aspects of fertility change in Russia’s post-transition era. The first paper covers the quantitative background of fertility patterns in Russia from 1989 to the present. I use both intensive description and modeling to assess the nature of Russia’s period of lowest-low fertility in the 1990s and early 2000s, its recovery from that period, and the recent decline in period fertility, focusing on parity-specific changes in fertility patterns, cohort and period effects, and the economic covariates of fertility change.

In the second paper, I turn to the topic of cultural change in the culture of the body, and to qualitative data obtained from open-ended, semi-structured interviews conducted with 41 women of reproductive age in Taganrog, Russia in the fall of 2017. In particular, I explore the notion of the body’s “hormonal baseline,” its relation to older notions of temperature equilibrium, and its perceived role in reproduction; ways women talk about ideal birth timing from the perspective of physical health and social/economic wellbeing; and their own perceptions of how giving birth and parenting have changed in the last 20 years.

The third paper also draws on my fieldwork in Taganrog. While there, I was unexpectedly able to gather a wealth of material on a project that was being implemented at the institute – a small, local college of economics and management – that hosted me. As part of a grant from the Russian Orthodox Church, the psychology department had opened a center called “Sokhrani mne zhizn” (“Preserve my life”) dedicated to anti-abortion education and counseling, as well as assistance for pregnant women in difficult situations. As part of my research, I collected and documented the literature and educational materials available at the center, photographed the center itself, attended center events, and interviewed three institute staff involved in the project, including two women who were regularly conducting anti-abortion counseling at the local abortion clinic. This paper examines the functions of demographic and moral arguments in the contemporary Russian anti-abortion movement. I

argue that the use of demographic and moral schemas together serves an extremely important purpose: to expand the scope and type of resources that can be used for biopolitical aims, and thereby generate a robust, rapidly emergent and well-funded anti-abortion movement that enjoys a great deal of attention from both the church and the state. I also argue that the combination of these schemas is engendered by, and partially constitutive of, a larger anti-neoliberal, post-secular political project within Russian society, which positions Russia in opposition to the West and Europe. Finally, I consider these schemas' significance to individual women.

Two questions I posed at the start of this introduction were whether Russia's demographic situation will improve in the near future, and whether Putin's pro-natalist policies really had an effect on the birth rate. None of the papers contained in this dissertation can fully answer these questions; rather, my dissertation as a whole is intended as an engagement with a society and set of circumstances that engenders such questions. Russia is neither fully canonical nor a totally unique case when it comes to demographic decline and anxiety, but, in a world where fertility rates in all developed countries are below replacement, populations are aging, and rates of natural increase will soon fall as well, the anxieties that have so deeply permeated Russia's political culture are coming for the rest of us as well. In this sense, this dissertation offers not only (I hope) a fuller and more nuanced consideration of the continuities and constant change of post-transition Russia, but a reflection on our shared future in a low-fertility world.

Chapter 2

A demographic account of Russia's fertility transition

Introduction

Over the past half century, sub-replacement fertility has become a feature of the developed world, and increasingly, the world as a whole. Fertility indicators have converged globally much faster than other socioeconomic indicators (H.-P. Kohler et al., 2002), and as of 2010, over half the world's population lives in regions with below-replacement fertility (Myrskylä, Kohler, & Billari, 2009). However, there is large variation within low-fertility contexts, from so-called “lowest-low” fertility, represented by period total fertility rates (*TFR*) below 1.3, to near-replacement rates of around 2.0 (H.-P. Kohler et al., 2002). This variation is of interest to demographers and policymakers both theoretically and for its implications for population growth and aging. At sub-replacement fertility levels, small changes in *TFR* imply large shifts in population growth rates; a stable population with a *TFR* of 1.39 would have a halving time of 50 years, but a modest fertility increase to a *TFR* of 1.70 extends the halving time to 100 years.

There are several main, often interlocking, approaches to understanding spatial and temporal variation in low-fertility contexts. Broadly, they can be divided into two groups: the demographic, which seek explanation for very low period fertility in the mathematical properties of population dynamics; and the social, which focus on the portion of fertility change that is explained by variation in economic, societal, and ideational factors. The former literature sees low period fertility as at least partially a transient problem of tempo – that is, the pace of birth timing – rather than quantum, or the total completed fertility of a cohort. The latter literature, on the other hand, explores the causal mechanisms behind fertility decision-making in low-fertility contexts, but does not always engage with the distinction between tempo and quantum. For example, gender-focused accounts of low fertility attribute cross-national differences in period *TFR* to differences in the level of equality experienced by women in the labor force and the family, through the mechanism of changes in desired

fertility (McDonald, 2000).

Russia's fertility path after the collapse of the Soviet Union began with a fall to lowest-low fertility, which persisted for approximately a decade before the period *TFR* began a substantial rebound in 2006. Within Russia, the period of very low fertility and high mortality that began in the 1990s is often referred to as a "demographic crisis," with particular reference to the negative rate of natural increase the country experienced from 1992 until 2012. In 2006, Vladimir Putin addressed this crisis in his annual address to the Federal Assembly, in which he introduced a suite of family policy reforms, presented as remedies to persistent low birth rates (Putin, 2006). The total fertility rate rose each year until 2015, and has dropped precipitously since.

This paper uses both descriptive analysis and modeling to examine Russia's fertility path in the Putin era. The main findings are:

- (1) Parity-specific paths toward fertility postponement: for first births, a relatively slow postponement transition caused and continues to cause moderate depression of period fertility; for higher-order births, a long period of delayed or forgone births ended only in 2007, after which compensation at relatively older maternal ages began.
- (2) Cohort resilience to period shocks: a simple projection method indicates that completed cohort fertility has begun to recover from the fertility shocks of the 1990s. Parity-specific data suggests that the timing and nature of the Putin administration's family policy reforms likely played a role in this.
- (3) Falling fertility in recent years is likely related to Russia's worsening economic situation, rather than the end of an incentive-driven boomlet: linear regression exploiting regional variation in fertility and the economy demonstrates strongly procyclical fertility.

Background

Demographic explanations for lowest-low period fertility rates start from the premise that period *TFR*, as the sum of period age-specific fertility rates, represents the experience of a synthetic rather than an actual cohort, and is thus subject to distortions when the mean age at childbearing is changing. If the mean age at childbearing by parity is rising, transitory tempo effects depress period measures vis-à-vis completed cohort fertility (Bongaarts & Feeney, 1998). These effects lessen or disappear when the mean age at childbearing begins to stabilize once more; this proposed transition from an early to a late equilibrium mean age at childbearing has been called the postponement transition (Bongaarts & Sobotka, 2012; Goldstein et al., 2009; H.-P. Kohler et al., 2002; Sobotka, 2004). Kohler et al. (2002) theorize that it is driven by a combination of societal incentives for delayed childbearing and social interactions; in their model, age at first birth is determined by individual characteristics (such as education level) and aggregate determinants (such as the cost of child care). Crucially, individual preference for birth timing is influenced by the population mean;

this mechanism accounts for the (so far, universally observed) inevitable continuation of the transition once it has started.

Whether the postponement transition necessarily induces some loss of cohort quantum, as births are pushed later in the life course, is debated; Kohler et al. (2002), writing before European fertility bounced back from lowest-low levels in the early 2000s, argue that it does. Lutz and Skirbekk (2005) discuss a low-fertility “trap,” in which low period fertility engenders new family size norms. Goldstein et al. (2009), writing after fertility had rebounded from lowest-low in most European countries, assert that, given relatively low target numbers of children, most women will have time to meet their childbearing goals, even with a later start; a country experiencing a decade of lowest-low period *TFR*s could still have a constant cohort *TFR* of around 1.6, given a standard postponement transition experience.

The Russian case

Period total fertility rates (*TFR*) in Russia have changed dramatically over the past thirty-five years. At the end of the Soviet era, Russia was coming off of a pronatalist campaign that had led to falling mean age at childbearing (MAC) and period *TFR* that rose from slightly below replacement in the 1970s to a high of 2.23 in 1987 (Zakharov, 2008). Period *TFR* fell dramatically beginning in 1987, during the social and economic turmoil of perestroika. The fall worsened as the Soviet Union collapsed in 1991, and the *TFR* continued to decrease nearly every year in the turbulent 1990s, bottoming out at 1.15 children per woman in 1999, the year after a major Russian financial crisis and government debt default. While small gains began to be observed in 2000, the year Vladimir Putin took office as president, period rates stayed near or under 1.3, or “lowest-low,” until 2006. The period *TFR* increased from 2006, the year the Putin administration announced new pro-natalist measures, including improvements in maternity leave and child benefits, a demographic plan with targets through the year 2025, and a “maternity capital” program granting a one-time, limited-use gift of approximately 11,000USD (indexed to inflation until 2016) to mothers of two or more children. Fertility peaked at 1.75 in 2016, and has fallen rapidly since, to 1.54 in 2018 and reportedly as low as 1.5 in 2019.

The former Eastern Bloc, and sometimes Russia specifically, is incorporated into much of the work on lowest-low fertility; Kohler et al.'s 2002 paper includes Southern and Eastern Europe as examples of regions with very low fertility. Both this paper and other cross-national comparisons (e.g., Billari & Kohler, 2004) point out the many differences between fertility patterns between Southern and Eastern Europe, including high versus low age at first birth, low versus high non-marital fertility and divorce rates, and relatively low versus relatively high female labor force participation. They tend to attribute the causes of low Eastern European fertility to the economic turmoil of the transition to capitalism.

Work that focuses specifically on the post-communist region also attributes low fertility to economic turmoil. Kohler and Kohler (2002), integrating micro- and macro approaches to the question, find that during the Russian economic crisis of the 1990s, economic distress did correlate with low fertility at the macro level; however, within individual households, it

did not. Perelli-Harris (2005), studying Ukraine – not identical to Russia, but experiencing many parallel social, political and economic trends, especially in the early post-Soviet period – associates low fertility with a pattern of childbearing in which women still prioritize having a first child at a relatively young age, but delay or forgo later births due to economic crisis. Billingsley (2010) uses cross-sectional time series data from across the post-socialist region to separate higher-order stopping behavior in Eastern Europe from birth postponement, associating the former with economic crisis and the latter with economic improvement and the ideational changes of the Second Demographic Transition.

Russia is an interesting case in that, since the late Soviet era, demographic crisis has loomed large in the national discourse, and Russian demographers themselves are often pessimistic about the future size and composition of the population. Concern that Soviet society was not arranged to encourage childbearing, and efforts to correct this, began in the 1960s (Attwood, 1990; Desfosses, 1981); more recently, Frejka and Zakharov (2013) argue that the Putin-era pro-natalist policies will not stop Russia's fertility decline, which Zakharov (2008) attributes to the Second Demographic Transition. Even when optimism regarding rising birth rates is expressed, it is tempered with concern over the demographic "hole" created by small birth cohorts in the 1990s and the effect they will have on the rate of natural increase as they reach childbearing ages. A great deal of ink is spilled in the popular press; among policymakers; and within the politically and culturally powerful Russian Orthodox Church and social organizations in its orbit in attempting to address incipient demographic degradation (see the other two papers comprising this dissertation for extensive discussion of this phenomenon). Furthermore, popular Western accounts of Russian population troubles, in an effort to emphasize the many shortcomings of Vladimir Putin's authoritarian-style leadership and corrupt administration, often end up reductive, swift to emphasize the poor demographic indicators of the 1990s and reluctant to acknowledge the possibility that, even under Putin's rule, Russia over the last 20 years has seen real improvements in population health and wellbeing.¹ In this context, discussion of sub-replacement fertility and its impacts on the economy and the nation are even more heated and urgent than in other developed countries.

Data and Methods

Demographic data, including age- and parity-specific fertility and age-specific mortality rates for the Russian Soviet Federative Socialist Republic and the Russian Federation from 1989 through 2018, comes from the Human Fertility Database (HFD) at the Max Planck Institute for Demographic Research (Germany) and Vienna Institute of Demography (Austria), and the Russian Fertility and Mortality Database (RFMD) housed at the New Economic School (Moscow, Russia). Demographic calculations were done in R.

¹An example of this genre is Masha Gessen's (2014) *New York Review of Books* review of Michelle Parsons' (2014) *Dying Unneeded*, an ethnographic account of discourses of death in the early Putin era.

Economic indicators for the Russian regions are published by the Russian State Statistical Service, and freely available online at [/https://rosstat.gov.ru/](https://rosstat.gov.ru/).

Tempo Adjustment

Tempo distortions can be corrected using the Bongaarts-Feeney method of tempo adjustment, in which the adjusted formula for the period TFR (TFR^*) at a given birth order i is equal to:

$$TFR_i^* = TFR_i / (1 - r_i)$$

That is, the unadjusted TFR_i , divided by $(1 - r_i)$, where r_i is the change, in years, in the mean age at childbearing at birth order i . A positive r_i , or a shift toward later childbearing, leads to a higher adjusted TFR_i^* vis-à-vis the unadjusted period measurement. A negative r_i , or a shift toward earlier childbearing, leads to a lower TFR_i^* . The overall TFR^* , in turn, is the sum of the $TFRs$ at each birth order (Bongaarts & Feeney, 1998). This form of tempo-adjusted TFR is very sensitive to small year-on-year changes in birth timing, so it is best used not as an indicator of the “true” TFR in a given year, but as a guideline over several years of fertility timing changes. Accordingly, tempo adjustments in this paper have been smoothed by the application of a three-year moving average.

A further extension of this tempo adjustment work is suggested in Bongaarts and Feeney (2008) and further discussed in Bongaarts and Sobotka (2012). This method uses fertility hazard rates rather than frequencies, treating births at each parity as non-repeatable events; therefore, it requires the person-years of exposure by women at each parity. It adjusts not only for the changing tempo of childbearing, but for changes in the composition of the population by parity; that is, it accounts for the size and age structure of the population of women at risk of giving birth at any given parity i , and yields an estimate that removes the effects of these compositional changes. A practical advantage of $TFRp^*$ over TFR^* is that it is not as prone to large fluctuations, and so does not need to be smoothed.

Bongaarts-Feeney tempo adjusted TFR^* is available from the Human Fertility Database (HFD); however, HFD period data for Russia ends in 2014, while the RFMD has data through 2018; therefore, for the latest years, I calculated it myself using RFMD data.² The RFMD data does not include the necessary measures of parity-specific person-years of exposure, so tempo- and parity-adjusted $TFRp^*$ was calculated using the HFD births, exposure, and mean age at birth files; as such, it is only calculated through 2014.

Projection

A significant component of Frejka and Zakharov's (2013) work, which argues that Russian pro-natalist policy will fail to produce significant changes in birth rates, hinges on the assumption that current cohorts will have ASFRs similar to those of past cohorts, particularly

²Fertility rates and adjustments calculated from these two data sources differ slightly; a plot comparing them can be found in Appendix 2

in their later childbearing years. This is by no means impossible, but, since ASFRs in the later part of the fertility schedule have been rising, it seems likely to underestimate future fertility. Myrskylä, Goldstein, and Cheng (2013) suggest a method of fertility projection that is almost as simple as this “freeze rates” method, but significantly more effective; based on the Lee-Carter model for period mortality (Lee & Carter, 1992), they model future age-specific fertility as based on a general baseline age schedule and two fertility change components, an age component and a time component. The rate of change in the time component is assumed to remain the same for five years in the future, before it goes to zero. Thus, the projected fertility experience of the 1990 birth cohort at age 29 (that is, in 2019, a year for which data is not yet available) is a function of the observed fertility experience of the 1989 birth cohort at the same age in the previous year, as well as of the observed overall changes in fertility in 2014 through 2018. Although this method is fairly simple, it performs better than more complex models, and has the advantage of requiring very little data and processing power (Bohk-Ewald, Li, & Myrskylä, 2018). I implement the model fairly conservatively, forecasting fertility for ten years, through 2028, to yield complete (through age 45) fertility for birth cohorts through 1983.

Regression analysis

This section contributes to the study of fertility in post-Soviet context by utilizing regional variation to assess the relationship between economic covariates and first-, second-, and third-order births, respectively. Economic covariates include per capita income (measured on a log scale), the average per-square-meter cost of building an apartment (also on a log scale), and the percent of working-age adults who are employed - a measure similar to labor force participation, but excluding the unemployed. Other covariates that were considered, but which were found not contribute to the model, included the average percentage of income spent on consumer goods and services; and the ratio of apartment building costs to per capita income. I also included controls for region-level urbanicity and percentage of the population that is ethnically Russian - historically, ethnic Slavs have had lower fertility than other ethnic groups native to the former Soviet Union, and, as Russia has many regions that are national homelands for native minorities, this could be a significant driver of regional fertility variation. It is unfortunate that urbanicity is rather imprecise, as the designation of “urban” is a binary measure that lumps together large cities and villages designated as “urban-type settlements” with as few as a hundred inhabitants. As a result, urbanicity is tightly clustered around the mean of 70.3%; the fertility gradient could well be stronger if a different division were used. Percent Russian varies more widely, from less than 1% in the Republic of Ingushetia to 97.3% in Vologda Oblast, with a mean of 77.2%. Economic data for 2013 through 2017 were linked to region-level parity-specific total fertility rates for 2014 through 2018, respectively, on the assumption that economic conditions affect fertility through the mechanism of decisions to delay or proceed with pregnancy, and are thus time-shifted by 9-18 months.

I implement a straightforward panel regression, with time dummies to control for time trends and geographic dummies for Russia's eight federal districts, rather than individual dummies for all 83 included regions.³

Results

Tempo Adjustment and Mean Age at Childbearing

Period fertility in Russia over the last 30 years very much resembles the pattern described in Goldstein et al. (2009), of an approximately ten-year period of very low fertility in the midst of a postponement transition, followed by a steady emergence from this trough (Figure 2.1). The Bongaarts-Feeney tempo adjustment with smoothing yields a greatly attenuated low-fertility trough; the observed fall in fertility in the 1990s, from a TFR of 1.96 to 1.14, or 0.82 children per woman, becomes a fall in TFR^* of only 0.32 children. Thus, over 60% of the fertility fall is attributable to tempo effects. Conversely, although tempo-adjusted fertility is still higher than unadjusted fertility in the more recent period, the unadjusted increase in fertility from 1999 to 2015, the year fertility peaked, is 0.61 children, while the tempo-adjusted increase is 0.49 children; 20% of the increase in fertility is accounted for by tempo effects (largely by the fact that these effects were suppressing period fertility much more in 1999 than they were in 2015).

The negative effect of tempo on period fertility has lessened in recent years; while TFR^* was nearly 30% higher than TFR in 1999, from 2009-2014, the last five years with adjusted data available, the difference between the two measures is less than 10%, indicating that tempo is now only weakly suppressing fertility. (See Appendix 2 for TFR , TFR^* and $TFRp^*$ numbers corresponding to Figure 2.1.)

Tempo and parity adjustment is similar - a drop of .34 children per woman in the 1990s, and a gain of only .23 to 2013, the last year for which $TFRp^*$ can be calculated. Tempo and parity-adjusted TFR is higher than its tempo-adjusted counterpart until 2007, indicating the negative effect of the parity distribution on fertility during the worst of the crisis, and lower thereafter.

Figure 2.2 illustrates that the observed narrowing of the gap between TFR and TFR^* in recent years has been caused by differing changes in the mean age at childbearing (MAC) at different parities. During the period of largest difference between TFR and TFR^* , MAC was rising at all parities. While mean age at first birth (MAFB) has continued to rise – indeed, it has increased nearly linearly from 1994 to 2018 – age at childbearing for all other parities

³Two regions, the Republic of Crimea and the Federal City of Sevastopol, which Russia annexed from Ukraine in 2014, are excluded from the analysis because of limited data availability. Two others, the Republic of Chechnya and Magadan Oblast, are only included in a subset of years, for the same reason.

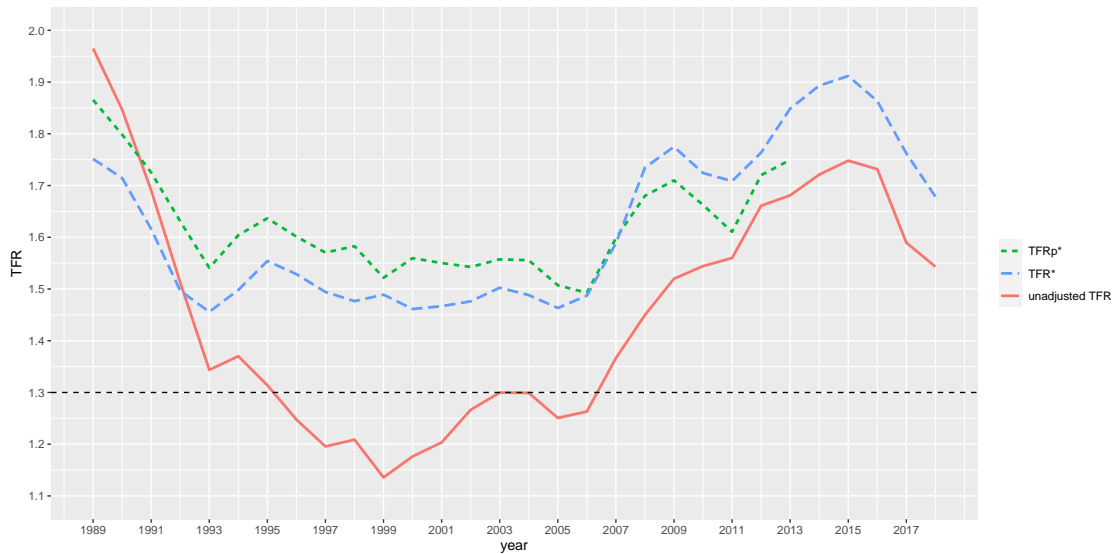


Figure 2.1: Unadjusted, Tempo-Adjusted, and Tempo- and Parity-Adjusted Total Fertility. Data via Human Fertility Database and Russian Fertility and Mortality Database.

has flattened or declined slightly since 2010. This halting or reversal of postponement of higher-order births reduces the tempo effect.

Parity

The experience of different parities across the postponement transition has been vastly different. Using unadjusted period rates, TFR at parity 1 fell by approximately 30% between 1989 and 1999 – the year with lowest overall period TFR – while TFR at parities 2 and above fell by 50% or more. (Table 2.) With tempo adjustment, these numbers are attenuated, as shown in Table 2. The adjusted change in TFR at parity 1 between 1989 and 1999 – equivalent in theory to the actual quantum reduction – is only 1%. The quantum reduction is larger for each successive parity, but only at parity 4 and above did quantum fall by more than 50%.

Since 2005, the year from which the post-collapse secular period TFR increase decisively began, gains at different parities have differed as well. Table 2 gives unadjusted and adjusted growth by parity between 2005 and 2015, the year fertility peaked. Here, tempo effects dampen the quantum change in period TFR at parity 1, but amplify it for all other parities. With tempo effects removed, TFR at parity one was 13% larger in 2015 than 2005. The effect is over four times larger at parity 2: the pure quantum effect amounts to a 57% increase in fertility. Growth at parities 3 and higher, which have substantially smaller numbers of births, is also at or above 50%.

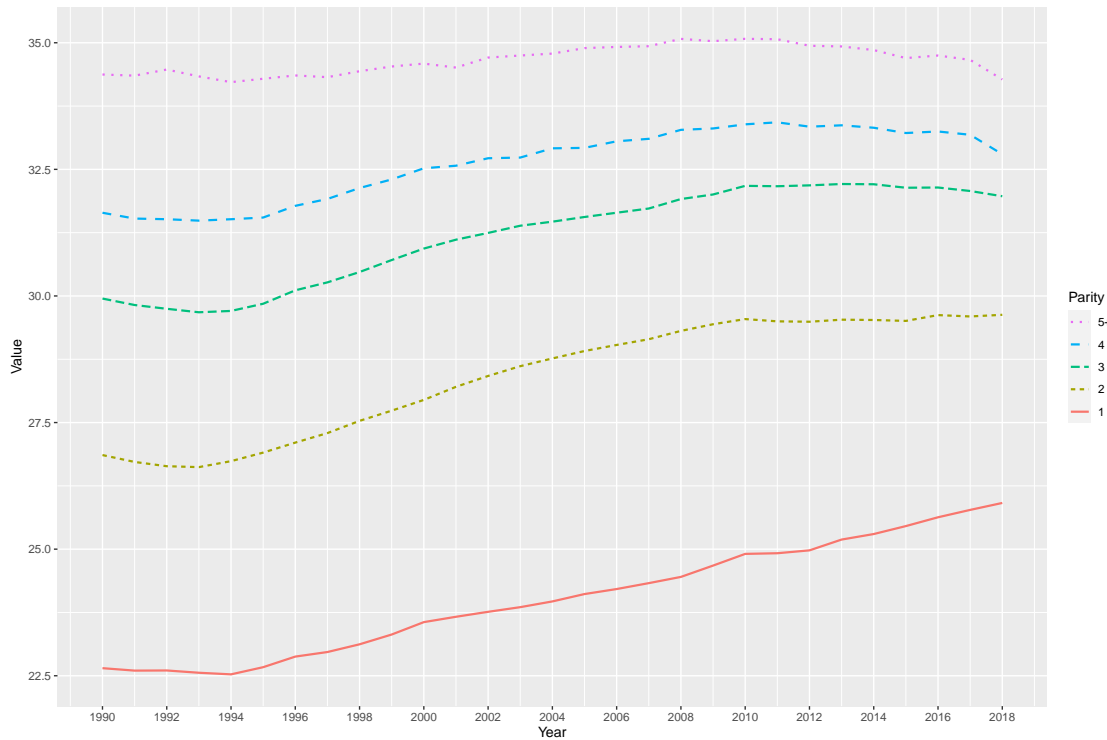


Figure 2.2: Mean Age at Childbearing by Parity. Author’s calculations based on data from the Russian Fertility and Mortality Database, Center for Demographic Research, Moscow (Russia). Available at www.demogr.nes.ru.

Year	Total	Parity 1	Parity 2	Parity 3	Parity 4	Parity 5+
1989	1.96	1.00	0.70	0.20	0.06	0.05
1999	1.14	0.68	0.34	0.09	0.03	0.02
change	-42%	-32%	-51%	-55%	-50%	-60%
2005	1.25	0.73	0.40	0.10	0.03	0.02
2015	1.75	0.79	0.69	0.22	0.06	0.03
change	+40%	+8%	+72%	+120%	+100%	+50%

Table 2.1: Fertility change by parity using unadjusted period TFR, 1989-1999 and 2005-2015. Author’s calculations based on data from the Russian Fertility and Mortality Database.

Figure 2.3 shows fertility schedules by parity (for parities 1, 2, and 3, which account for approximately 96% of the period *TFR*) in 2005, 2006, 2007, and 2018. At parity 1, the age schedules are similar in 2005, 2006, and 2007. By 2018 a much more dramatic shift in the pattern and quantity of births at parity 1 is apparent. At parities 2 and 3, however, a period quantum effect is seen in the upward shift of the curve beginning in 2007, and can still be seen in 2018.

Year	Total*	Parity 1*	Parity 2*	Parity 3*	Parity 4*	Parity 5+*
1989	1.79	0.88	0.63	0.18	0.06	0.05
1999	1.47	0.87	0.43	0.11	0.03	0.02
change	-18%	-1%	-32%	-39%	-50%	-60%
2005	1.44	0.83	0.46	0.11	0.03	0.02
2015	1.96	0.94	0.72	0.21	0.05	0.03
change	+36%	+13%	+57%	+91%	+67%	+50%

Table 2.2: Fertility change by parity using tempo-adjusted period TFR, 1989-1999 and 2005-2015. Author's calculations based on data from the Russian Fertility and Mortality Database.

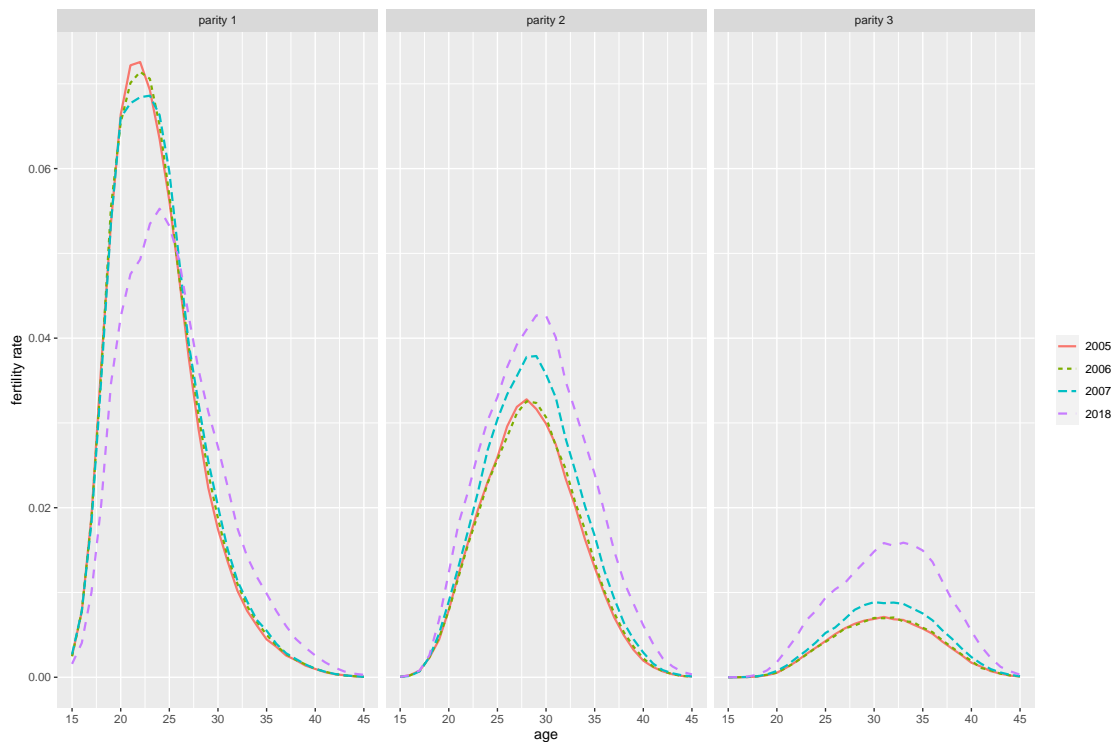


Figure 2.3: Period fertility schedules by parity, 2005-2007 and 2018. Data via Russian Fertility and Mortality Database.

The Bongaarts-Sobotka TFR_p^* adjustment method also suggests the utility of a descriptive plot of person-years of exposure at each parity across the postponement transition. This plot, showing, in effect, the distribution of the female population of reproductive age by parity, is shown in Figure 2.4. This distribution is affected by 1) the age structure of the

population - a population that skews younger will have a larger share of person-years lived at lower parities; 2) both the timing and rates of transition between parities; that is, the same tempo effects that can make period *TFR* difficult to interpret are in effect here. The figure shows that, at the beginning of the postponement transition, the share of women at parity 0 was quite small. Around a third of women in 1990 had one child, and a bit over a third had two children. The share of women at lower parities grew and the share with two or more children shrank throughout the transition, until, between 2008 to 2010, the tide reversed. As fertility increased, the share of women at parity 0 and 1 began to fall, while the share of women at higher parities began to rise.

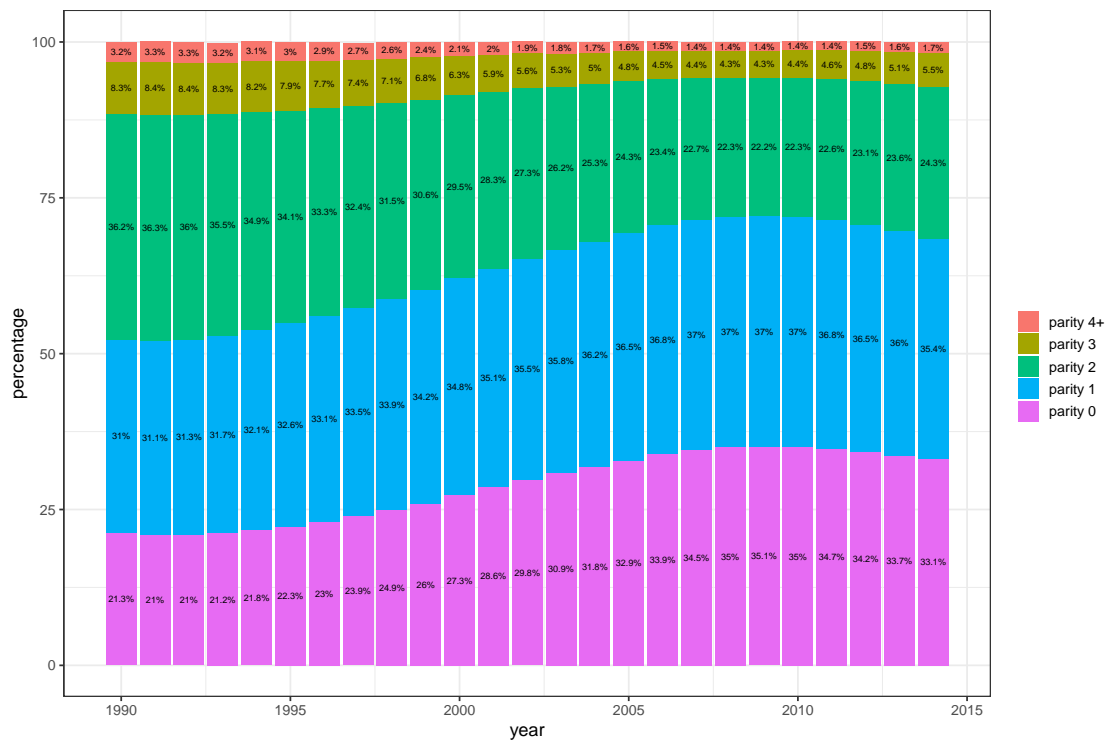


Figure 2.4: Share of period person-years lived at each parity (among women aged 18-44). Data via Human Fertility Database. Max Planck Institute for Demographic Research (Germany) and Vienna Institute of Demography (Austria). Available at www.humanfertility.org.

Cohort projection

Projection for cohorts with schedules completed through age 45 are shown below. As Table 2.3 illustrates, with ten-year projection, cohort fertility through age 45 ranges from an

observed 1.859 children per woman for the 1960 cohort, who completed much of their child-bearing before 1991, down to 1.575 for the 1973 cohort, who were just turning fifteen when the fertility drop associated with perestroika hit, and who spent their twenties and early thirties in the most difficult years of the transition. Fertility rises to 1.759 for the 1983 cohort.

Cohort	Cohort Fertility (observed)	Cohort Fertility to age 45 (projected)
1960	1.859	***
1961	1.831	***
1962	1.768	***
1963	1.738	***
1964	1.709	***
1965	1.685	***
1966	1.671	***
1967	1.645	***
1968	1.631	***
1969	1.627	***
1970	1.607	***
1971	1.600	***
1972	1.588	***
1973	1.575	***
1974	1.607	1.608
1975	1.609	1.613
1976	1.613	1.621
1977	1.632	1.648
1978	1.639	1.669
1979	1.644	1.692
1980	1.600	1.675
1981	1.589	1.695
1982	1.602	1.749
1983	1.563	1.759

Table 2.3: Cohort fertility through oldest age observed and, for younger cohorts, projected cohort fertility through age 45. Data via Russian Fertility and Mortality Database.

The shape and magnitude of the change in cohort fertility is illustrated in Figure 2.5.

Although completed fertility varied by only about a quarter of a child per woman among these cohorts, their fertility schedules look very different from each other. Figure 2.6 below shows three such schedules. Birth cohort 1975, one of the cohorts with lowest projected



Figure 2.5: Cohort completed fertility with projection, 1960-1985 birth cohorts. Data via Russian Fertility and Mortality Database.

completed fertility (1.6 children per woman at age 45), exhibits the old pattern of fertility, with a high, early peak and a quick descent. Already the 1980 and 1985 cohorts, who did not enter their childbearing years until around the turn of the millennium, show a pattern of later, lower, and more extended peaks, with markedly more childbearing at ages above 25. For both the 1975 and 1980 cohorts, an inflection point can be seen at the age corresponding to the year 2006, at which falling fertility suddenly increased again.

Regression

Regression results are reported in Table 2.4. Not all covariates reach significance at all parities, but broadly, employment is positively correlated with fertility, while the cost of building an apartment is negatively correlated. Per capita income is positively correlated for first and third births, but weakly negative (not reaching significance) for second births. Unsurprisingly, urbanicity and percent Russian (as measured at the 2010 census) are negatively correlated with fertility at all parities. The geographic controls indicate that, *ceteris paribus*, most regions of Russia have higher fertility than the baseline region, the Central Federal Dis-

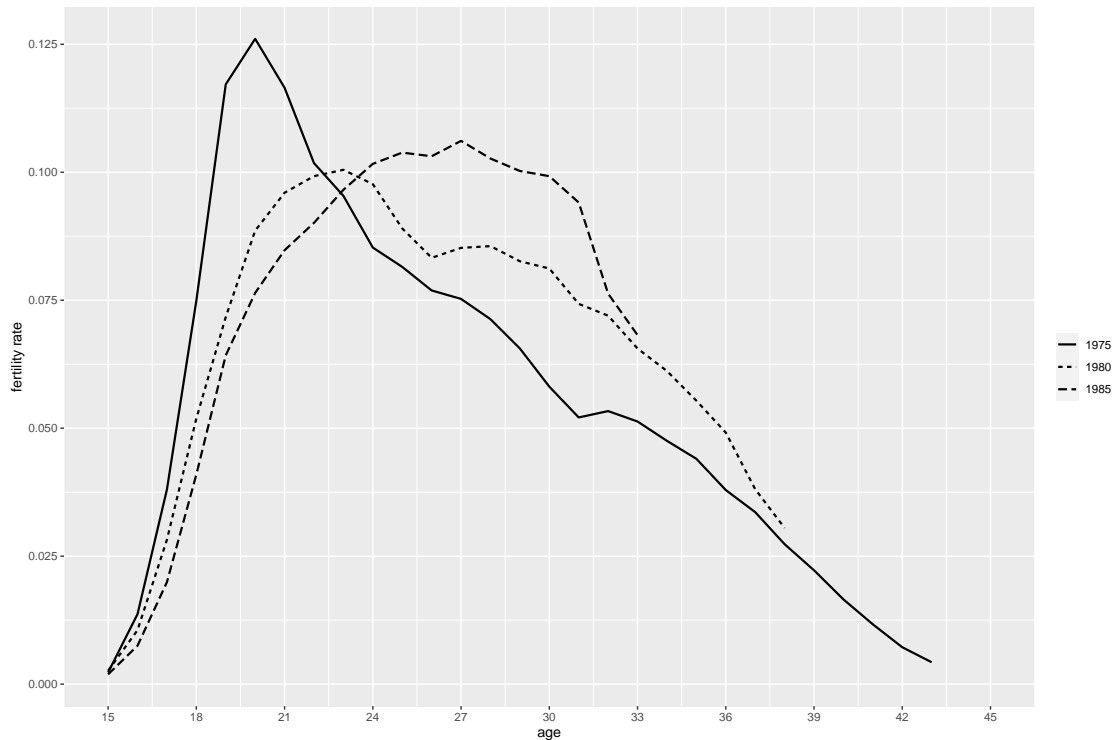


Figure 2.6: Cohort fertility schedules, 1975, 1980, and 1985 cohorts. Data via Russian Fertility and Mortality Database.

trict (i.e., the area around Moscow). Exceptions are the Southern Federal District (which is where Taganrog, the subject of my fieldwork, is located); the Caucasus Federal District, and, for third births, the Volga Federal District. Most effects are small, on the order of hundredths or thousandths of a child. Controls for year fixed effects, however, yield larger effect sizes, particularly for first births.

Discussion

Parity patterns

Since $TFRp^*$ adjusts for both tempo and parity, when it is higher than tempo adjustment alone, both effects are

The first-births postponement transition has been slow and steady, with approximately three years gained in MAFB since 1994 in a highly linear pattern. This is somewhat unexpected, in that the postponement transition literature discusses, in the canonical case, an accelerating increase in the mean in the first stages of the transition (Goldstein et al., 2009; Kohler et al., 2002). The Russian transition also started with a somewhat lower mean age

at first birth (MAFB) than similar transitions in other countries. This low start and slow growth means that first-birth postponement could continue for several decades, if it follows the path of other European countries. But if that happens – meaning these slow gains in MAFB do not accelerate – this transition's continuation is not likely to lead to large tempo effects, and Russia will not see tempo-driven lowest-low fertility again.

The transition for second and higher-order births has been rather different. As shown in Figure 2.2, postponement of higher-order births followed a similar path to postponement of first births, but the overall level of these births fell much more substantially than did first births. Indeed, Table 2 shows that TFR^* at higher parities fell substantially in the first ten years of the transition – by about thirty-two, forty, fifty, and sixty percent for second, third, fourth, and fifth-plus births, respectively. For first births, on the other hand, the fall was a mere 1%, and 1999 fertility levels were still such that, if they reflected actual cohort levels, 88% of women would finish their reproductive years with at least one child. Lowest-low fertility for first births, by contrast, is considered to be 0.75 children per woman or lower (Goldstein et al., 2009). This parity difference aligns with previous findings on lowest-low fertility in the former Soviet Union, which indicate that forgoing of higher order births was more important than long postponement of first births.

Three pieces of evidence point to a parity-specific quantum effect of the Putin administration's 2007 family policy reform package. First, the upward shift in 2007 of the fertility schedules for second and third births (Figure 2.3) indicates that the announcement of the new maternity capital policy in May 2006, which specifically provides a large monetary award for second- and higher-order births, may have had an immediate effect on couples' childbearing plans. This apparent effect of the 2007 family policy package is also visible in Figure 2.6, as an inflection point in the schedule of both the 1975 birth cohort, at age 32, and the 1980 cohort, at age 27. Second, the effect of this policy is visible in the large increases in second and higher-order births not just from 2006 to 2007, but in later years as well. As Table 2 shows, in the period 2005-2015, second births increased four times as much as first births, and third births increased seven times more. Tempo-adjusted period $TFRs$ at parities two and three were higher in 2015 than in 1989.

Third, the flattening of the mean age at childbearing (MAC) curves for parities two and higher indicate another possible effect of the maternity capital policy, which was initially set to expire in 2016 and thus offered women a limited time frame in which to have their second and higher-order births. (The policy has since been extended at least through 2021.) It is difficult to untangle the possible effects of the policy environment and of cohort-driven recuperation processes, and indeed, it seems likely the two go hand-in-hand; after all, part of the reason the policy was effective is likely that long delays in second and higher-order births had led to a very large share of the population of reproductive age being at parity 1 - 37% in 2007 - and thus at risk of a second birth (Figure 2.4). However, cohort recuperation should not, by itself, lead to a reduction in the MAC, as it is by definition driven by women at older ages; this flattening of the MAC curve must be driven by increases in higher-parity childbearing by younger women.

It is difficult to predict what might happen to time trends in higher-parity births in the

coming years, regardless of the policy environment; if the mean age at first birth continues rising, it would seem the necessity of child spacing demands MAC at higher parities eventually resume its rise as well. However, since the mean age does not contain information about the distribution of ages at first birth, it is possible that this will not happen right away; for example, if the distribution of first births is bimodal, with women who intend more than one child having their first birth relatively early, and those who intend only one having it later.

Cohort fertility

It is difficult to measure the cohort aspect of Russian lowest-low fertility and recovery, in that, while the cohorts we would expect to be the most affected – those who came of age around the end of the Soviet era – are now nearing the end of their childbearing years, the cohorts whose fertility we expect to improve are not yet old enough to have completed fertility. However, a short ten-year projection helps to address this, and indicates that a very large portion of the fertility changes Russia has seen in the last 25 years are due to transitory tempo effects. Among cohorts born from 1960 to 1985, the total variation in completed fertility (to age 45) is 0.28 children per woman. Put another way, this means that in the 1973 birth cohort – which has the lowest completed fertility at 1.575 children per woman – between a quarter and a third of women did not have a child that they would have had if they had been members of the cohort born ten years earlier. The combination of postponement and a long period of forgoing higher-order births did, it seems, result in some loss of cohort quantum. But younger cohorts are already beginning to recoup that lost quantum; the 1978 cohort, only five years younger, has already had 1.639 children and is projected to finish their childbearing years with nearly a tenth of a child more than the 1973 cohort.

These cohort differences are by no means immaterial – as mentioned above, small changes in fertility have large implications for population growth rates at the lower end of the *TFR* scale – but they are, nonetheless, significantly less dramatic than the story told by period fertility.

The unusual shift seen around the 1980 cohort - higher cohort fertility in 1979 and 1981, and lower in 1980 - may be due to slight age heaping in the denominator.

The recent fertility downturn

Much has been made of the recent fertility fall in the Russian media. It is sometimes treated as evidence of another severe crisis like the 1990s, although it is broadly in line with fertility trends of the last few years across the developed world. Other reports suggest that it is the end of a maternity capital- and cohort recuperation-driven boomlet whose dissipation will lead to cratering fertility rates. However, linear regression seems to indicate a fairly quotidian story: fertility is behaving procyclically, with both employment and income positively correlated with fertility, and the cost of housing negatively correlated. However, the relatively strong negative correlation between year and fertility at parity 1 (vis-a-vis the

baseline year of 2013) indicates that some portion of the change in fertility is not captured by the economic situation. This analysis is complicated by the fact that Russia's economy contracted dramatically in 2014 and 2015 due to international sanctions after the Ukraine conflict and annexation of Crimea, but recovered fairly quickly according to many indicators. It is possible, though speculative, that the current fertility fall is related to those poor economic conditions in 2014-2015, or to an incomplete or unequal recovery.

Limitations

The Bongaarts-Feeney adjustment measurement carries with it some strong assumptions; in particular, that changes in the age at childbearing are pure period effects, affecting all cohorts in the same way. This is justified by a body of research that suggests cohort effects play only a minimal role in fertility change (see, e.g., Brass (1974); Ni Bhrolchain (1992)); however, the contrary view, that cohort-driven processes occur specifically in cases where births have been delayed and fertility recuperation occurs, is also well-represented in the literature (see, e.g., Goldstein et al., 2009, Bongaarts & Sobotka 2012). These cohort recuperation processes could well play a role in the period of Russian fertility gains from 2006 onward; if so, the Bongaarts-Feeney adjustment is likely to overcorrect for tempo changes. Attempting other adjustment methods, or exploring measures other than period *TFR*, would be worthwhile for the sake of comparing their results.

In terms of cohort projection, it is worth noting that at ages above 35, the increase in ASFR over the last five years has been slowing, and a linear interpretation of the trend is likely to slightly overestimate fertility to age 40. However, fertility over age 40 has been increasing as well, which may compensate for this overestimate to age 40 in the later cohorts.

Finally, regression results would likely be stronger if more data were available - either more years of data, or a larger number of more detailed covariates.

Conclusion

This paper has contributed a description of the Russian fertility trough and rebound to the literature on low and lowest-low fertility. It has examined how much of the large swings in period fertility are accounted for by tempo effects, and how those effects differ by parity. I find that tempo shifts – a rise in the mean age at childbearing as births, particularly higher-order births, were delayed – were responsible for approximately 60% of the fall in fertility in the 1990s, and 20% of the subsequent increase. Cohort projection indicates that the cohorts who lost the most fertility quantum were those born 1969-1976, who entered their early 20s – peak childbearing years in that era – in the early- to mid-1990s. Given the amount of childbearing already completed and rising age-specific fertility rates at older ages, more recent cohorts, who are currently in their mid- to late thirties, are on track to have completed fertility more similar to that of the early 1960s cohorts. In addition to cohort recuperation, several characteristics of the fertility increase, including increases in

second- and third-order births and flattening mean ages at birth at higher parities, indicate at least temporary effects of the changing policy environment under Vladimir Putin, which incentivizes families with two or more children. General economic improvement over the course of the Putin era has likely also played a role, as seen by the procyclicality of fertility as Russia's economic situation has worsened in recent years. The future of Russian fertility, as of fertility in many advanced societies, is uncertain, with political and economic woes, continued fertility postponement, and now the challenge of a global pandemic exacerbating existing inequalities and health system challenges, but this paper has shown that the country has definitively escaped the low fertility trough of the early post-Soviet period.

Appendix: Additional plots

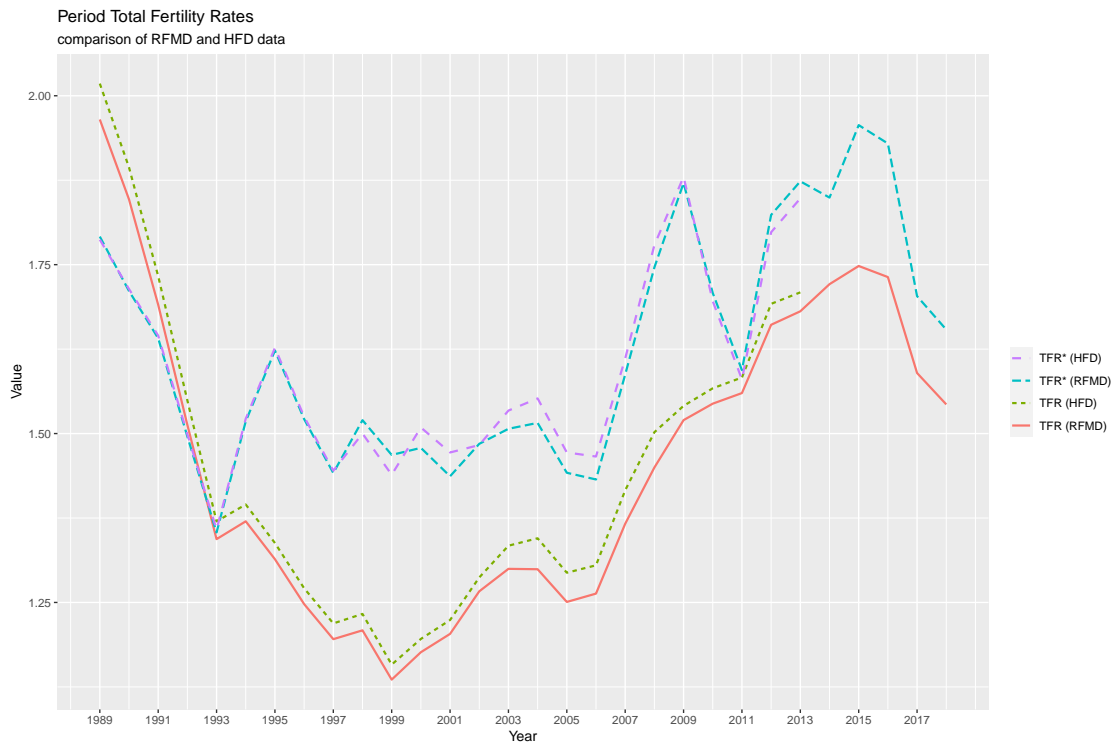


Figure 2.7: Comparison of Human Fertility Database and Russian Fertility and Mortality Database calculations of unadjusted and tempo-adjusted TFR.

Appendix: Additional tables

	TFR-1	TFR-2	TFR-3
per capita income (log)	0.0753 ** (0.0242)	-0.0085 (0.0268)	0.0198 (0.0174)
percent employed	0.0023 *** (0.0007)	0.0029 *** (0.0007)	0.0012 * (0.0005)
log cost of apartment construction	-0.0165 (0.0235)	-0.0752 ** (0.0271)	-0.0321 (0.0177)
percent urban	-0.0007 (0.0005)	-0.0017 ** (0.0005)	-0.0021 *** (0.0003)
percent Russian	-0.0008 (0.0005)	-0.0022 *** (0.0004)	-0.0028 *** (0.0003)
Northwest district	0.0186 (0.0106)	0.0537 *** (0.0120)	0.0409 *** (0.0069)
Southern district	-0.0363 * (0.0169)	-0.0210 (0.0162)	-0.0006 (0.0086)
Caucasus district	-0.1160 ** (0.0376)	-0.1710 *** (0.0335)	-0.0192 (0.0209)
Volga district	-0.0002 (0.0148)	0.0183 (0.0170)	-0.0384 ** (0.0118)
Urals district	0.0401 *** (0.0110)	0.1185 *** (0.0134)	0.0680 *** (0.0079)
Siberia district	0.0725 *** (0.0125)	0.1277 *** (0.0132)	0.0985 *** (0.0085)
Far East district	0.0672 *** (0.0148)	0.0598 *** (0.0141)	0.0461 *** (0.0082)
year 2014	-0.0294 * (0.0114)	0.0299 * (0.0124)	0.0040 (0.0072)
year 2015	-0.0690 *** (0.0123)	0.0224 (0.0126)	0.0097 (0.0082)
year 2016	-0.1397 *** (0.0119)	-0.0694 *** (0.0124)	0.0020 (0.0082)
year 2017	-0.1789 *** (0.0110)	-0.0912 *** (0.0121)	0.0082 (0.0087)
N	409	409	409
R-squared	0.6362	0.5995	0.7596

Table 2.4: Linear regression of parity-specific period fertility on economic, regional, and time covariates.

Year	Period TFR	TFR^*	TFR_p^*
1989	1.96	1.75	1.87
1990	1.85	1.71	1.80
1991	1.69	1.62	1.73
1992	1.51	1.50	1.63
1993	1.34	1.46	1.54
1994	1.37	1.50	1.60
1995	1.31	1.55	1.64
1996	1.25	1.53	1.60
1997	1.20	1.49	1.57
1998	1.21	1.48	1.58
1999	1.14	1.49	1.52
2000	1.18	1.46	1.56
2001	1.20	1.47	1.55
2002	1.27	1.48	1.54
2003	1.30	1.50	1.56
2004	1.30	1.49	1.56
2005	1.25	1.46	1.51
2006	1.26	1.49	1.49
2007	1.37	1.59	1.60
2008	1.45	1.73	1.68
2009	1.52	1.77	1.71
2010	1.54	1.72	1.66
2011	1.56	1.71	1.61
2012	1.66	1.76	1.72
2013	1.68	1.85	1.75
2014	1.72	1.89	NA
2015	1.75	1.91	NA
2016	1.73	1.86	NA
2017	1.59	1.76	NA
2018	1.54	1.68	NA

Table 2.5: Unadjusted, Tempo-Adjusted, and Tempo- and Parity-Adjusted TFR. Unadjusted and tempo-adjusted TFR are author's calculations based on Russian Fertility and Mortality Database data; tempo- and parity-adjusted TFR is calculated based on Human Fertility Database data.

Chapter 3

Bodily culture and the Russian postponement transition

Introduction

The body is central to childbearing, and in societies where most fertility is planned, women's experience of and perceptions about their bodies are likely to play a role in decisions about birth timing. In this essay I use the example of the contemporary Russian Federation to argue for more serious consideration of this aspect of culture in the demographic literature on the fertility "postponement transition" currently occurring across the developed world (Billari, Liefbroer, & Philipov, 2006; H.-P. Kohler et al., 2002). By "women's experience of and perceptions about their bodies," I mean such questions as: What do people think makes for a healthy body? How serious, and how easy to remedy, are various kinds of ill health? In the management of the body, what are the roles and responsibilities of medical expertise versus self-knowledge and self-care? How do women evaluate whether, and when, they are appropriate candidates for pregnancy and motherhood? What role do pregnancy and motherhood play in the making of a normal adult female body? I refer to the set of available answers to these questions as "bodily culture."

Consideration of bodily culture has the potential to address several gaps in demographic theory-making. First, we know empirically that fertility postponement proceeds at different paces in different circumstances, and complex economic and social theories have been applied in attempting to explain this phenomenon and the large observed differences in period fertility that it engenders (Anderson & Kohler, 2015; Bongaarts & Sobotka, 2012; Bongaarts & Feeney, 1998; Frejka & Sobotka, 2008; Goldstein et al., 2009; H.-P. Kohler et al., 2002; Lesthaeghe & Surkyn, 1988; Lutz & Skirbekk, 2005; McDonald, 2000; Myrskylä et al., 2009). Social theories incorporate relatively high-level ideational changes often referred to as the Second Demographic Transition: changes in ideals around marriage, beliefs about the importance of self-actualization, the role of entry into parenthood in the making of adulthood (Lesthaeghe & Surkyn, 1988; Van De Kaa, 1987). However, the physical and health-related

aspects of fertility are not very often included in this.

Second, in the historical literature and the literature on less developed societies, the calculus of reproduction is often understood to be deeply embodied (Bledsoe & Banja, 2002; Schneider & Schneider, 1996; Selin & Stone, 2009). But literature on contemporary developed societies often relegates it to the realm of rational – and particularly economic – thought. This echoes a general tendency in the field of demography to view pre-demographic transition societies as guided by superstition and tradition, and the demographic transition as a rationalization of fertility (see Davis (1963) and Notestein (1945) for classical treatments of demographic transition theory, and Szreter (1993) for a critical history of the idea). But even in societies where the primacy of the economic and social decisions involved in childbearing is readily apparent, fertility planning still requires planning to grow a child inside a body (even if, as in some cases of assisted reproduction, it's someone else's body), and postponement implies postponing the decision to do so.

Finally, consideration of bodily culture, and perhaps particularly its intersection with gender, has fruitful implications for reconsiderations of other topics in demography – including the effect of gender systems on fertility, and differentials in mortality and morbidity. Pregnancy and birth are an obvious entry point for incorporating bodily culture into demography, as demographic processes that are exceptionally “cultural” – involving, as they do, a large degree of choice and control – as well as being understood to be exceptionally “bodily.” (See, e.g., Schiebinger (2013) pp. 88-93 for a brief discussion of historical understandings of the female body as specially marked by sex and reproduction, and especially close to animal bodies in this way.) But of course, all demographic events involve bodies and culture to some degree.

Russia provides an interesting case study for the interaction of bodily culture and fertility postponement, as a country with a relatively recent, far-from-complete postponement transition. Like other post-socialist countries where postponement began in the 1990s, after the fall of state socialism, both the mean age at first birth and the variance in age at first birth were very low when the postponement transition started, and postponement itself has proceeded more slowly than in Western European countries (although more quickly than in the U.S. or Canada; see Figure 3.1). The postponement transition did not begin at the same time as the post-Soviet fertility collapse; while the total fertility rate began its precipitous fall in 1987, during perestroika, the mean age at first birth did not begin to rise until 1994. And as near-total social and economic collapse transformed Russian lives and contracted Russian futures in the 1990s and early 2000s, the average Russian woman continued to have her first child in her early twenties. The mean age at first birth did not reach 25 until the year 2013 (Figure 3.2). Furthermore, in the 1990s, first births had both a low mean and a small variance, meaning they were highly concentrated in the early 20s, and later first births were rare; as the mean age rose, the variance gradually grew as well, as the density plot in Figure 3.3 illustrates.

In this paper, I use a mix of ethnographic and interview data, internet forum posts and popular press health information to examine contemporary Russia's bodily culture and its relationship to fertility. In brief, I argue that persistent beliefs about the fragility of good

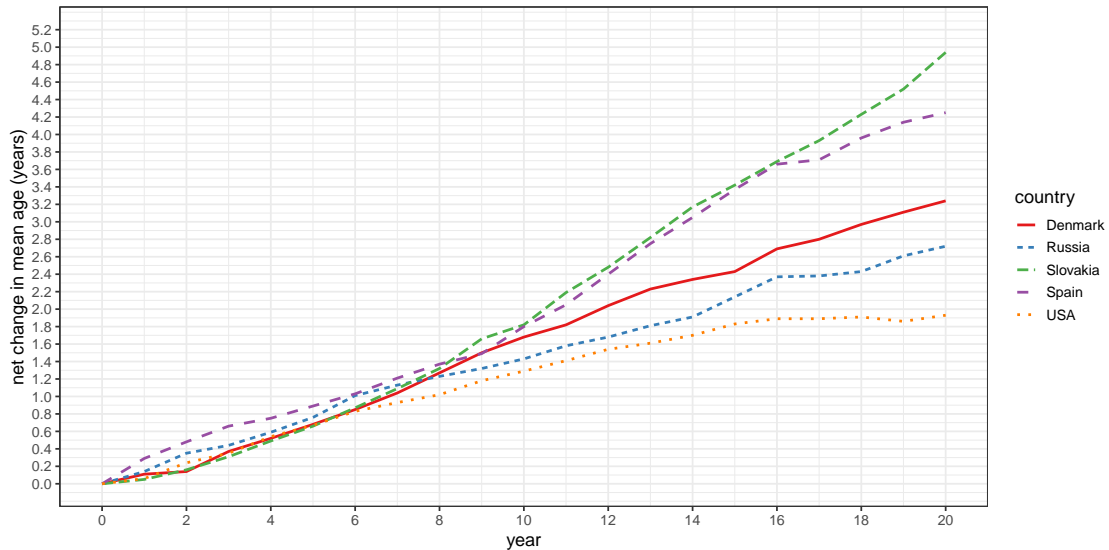


Figure 3.1: Pace of postponement: The net change in mean age at first birth in selected countries, starting from the first year of each country’s postponement transition. First year of postponement transition is defined here as the beginning of the first period in which the mean age at first birth rose for five consecutive years. Author’s calculations based on data from the Human Fertility Database. Max Planck Institute for Demographic Research (Germany) and Vienna Institute of Demography (Austria). Available at www.humanfertility.org.

health; notions of bodily balance; and perceptions of the body as capable of learning and being trained have affected the shape of the postponement transition in Russia in several ways. First, they have contributed to the slow uptake of modern contraceptives and continued low rates of abortion of first pregnancies. Second, they contribute to Russia’s low social age deadline, particularly, again, for first births; but they have also opened up space for new strategies that allow women to feel confident delaying births to older ages. Finally, I argue that this bodily culture interacts in unexpected ways with the changing doctor-patient relationship and the new availability of medical information to average women.

Although this essay is not a work of sociological theory, a word on theory is necessary. It is important to be clear about how culture can and cannot cause action. After Sewell (2005) and Johnson-Hanks et al. (2011a), I conceive of culture as “dual,” composed of mutually constitutive schemas (or “ideas”) and materials/resources (or “things”) that, together, structure action rather than causing it. Schemas relevant to fertility and bodily culture include notions such as *advanced maternal age* and *young motherhood* (or, at a deeper level, the paired dichotomies of young/old and strong/weak), *excess weight* or *morning sickness*. Materials include, for example, the obstetrician’s office; ultrasound machines; prenatal vitamins; paid parental leave; or the medical record card on which advanced maternal age is noted.

After Swidler (2001), I recognize that different cultural schemas can conflict and overlap,

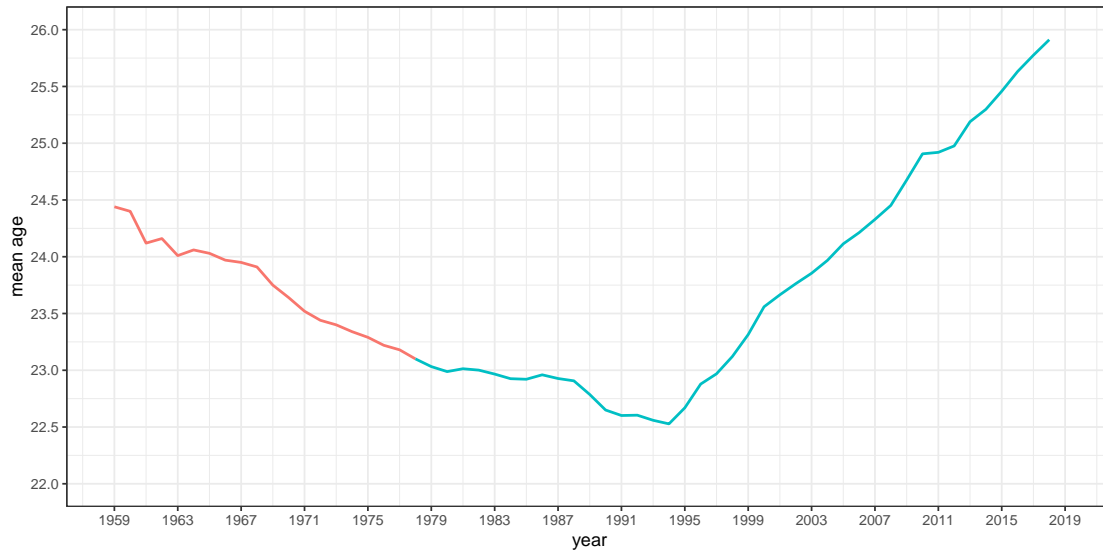


Figure 3.2: Mean age at first birth. Years indicated in red are from the Human Fertility Database, Max Planck Institute for Demographic Research (Germany) and Vienna Institute of Demography (Austria). Available at www.humanfertility.org. Years indicated in blue are author’s calculations based on data from the Russian Fertility and Mortality Database, Center for Demographic Research, Moscow (Russia). Available at www.demogr.nes.ru.

offering multiple contradictory interpretations of, or justifications and motivations for, behavior. Because of this, bodily culture is not deterministic, but rather a “toolkit” used in constructing intention and action (Swidler, 1986). There is also a large recent literature that takes into consideration the cognitive aspect of culture’s relationship to action, asking how culture relates to the unconscious, automatic processes that in fact comprise a great deal of human thought (see DiMaggio, 1997; Ignatow, 2007; Vaisey, 2009). Because childbearing decision-making often involves deliberation and planning, I argue that we can imagine it to fall substantially within the domain of what Vaisey (2009) terms “practical” culture, used in motivating behavior rather than simply justifying it.

At the same time, reproductive practice is an area heavily laden with “public”, “declarative culture,” or the performance of and adherence to normative frameworks in “producing justifications for ... public stances and commitments, spinning out vocabularies of motive, and generating post hoc justificatory rationalizations for actions” (Lizardo, 2017, p. 92; for more on declarative culture see Jerolmack & Khan, 2014; Pugh, 2013). In this sense, public statements, assertions made on social media, and answers given in interviews with a researcher the subject has never met before can be useful in obliquely thinking out the relationship between bodily culture and repertoires of behavior.

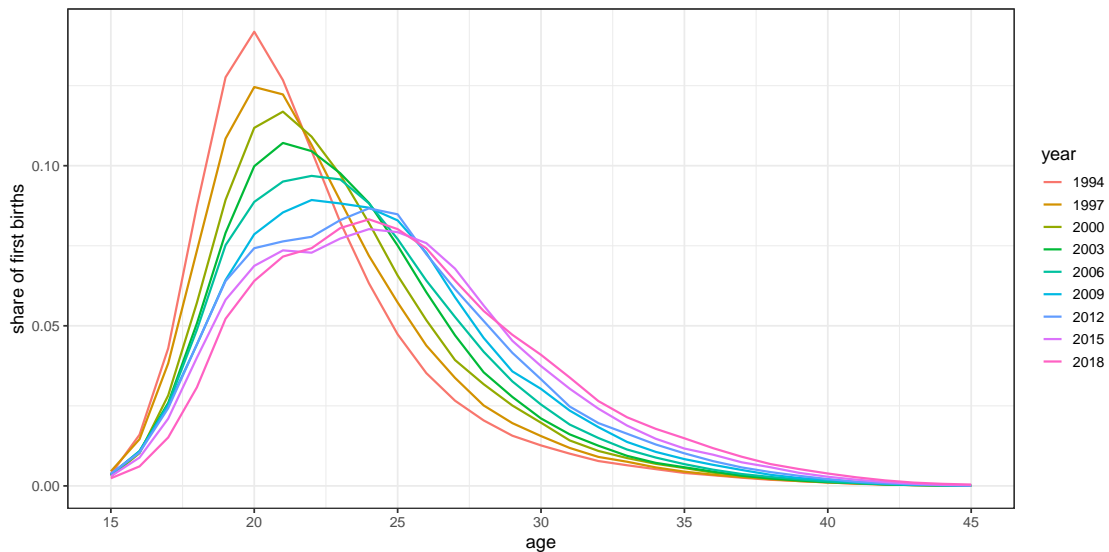


Figure 3.3: Density of first births by age, 1994-2018. In 1994, 14 percent of first births occurred at age 20; by 2018, the peak age for first birth was 24, which accounted for only 8 percent of all first births. Author’s calculations based on data from the Russian Fertility and Mortality Database, Center for Demographic Research, Moscow (Russia).

Background – Russian bodily culture and fertility patterns

Russian bodies

The previous literature on the culture of the body in Russia is relatively small, but important work has been done by anthropologist Cynthia Gabriel (2003a; 2003b). Studying pregnancy, birth and breastfeeding practices in the early post-Soviet period, she documented a general discourse of bodily weakness, and specifically a belief that in contemporary Russia, new mothers and infants are weak and unwell, and must be treated with special care – for example, by bottle-feeding newborns instead of initiating breastfeeding in the first days of life. Early breastfeeding is associated with weight loss, and while this is acceptable in contexts where infants are born healthy, her informants explained that it is a risk that cannot be taken with weak Russian babies. She argues that this perception of weakness is a specifically post-Soviet phenomenon, driven by the disintegration of the social fabric, poverty and literal ill health and poor nutrition in the 1990s, and more broadly by Russia’s “national weakness” - its loss of power on the world stage.

Though this discourse of weakness may have been especially relevant in the immediate post-Soviet period, Gabriel also notes its deeper historical roots; it stems from an older tradition around the importance of bodily equilibrium, and of guarding that equilibrium

from a multitude of external threats (2003a). This is by no means unique to Russia; the concept of disease as originating in deviations from balance is central to many health belief systems, including the ancient Greek humoral medicine that spread across much of Eurasia and gave rise to the Western biomedical tradition; Ayurvedic medicine in South Asia; and traditional Chinese medicine (Bates, 1995; Kuriyama, 1999).

The substances or measures to be kept in equilibrium vary in different belief systems – they may be the bodily humors, the classical elements, or concepts such as wet and dry. The relative importance of these substances can also evolve over time; Whitaker (2003) describes how, in Italy, modern biomedical categorizations of the body’s components gradually supplanted many of the older humoral medical beliefs, but left in place beliefs in the importance of balanced, moderate secretion of bodily fluids such as sweat and semen. As Gabriel notes, in Russian folk medical belief of the last century or more, the primary concern has been not the humors or other fluids, but the maintenance of steady body temperature (Gabriel, 2003a). The traditional answer to the threat of temperature disbalance is the practice of *zakalivanie*, or tempering, by exposing the body to alternating extremes of hot and cold (for example, by rubbing oneself with a cold washcloth, or visiting the sauna and dousing oneself in cold water). This trains the body to withstand the threat of sudden temperature changes posed by drafts, improper dress, sweat evaporating from the skin, etc. *Zakalivanie* existed as a pre-Revolutionary popular medical practice, and was actively encouraged in early Soviet physical culture as a part of a broader project of developing a new Soviet physical and mental fortitude (Kelly, 2002). The popular Twitter account “Soviet Visuals,” which collects posters, photographs, songs and film clips from the Soviet era, has tweeted images from several public health campaigns, dating from the 1930s through the 60s, about the practice of *zakalivanie* – showcasing advice on tempering babies, children, adults, and even women’s breasts (sovietvisuals, 2020b; sovietvisuals, 2020a; sovietvisuals, 2016; sovietvisuals, 2019).

The notion of temperature-based equilibrium still exists in Russia today, manifested both through continued practices of *zakalivanie* and through careful protection of vulnerable, untempered people from the cold (see discussion below, as it pertains to children and pregnant women). Indeed, it is not just the existence of this equilibrium, but its fragility that is important: drafts are a threat not because the body is *in* equilibrium, but because it can be knocked out of it.

The fragility of the body has a gendered component, as reflected in Russia’s paternalistic legal code that limits women’s ability to work in a range of jobs, including professions requiring heavy lifting, most types of underground work (including as e.g. subway operators), professions associated with metallurgy, construction and renovation work, mine construction and operation, peat harvesting, the operation of explosives, well-drilling, oil and gas mining, ship-building, and chemical and paper production. These restrictions were more stringent in the Soviet period, and also included prohibitions on women working night shifts or in jobs involving overtime. As Kozina (2004) notes, this is not necessarily because women are more fragile than men, but rather (or also) because female bodies are “marked” by the “biological capacity to be mothers,” and therefore the stakes for preserving women’s health are higher (p. 52).

Russia's fertility patterns

Fragility also has implications for aging, and it is often assumed that this is why Russian women have children so young. Certainly, as I discuss below, women talk about early childbearing in terms of youth, strength and the degradation and weakness of the body as it ages. But it is also important to note that the early completion of childbearing is a late-Soviet norm, not a longstanding Russian tradition. The gradual rise in the mean age at first birth that accompanied the transition to lower fertility in Western countries did not do so in the USSR; in fact, over the course of the 1960s to the mid-1990s, the mean age at first birth in Russia consistently fell (Figure 3.2). As a result of the falling mean age at first birth and norms of small families, childbearing was completed at earlier ages as well; women born in the 1960s completed around 85% of their childbearing (as measured by cohort completed fertility) by age 30 (Zakharov, 2008, p. 918). Earlier cohorts had more children, but had even their first and second births later than the 1960s cohort (*ibid.*, p. 923). The reasons for this are complex, but Zakharov argues that one factor is that the Soviet Union experienced to some degree the same “sexual revolution” as Western Europe and North America, but without the concomitant rise in availability of contraceptives (*ibid.*; see also Nakachi (2016)). Given norms against termination of a first pregnancy (Nakachi, 2016; Randall, 2011), as age at sexual debut fell, naturally, age at first birth did as well. The timing of second births advanced as the Soviet Union introduced a family leave policy that allowed parents (in practice, mothers, although theoretically either parent could claim the leave) to leave their jobs for up to three years after each birth with guaranteed return. Zakharov contends that this long leave policy led women to space desired first and second births only a few years apart, such that they could take all of their leave in one large block (Zakharov, 2008).

Of course, this has changed a great deal in the post-Soviet period. In addition to the postponement of births described above, Russian fertility in the post-Soviet era has undergone other rapid and profound changes. Fertility fell throughout the tumultuous 1990s and gradually rose again thereafter, especially after 2006; in the past few years, it has fallen again (Figure 3.4). A great deal of literature exists on this transition. Zakharov (2008) describes a transition to later and fewer births and a growing culture of single-child families, and attributes it in large part to the ideational changes of the Second Demographic Transition. Billingsley (2010) agrees on the ideational drivers of the rise in the age at first birth, but attributes the steep drop in second and higher-order births to the economic upheaval of the immediate post-Soviet era. Perelli-Harris (2005), using mixed methods in Ukraine, finds that around the turn of the millennium, women still prioritized having a first child at a relatively young age, while they were more willing to delay indefinitely or forgo higher-order births due to economic conditions. Much of the more recent literature focuses on the effect of family policy reforms made in 2006-2008 on the observed fertility rebound (Borozdina, Rotkirch, Temkina, & Zdravomyslova, 2016; Frejka & Zakharov, 2013; Slonimczyk & Yurko, 2014).

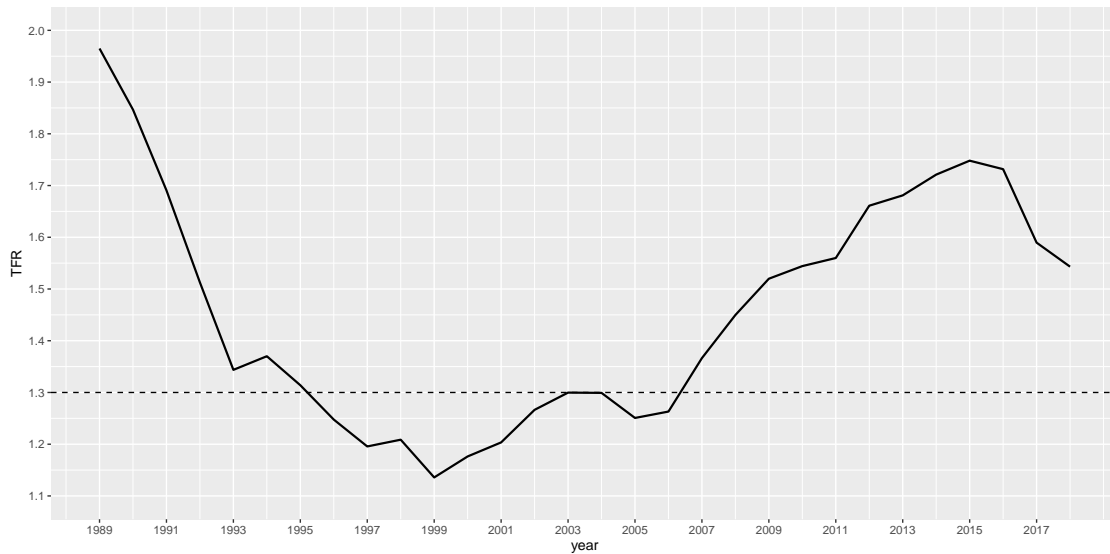


Figure 3.4: Total fertility rate, 1989-2018. Author’s calculations based on data from the Russian Fertility and Mortality Database, Center for Demographic Research, Moscow (Russia).

There is less data available on fertility behavior and practices in Russia, and thus less research. Most relevant to this essay is research that finds that contraceptive prevalence in Russia is still relatively low, and attributes Russia’s continued high abortion rate compared to neighboring Ukraine and Belarus to this fact, connecting it to conservative views on sex education that have dominated the Russian education system since the late 1990s (Denisov, Sakevich, & Jasilioniene, 2012). A 2010 study found that, of residents of eight countries studied, Russian users of hormonal contraceptives had the lowest confidence in their contraceptive knowledge, with only 30% of respondents characterizing themselves as “well-informed” (Hooper, 2010). Finally, as concerns the appropriate age to have children, research by Billari et al. (2011) using the 2006-2007 round of the European Social Survey found that Russians perceived social age deadlines for women’s childbearing similar to the European average. When asked ‘After what age would you say a woman is generally too old to consider having any more children?’, 60.6% of surveyed Russians named a deadline at or below age 40 (57.2% European average), and the mean deadline given was 41.1 years (41.7 European average). All of these studies use data that is now at least ten years old, which is certainly a problem in a society like Russia that is still clearly in transition; it is my hope that this qualitative work contributes to the sparse quantitative literature.

The culture of the body as medical culture

Finally, the relationship between the body and expert knowledge is also a component of bodily culture, and one that is crucial in any context where individuals manage their bodies

through participation in a biomedical health system. In considering how the body/expertise relationship plays out in the contemporary Russian context, several aspects of the Soviet and Russian health system are important to understand.

The Russian medical profession developed, in both the imperial and Soviet periods, under tight state control. Bernstein et al. (2010) describe how the Bolsheviks relied on medicine to a large degree to manage “moral and aesthetic” questions like sexuality and physical fitness, and situate this in the broader context of what historians of medicine call the modern project of medicalization – the classification of human problems and conditions as “medical,” manageable by a process of study, diagnosis, treatment, and prevention. In the Soviet case, Bernstein et al. argue, the state’s enlisting of physicians to directly manage this medicalization and ensure citizens’ compliance meant that Soviet doctors’ authority tended to be subject to a degree of patient suspicion, due to its close relationship to state power.

Rivkin-Fish also describes these tensions in her work on women’s health in the post-Soviet era (2005), describing an antagonistic relationship between providers and patients; on the provider side, she finds they often cast patients as incompetent, not having enough “culture” to take care of themselves and continually undoing doctors’ work and ruining their own health. She connects providers’ contempt for patients to some degree to the Soviet doctor’s orientation toward modifying patients’ behavior in the service of the state, but also locates the source of their frustration in their relative powerlessness and poor working conditions: medicine in the Soviet Union and post-Soviet Russia is a poorly-paid, feminized field, and especially in the early post-Soviet era that Rivkin-Fish describes, hospitals and clinics were desperately underfunded. From the patient side, she elaborates, echoing Bernstein et al.’s diagnosis of patient mistrust as a matter of doctors’ relation to state power: “Their challenge to the legitimacy of health providers’ endeavors did not express a critique of relations based on expert domination per se; nor was their reluctance to trust physicians generally based on doubts about science as a mode of knowledge or source of truths. It emerged out of the contradictions between the state’s ideology of providing humanitarian care and the women’s practical experiences, rumors they heard, and expectations they developed of indifferent, incompetent, and uncaring treatment provided in health care institutions. It was the association between expertise and state bureaucratic power that rendered medical authority and professional domination highly suspect in Russia.” (Rivkin-Fish, 2005, pp. 26-27).

As medical science and public health developed in the Soviet Union and its satellite states in semi-isolation from the capitalist West (First, 2018; McKee, 2007), Russia also provides an example of the diversity of diagnosis and treatment norms that can exist even within contexts that can be broadly described as based in Western biomedicine. One example of this relevant to the current topic is the use of cesarean or forceps delivery for women with myopia, based on the belief that pushing during labor could increase the risk of retinal detachment in these patients. This practice used to be widespread across Europe, but research in the 1970s showing no increase in risk of retinal damage led to discontinuation outside of Eastern Europe, where it still occurs (Neri, Grausbord, Kremer, Ovadia, & Treister, 1985; Photopoulos, 2019).

In general, the Soviet health system, stretched thin and underfunded as it was, did not

place much emphasis on the rigorous evaluation of therapies; this legacy continues to be felt today, partly because most Russian medical practitioners are still unable to access new research and training materials, due both to a lack of funding for such access and due to the fact that most research internationally is published in English, which an estimated 95% of Russian doctors cannot speak or read (Rechel et al., 2013). McKee (2007) attributes the historical popularity of untested therapeutic techniques such as light therapy and mild electromagnetic pulses to the Soviet Union’s inability to source Western pharmaceuticals, paired with the late Soviet medical system’s need to offer some semblance of treatment for chronic conditions, after its victory over communicable disease in the 1950s stopped improving mortality. Today, these treatments retain popularity partly out of economic necessity; Russian medical practitioners remain poorly paid, and offering supplemental therapies in exchange for direct patient payment is one way to make a living (ibid.).¹

There is both continuity and change in patients’ relationship to the health system from the Soviet through the post-Soviet eras. Though the Russian medical system remains publicly funded, the relationship to state power that motivated patients’ distrust in Soviet doctors has eroded substantially. However, many Soviet-trained doctors remain in practice, and despite health system reforms that included improvements to salaries, medicine remains an underpaid, highly feminized profession with little prestige or structural power (Rechel et al., 2013; Marten et al., 2014). Thus the perception of “indifferent, incompetent, and uncaring” treatment that Rivkin-Fish recounts has not entirely faded.

On the other hand, as Jennifer Utrata argues in her ethnographic work on single motherhood and family life in post-Soviet Russia (2015), one thing that has changed is women’s identities and roles within their families under post-Soviet free market conditions. Utrata identifies in women’s narratives of their successes and failures as parents and partners an identity of the “competent neoliberal subject” whose value to themselves and their families rests on their ability to navigate the post-Soviet free market with “practical realism,” managing themselves and their time skillfully and efficiently. As I argue below, women view themselves as responsible for their own and their families’ health and are able to gather information from a wide array of sources, middle-class Russian women sometimes turn a skeptical eye toward doctors not because of any particular Soviet legacy of health care, but because of newer, and to some extent global, trends toward finding their own solutions to body problems.

Data description

I completed 41 individual oral interviews with women of childbearing age, ranging from age 20 to age 45, median age 31.5, mean age 31.6. Most interviews lasted around 45 minutes, though they ranged from as short as 15 minutes to nearly 2 hours in length. Short interviews were

¹Of course, not all differences can be understood as the Iron Curtain cutting Eastern Europe out of advances in biomedical research. As a perhaps-trivial example, it is common in Russia to use the dye known as brilliant green as a wound and surgical antiseptic in contexts where iodine would likely be used in the U.S. Both substances are effective.

particularly common among the youngest respondents – who had not yet begun childbearing and were often not yet in relationships that they anticipated would lead to children in the near term – and among those older interlocutors whose children were already grown. All interviews were conducted in Russian, and all were audio-recorded and transcribed to text.² All analysis was conducted on the texts in the original Russian, and I translated them to English as needed for quoting them.

In addition to the recorded conversation, interlocutors were asked to provide a small amount of standard demographic information on paper, including their age; current marital or relationship status; number of marriages; number of children ever born; educational attainment and employment situation; and a screening question about whether they had always lived in Russia, included to screen out interlocutors who had grown up or spent a significant part of their adult life elsewhere.

Eleven interlocutors had never been married (three of these were either formally or informally engaged), twenty were in a first marriage (legal or common-law), and ten had been divorced at least once; of these, two were divorced from a first marriage and had not remarried, six were divorced from a first marriage and currently in a second marriage, and two were twice-divorced and had not remarried. Sixteen had never had a birth (one of these was pregnant at the time of interview), nine had had one birth, fifteen had had two births, and one had had three. Not all participants identified their ethnicities, but of those who did, most identified as ethnically Russian, Ukrainian, or a mix of the two, sometimes mentioning Cossack roots. One interviewee was originally from the Russophone Korean community in Uzbekistan, two were Armenian, one was of mixed North Caucasus descent, and one identified as part-Jewish. Three interlocutors had a middle professional education, which consists of nine or ten years of general schooling followed by three or four years of specialized vocational training. Seven were currently studying for their bachelor's degrees. The remainder (31) had completed at least a bachelor's degree or the older five-year specialist degree. All had spent most or all of their lives in Russia, and all spoke Russian with native fluency.

Initial interlocutors were prior contacts – colleagues and former students from my time in Taganrog ten years ago on the Fulbright English Teaching Assistant program. Subsequent interview contacts were gathered via snowball sampling, as these initial contacts suggested friends, colleagues, neighbors and relatives to interview. Snowball sampling has its limitations, and in this case it almost certainly made my sample less educationally and socioeconomically diverse than it might have been, but it was also enormously useful – I found that potential interlocutors who were contacted by a trusted friend or colleague were far more likely to agree to an interview than those I reached out to myself. I contacted new acquaintances on my own through various avenues, including a prenatal yoga class I was attending, an internet forum for local parents, and friends and acquaintances I made in day-to-day life. However, only a small handful of interviews came of these contacts, and the majority of my participants can be described as somehow connected to one of three networks – employees of TMEI and their friends and families, alumni of TMEI, and English teaching professionals

²Deepest gratitude to Yulia Chigrin for her invaluable transcription assistance.

and their adult students.

The most disappointing aspect of the sample was my inability to reach women of lower socioeconomic and educational status. When asking interlocutors to suggest further contacts, I mentioned that I was actively seeking women who fit this demographic profile, but most stated that they did not have close enough relationships with anyone with less education to feel comfortable inviting them for an interview. On two different occasions, interlocutors who worked in higher education contacted colleagues who taught at “middle professional” institutions – a medical training college for nurses and midwives, and a metallurgical college – to inquire about spreading word with their alumni, but both were rebuffed. Ultimately, this means that I will be performing an analysis of a slightly more specific subset of women than I initially planned – highly educated women in a mid-sized provincial city. This does not make the analysis itself less worthwhile, but it requires careful thought about what my findings represent in the broader Russian context and how this group differs from others along several axes.³ In Rostov Oblast, as in Russia as a whole, the share of the adult, working population with higher education is around 30%; the share with higher or middle professional education is 56% in Rostov Oblast and 57.5% in Russia as a whole (Kliachko, 2016).

The interviews themselves were composed of a set of questions that varied somewhat with the interests and life situation of the interviewee. Typically, I started by asking women with a partner and/or children to begin by describing their own family; for those who were unpartnered and childless, the interview began with questions about their family of origin. From the information given about the number and spacing of children, discussion of ideal and desired number and spacing usually followed, and then questions on appropriate timing of childbirth in a woman’s lifecourse. Further questions touched on women’s experiences with gynecological and obstetric care, their perceptions of what counts as “early” and “late” childbearing and the risks of each, family structure and economic or childcare support, and gender dynamics within the family. All interlocutors were asked if they had heard the phrase “demographic crisis” and whether they could describe what it meant. This often led to in-depth discussion of family policies, and specifically the maternity capital policy, which grants a one-time, limited-use payment of approximately 400,000 rubles (about one year’s average salary) to mothers of second or higher-order children. Last, interlocutors were asked about birth control practices – either their own preferred practices, those of others in their social circle, or the advice they had received from medical professionals. Because the interviews were open-ended, this script varied, but most of the interviews touched on most of these research topics in some way.

Finally, I gathered ethnographic data during the trip. I spent a great deal of time with friends and their families. Because I myself was pregnant during this fieldwork, I was also

³For example, as noted by Frye (2017), highly-educated women have been shown to be at the vanguard of fertility change. On the other hand, women in small provincial cities face very different limitations on their fertility than do women in Russia’s larger cities – less access to fertility treatment, less housing pressure, more kin availability. The demographer Olga Isupova (2017, personal communication) also claims that gender norms within the family are more rigid in Southern Russia than in Central and especially Northern Russia, influenced by differences in the organization of the peasant family in Cossack vs. northern rural cultures.

able to experience local obstetric care firsthand, attend a prenatal yoga class three times a week, and participate deeply in the kinds of conversations that newly pregnant women have with their more experienced friends and acquaintances and among themselves – trading advice and sympathy, and experiencing the types of care directed toward pregnant women. Toward the end of the trip, as my condition became more visible, I was able to participate in and observe life as a visibly pregnant woman in the community.

Aging and the fragility of good health

At the center of bodily culture's relationship to fertility postponement is the body's frailty and susceptibility to injury. Putting off fertility is riskier for bodies that are (perceived to be) easily injured or unable to fully recover from injury. In terms familiar to demographers, we can imagine that different bodily cultures assume something like different hazard rates, and thus different survivorship curves, where the "survivors" are the percentage of people at each age who are still able or fit to give birth. We can imagine that a bodily culture that assumes hardiness is represented by a relatively high and flat survivorship curve, while one that assumes frailty has a steeper one. People make decisions about childbearing partly by assessing whether childbearing is physically appropriate for them and by estimating how quickly that situation will change.

But what is frailty? This survivorship metaphor makes clear the connection between frailty and chronological age, and encourages us to imagine it as something like wear-and-tear, or constant degradation of some early stock of health. This is not the only aspect of frailty that is important, but it is certainly one component of it, and one that figured prominently in conversations with my interlocutors.

One example of age-related frailty in Russian bodily culture is the idea that the body is better able to recover from pregnancy earlier in life. Sofia, a 33-year-old never-married woman with no children, discussed with me at length the challenges of being over 30 and not yet in a position to bear children. She explicitly connected cultural ideals about the appropriate age for childbearing to bodily recovery.

I studied psychology in university, and we covered all these comparisons with Americans, and they said that for you it's the other way around, people approve of having kids after 33, right? Or maybe even later. But here, all the same, it's most welcomed at 19, 20 – the body heals itself faster before 30.

Dasha, a married 28-year-old with no children, had personal experience with these norms, and sought the advice of a doctor to help assuage her fears.

As for health, I, for example, consulted with doctors. My parents are saying, "Hey, you need to... when are you planning on kids?" Everyone tells me I need to manage it before I'm 30, but the doctors say that now you can do it up to age 45. For me, all the same, 30, yes, 32 – it's the perfect age. I decided for

myself – I have at minimum two years for sure in reserve, and in this timeframe my housing problem will resolve itself, and then we'll see.

Tamara, a never-married 23-year-old with no children, notes the cultural specificity of Russian norms:

Yes, here the optimal age is considered to be up to 25 years old, because while the body is young it's just the time to give birth. Later, you age, plus you have a ton of work, cares... Maybe [later childbearing is okay] in countries where people live to 90, and their health is better, but for us there is some kind of logic to it. Because when you get older your body wears out, and all the same carrying a person inside you is a stress on your body.

This hearkens back to Gabriel's 2003 findings that post-Soviet Russians perceived themselves and their compatriots to be particularly weak and in need of special care. Tamara's comment about living to 90 specifically refers to Russia's low life expectancy, which she mentioned having recently watched YouTube videos about.

Antonina, a 44-year-old with births at age 20 and 28, connected earlier birth timing with both an easier pregnancy and better health for the mother and the child, saying:

Of course, the younger the better. So 20, from 20 to 28, that's the optimal age for childbirth. But at this time everyone's still studying, everyone's going somewhere to work, to assert themselves, and so it doesn't always happen. Everyone understands that this is better for your health, but nonetheless many people delay the process, although of course, even based on myself, I can say that the first child was much easier, and probably his health was stronger because my body was newer. And the second time, yes, there were already some complications.

Antonina's assertion that her "body was newer" is worth noting on several fronts. The word for "body" she uses, common in most health-related contexts, is *organizm*, cognate, of course, with English *organism*.⁴ This usage underlines the conception of the body as a complex system of parts rather than an undifferentiated whole. The use of "newer" rather than "younger" cleverly extends the metaphor into the mechanical; she was able to give her child a stronger stock of health because he was produced by a bodily machine that was in top working order.

Unsurprisingly, it is not only pregnancy, but parenting that is seen as physically easier for younger parents. When asked how late was too late to have a child, Diana, a 39-year-old with two children, gave a relatively high age threshold of 45 to 50. But she then explained:

⁴The body as an undivided whole or a visual object is *telo*, also used for, e.g., celestial bodies. I believe, but am not certain, that this usage of *organizm* is borrowed from French.

It would be physically difficult to do all that, to endure it. It was hard for me at 30 – I just remember that at 20 I could more easily endure everything than at 30. Especially caring for a newborn. If it weren't for my elder daughter, who helped me with everything, I honestly don't know how I could have endured all those sleepless nights and caring for a baby – although I had raised [my elder daughter] alone, because I had neither my mother nor my grandmothers nearby to help me.⁵

This was common: many interlocutors were hesitant about the idea of “too late” being defined solely by numerical age, and found it more useful to consider individual situations and health. They often gave a numerical answer of 40, 45, or even 50, but in discussing specifics suggested that it would be somewhat rare for health to actually allow a birth at these ages.

In discussing age thresholds, Nadia, a 40-year-old with two births at ages 24 and 33, argued that aging happens more slowly now than it used to:

It seems to me that before, if a woman near 40 was already considered totally middle-aged, now women have the opportunity to look better, look younger, exercise more, take care of themselves, and some tasks that robbed them of time and energy have been taken over by technology – because of all this, it's normal for women to become moms, especially for the second or third time, from 30 to 40. Or even a bit after 40. But only a bit.

Age and the medical system

The discourse on aging is also an important site of interaction with biomedical bodily culture. As in the U.S., the Russian medical system has a category for advanced maternal age (*starorodiashchaia*, a verbal adjective meaning, literally, ‘old-birthing’). It is a widely recognized term, but it is contested, not only in the sense that it has begun to be considered a bit rude (much like the older term “geriatric pregnancy” has in the U.S.), but in the sense that its definition is difficult to pin down. Some say it begins at age 30, or even 35, but many believe it starts from 25; sometimes it is specified as *starorodiashchaia pervoberemennaia*, an ‘old-birthing woman pregnant for the first time’ and sometimes it applies to a pregnancy of any parity.

Among my interlocutors, as well as on internet forums, there was a wide variety of experiences with being labeled *starorodiashchaia*. I encountered an illustrative story on a forum post from 2012, in which a woman relates a work colleague's story:

When she went for her first prenatal appointment, they wrote *STARORODIASHCHAIA* in big red letters on her medical card! To be honest, I was shocked. The fact is, this is her second birth, and she is only 29 years old, and she is

⁵Note that “alone” here means without other female help; Diana was married for both of her births.

already *starorodiashchaia*. What about me, then? My first birth was at 35, my second at 38. No one, I repeat, no one, not one doctor, told me that I was *starorodiashchaia*, to say nothing of writing it on my medical card. When I began prenatal visits the second time, I subtly hinted to the doctor, “I’m no longer 25, or even 35,” and she actually started scolding me – even forbade me to think about this topic. She said that now [later motherhood] is called “conscious motherhood,” my age is wonderful, etc. And that the term “*starorodiashchaia*” is no longer used anywhere. But that is not all. When she [the colleague] went to the maternity hospital, they began to talk with her about the upcoming birth. And what’s most shocking, they began to insistently recommend a cesarean section, since at this age, she can ‘hardly give birth on her own!’” (“Starorodiashchaia: eto vo skol’ko?”, 2012)

This sense of the uneven application of the label was shared by my interlocutors. When I asked Elena, a 41-year-old with two births, at ages 25 and 33, whether she had encountered the term *starorodiashchaia*, she explained:

No, honestly, the doctor has already known me for 20 years, since the moment I got married. I had my son with her, and then I came to her for my second pregnancy. And after my first birth she asked me often whether I was planning on more. And somehow the question – because she understood that, all the same, I would have a second child sooner or later, she didn’t refer to me as *starorodiashchaia*.

In Elena’s telling, it is subtly suggested that the term might be applied to encourage a woman to make a decision to have a second birth before it’s too late, or to shame a woman who waited. Elena perceives that she was able to avoid this by having a good relationship and openly communicating with her doctor. Ksenia, a 42-year-old who tried for seven years to have a child before finally being diagnosed and successfully treated for endometriosis and giving birth at ages 32 and 37, also avoided the term, and also attributes this to the rapport she developed with her doctors over her years of treatment.

Since [by the time I was pregnant] all the gynecologists in the district already knew me, yes, they were more attentive with me, and I already had good relationships with them by then, friendly ones, you could say. So I felt their increased attention, and they all knew that if I lost this child it would be a huge tragedy, that is, that he had come at great cost. So there was no critical treatment toward me.

Anjelika, a 28-year-old who had recently given birth to her first child, recalled that there was a change in the use of *starorodiashchaia* even over the course of her experience with gynecologists.

We have an expression, *starorodiashchaia*. It's used by doctors, and people in general, and it's for everyone who's over 25 probably, for women who give birth [later]. But now you don't really feel that social pressure, that all your girlfriends are having kids, how come you aren't? People have stopped talking that way, it seems. At least in my social circle there wasn't any of that. I even – when I went to the doctor when I was maybe 23, they said to me, you need to have kids sooner rather than later, or all your processes – they'll wilt, and all that. That is, even doctors were saying that to me. But then later I didn't hear anything like that.

Anjelika's experience with doctors in her early 20s reflects the metaphor of the body as a complex system, here, as in Antonina's quotation above, both mechanical ("processes") and organic ("wilt"). It also directly reflects the idea of swift degradation in health as a straightforward function of chronological age.

However, in contrast to this perception of aging as highly risky, another point mentioned in the above forum post appeared in my interlocutors' reflections on the appropriate age to give birth: the tension between young, physically optimal motherhood and older, "conscious" (*osoznannaja*) motherhood, both of which have their benefits. Olia, a 28-year-old who had her first birth at age 21 and her second about six months before our conversation, reflected on the optimal age for motherhood by taking into consideration her own experiences managing her children as infants:

For the health of the mother, the earlier the better, because the further on you go, the harder it gets. For the baby, I don't even know. At a more conscious age. Closer to 30 you already have a completely different understanding of children.

My friend Nadia several times expressed wistfulness on this topic, feeling that, due to her own immaturity, she had been too strict and not enough of a friend to her older son, and enjoying the opportunity to treat her seven-year-old more like a child and not have so many behavioral expectations of him.

Renata, a 43-year-old who had had one birth at age 24, also mentioned age 30 as a marker of maturity, explicitly referring to it as "a grown-up age" (*vzroslyi vozrast*): "Now, increasingly, this [giving birth later] is becoming the norm. Now women are increasingly giving birth already at a grown-up age – after 30, I mean. Giving birth at 40, of course, is rare, although it's changing in general, it seems to me, the perception of society, in the direction that it is normal to give birth at a grown-up age." Renata was ambivalent about the markedness of her own childbearing at age 24 in the late 1990s. She recalled that she may have been labeled *starorodiashchaia*, but wasn't sure, and said that she had wanted to have her child sooner, but ultimately honored her husband's wish to wait until she had finished her master's degree. On the other hand, she recalled being the first or second of her master's classmates to have a child, so she also did not feel she was particularly late.

Kira and Vika, age 29, each married with one young child, were best friends and university classmates who had a conversation with me together. They discussed being labeled

starorodiashchaia, but also the “conscious” aspect of motherhood. Kira said, “I gave birth at 28. You [Vika] were 27, and I was 28. And actually in the maternity hospital they wrote [on my chart] that I was *starorodiashchaia*. Yes, really! But I think that you have to give birth when you’re morally prepared, not when— because at 20 I would have done everything differently, I think.” Vika added, “Me too. Although I don’t know— it seems to me that it would have been simpler at 20,” to which Kira replied that her husband had just joked the day before that you have to have kids in your early 20s, when you still haven’t tasted freedom and don’t know what you’re missing when you’re stuck at home with the baby.

Galina, a 39-year-old who was my only interlocutor to have three children, experienced approval of later motherhood within the medical system itself. Having first given birth in 1997, she describes the precise late-Soviet and early post-Soviet norm of early completion of childbearing described by Zakharov (2008). However, she also had a child in 2015, at the age of 37. She was able to compare the two experiences, describing a framing of aging as a process of strengthening. This framing retains the organic metaphor of the body as plant-like, but stands in stark contrast to the idea of wilting and decay:

Yes, in Russia, [the benefit of early motherhood] was a stereotype, probably in the 90s. Now it doesn’t exist anymore. It existed when I was having my first child. Then, my birth at 19 years old was considered super. Just super, and all the doctors were inclined to think that you should have two or three kids before 25, and that’s it, after that you’re already *starorodiashchaia*. That was always funny to me. But this time, when I had my third child at 37, not one doctor said that I was *starorodiashchaia*. Not one. The stereotype has changed. Now it’s the other way around, doctors try to push births further along, because the body must mature, strengthen. And it’s not unimportant to have in your head the idea of responsibility for what you’re doing, that you’re having a child.

The medical point of view on the appropriate age for childbearing certainly matters in terms of the care and advice women receive, but as the forum post quoted above illustrates, and as my interlocutor Olia (28) described when relating the experience of a neighbor who had her third child at 39, women don’t necessarily accept it quietly.

Our women are such that we can answer back. If the doctors say to us, “Hey, what are you doing, you’re already getting older, it’s late,” we don’t keep silent. We decided to give birth and that’s it, it’s none of your business. Your business is to watch over our health. Why should a doctor dictate to you when you should give birth? If everything is in order with your health, that is, if it allows it, then it’s not a problem at all.

Olia’s quote here also echoes the idea that numeric age is not a good heuristic for determining the limits of childbearing – that the only limiting factor is whether or not “health allows it.”

Age and parity

Although several of my interlocutors agreed that the term is falling out of favor, along with the mentality that doctors have a right to scold women for their reproductive choices, *starorodiashchaia* retains political relevance. In 2019, responding to news that the Russian State Statistical Service had calculated the country's mean age at first birth to be 26 years, Gennadii Onishchenko, a parliamentarian from the governing United Russia party and the former Head Sanitary Doctor of the Russian Federation (a position similar to Surgeon General), reminded Russian women that technically, *starorodiashchaia* begins at age 25 for first pregnancies. He was quoted in the media as saying that a second or third birth at age 26 is fine, because that is “peak reproductive age,” “but if at age 26 a woman is giving birth to only her first child, then that is not very good either for the mother or the child” (Khramova, 2019).

The sense in which Onishchenko considered a first birth at 26 “not very good” was not elaborated upon, but it reflects a common understanding in Russian bodily culture that first pregnancies are different from other pregnancies. The sense in which this is likely most relevant to birth rates is the still-common belief that one must not abort a first pregnancy for fear of permanent sterility (see discussion below). But there were also among my interlocutors several discussions of first versus later births that illuminated the idea that certain ages are appropriate for childbearing only if the body already has knowledge of the process. Maria contrasted *starorodiashchaia* designation for a first birth with a parity-independent change in treatment at age 35, similar to standards of care for pregnancy at 35 and above in the U.S. Her second birth was at age 34.

It's normal – 33 or 34, it's normal [for a birth]. First of all, it wasn't my first birth. If it had been my first birth, you're considered, I believe, starting at age 29... there's some kind of term... (*Starorodiashchaia*?) *Starorodiashchaia*, yes. If your first birth is at 29. For you [in the U.S.] that's not an indicator at all, right? It's normal, most likely. From the age of 35, the medical workers determine a completely different composition of doctors, which includes a geneticist. Up until age 35, genetics is not considered, as long as there's no indication for it. But starting at 35, a visit to the geneticist is mandatory. And, again, natural birth or cesarean section. The later the age, doctors definitely prefer to have a cesarean section. None of this happened to me, but my friend gave birth just a year later, at 35, and she had to go to all those doctors. After 35, they study you in depth.

Vasilisa, a 32-year-old with two children who works as a school nurse, also noted a distinction between first births and later births after 30:

After 30 they send everyone for a cesarean, without consideration of— that is, everyone who's giving birth for the first time. I think that all the same it must be harder to carry the child [if you're pregnant for the first time after 30], your health isn't what it used to be.

However, Galina, who had her third child at 37, noted that the meaning of higher parity births can change depending on duration since last birth. Referring specifically to what she was told to expect with regard to the birthing process, she explained:

And my third birth, since 12 years had passed, my doctor, a professor of medicine here, said “consider it your first birth.” When it’s been more than 10 years, it’s considered as if the woman is giving birth for the first time again. That is, the body has already forgotten that it gave birth, it’s completely overgrown, or how do you say it, I don’t know, everything has closed up, your organs... when there’s such a big gap, it’s like a first birth.

Here we see another complex bodily metaphor, in which the *organism* behaves like an intelligent creature - it can “forget” - but also like a plant that can become overgrown or closed up. Here it is not the body’s age and fragility that demands extra care, but the fact that it has lost important knowledge and plasticity gained from prior experience.

Bodily equilibrium

Temperature shocks and inflammatory processes

In addition to aging, notions of bodily balance were important to the bodily culture I observed, experienced and discussed with my interlocutors. Vasilisa, the school nurse mentioned above, remarked during our interview that in Russia today a lot of people are being treated for infertility. When I asked her why, her explanation centered on the threat of cold. In describing this, she invoked medical authority even higher than her own, quoting a professor of medicine: “My opinion— In Stavropol I worked at the medical academy, and matriculation was overseen by the head of department of gynecology and obstetrics. As he said, “[these girls] all walk by, it’s winter, it’s cold, they’re in short skirts...” That is, they’re freezing. That is, there are inflammatory processes happening that affect their health.”

I also had a great deal of personal experience with the threats of temperature shocks. Traveling to Rostov on a cold December evening to see a ballet with two friends and their seven-year-olds, I learned that it is crucial that children take their coats off when they get into a car. I remarked that it must make them much more comfortable to ride without coats, and I was quickly given the more important reason for it: if children sweat in their coats in the warm car, then when they get out of the car into the cold, the sweat will begin to evaporate and they will experience a greater temperature shock, putting them at risk for illness.

Though I had long since learned not to sit on floors or cold park benches, walk without slippers on the ground floor of a home, or go out with wet hair, as a pregnant woman and a foreigner I still frequently found that I was unable to correctly identify and guard against temperature threats. I received a gentle scolding for walking to a friend’s house in cool autumn weather (about 40 degrees Fahrenheit) in canvas Chuck Taylor sneakers, and for

walking the few steps across the hallway from my prenatal yoga classroom to the changing room in only my socks; I was begged to buy fur-lined Russian boots to replace the American ones I had brought with me (good-quality leather, but apparently no match for even the southern Russian winter); and was the subject of an institute-wide search for a warm down coat that would fit over my pregnant belly. The coat, ultimately borrowed from a plump older professor, was a symbol of the goodwill and care my hosts wished to provide me, and probably to some degree a measure of control, as it was clear to my hosts that, lacking expertise in cold weather living, I could not be trusted to select an appropriate coat myself.

There was also a stir relating to the fact that the room I rented from the institute was situated in the last in a long row of buildings, so that the hot water in the radiators was no longer so hot by the time it reached me, no matter how many times the institute's handyman came to tinker with the pipes. I was given an electric space heater for my room, but in the end, as the weather grew colder, I was evacuated to my friend Nadia's house, where I slept on a fold-out couch in her home office. There, I vividly remember waking up in the middle of the night to open the window in the tiny office, which got unbearably hot with the door closed. Knowing that I was sleeping with such a cold draft blowing directly on my head would have horrified my hosts, so I would set my alarm to wake up again in the wee hours of the morning and close it before anyone in the household could catch me.

Nadia was in general a great believer in the harm that cold could do. Another anecdote from my field notes illustrates the insidious power of cold food. Like Vasilisa's story above, this belief centers on the idea that a cold shock can arouse inflammatory processes; just as an exposed midriff or thighs can cause fertility issues, eating cold food can cause illness by irritating the throat:

A single-serving yogurt cup had been opened at dinnertime, but no one had eaten it. In the evening after tea, Nadia asked Aleksei (her teenage son) if he would eat it. He said that he would, but not until later, as a snack, and asked her to put it in the refrigerator in case he forgot to eat it. She refused, saying that this would mean he'd be eating cold yogurt. He continued to insist that it should be put in the fridge because he might forget, and she replied with frustration, "Nothing is going to happen to it from just sitting on the counter!"

Microbial contamination from a short stay on the counter was, at least in this case, less of a risk to Nadia than consuming food and drink at the wrong temperature. Although she had spent time in the United States and was aware of cultural differences on this front – once she remarked to me that when she was living in Florida, she could drink cold and even iced drinks without negative consequences, but somehow in Russia they bothered her throat – Nadia also offered several times to warm refrigerated foods in the microwave for me. Her concern with cold was also clearly a way of demonstrating care and affection, as well as – in the case of Aleksei's yogurt – her maternal role as expert in guarding her family's health.

Hormones and hormonal imbalance

While it was a regular part of my daily experience, the quotidian and obviously deeply-felt idea of thermal equilibrium actually came up relatively infrequently in my interviews. On the other hand, hormones and their role in the body's equilibrium state were frequent subjects, both in discussions of pregnancy and of hormonal contraception.

Two of my interlocutors mentioned being put on progesterone in their first trimester. Progesterone helps keep the uterine lining fit to support a pregnancy, and is used in early pregnancy to reduce the risk of miscarriage (for example, it's commonly prescribed in the U.S. in cases of repeated miscarriage, and to support assisted reproductive treatments such as in vitro fertilization). Kira, a 29-year-old with an infant son, explained:

My pregnancy was— I wouldn't say hard, but from the very beginning they put me on Duphaston [a prescription progesterone], because I went in at 5 weeks and my stomach kind of hurt. But our doctors are overly cautious, they go immediately to hormones.

Uliana, a 31-year-old with no children who was about six months pregnant when we talked, had a similar perspective on doctors' reliance on hormones, which she mentioned as part of a larger story about others being, as she perceived, overly cautious about her pregnancy:

I did yoga a long time ago. Then I did aerial acrobatics. It's what I loved to do, and when I went to my trainer and said listen, I'm pregnant— I considered it necessary and correct to tell her. Although then I regretted it, of course, because she immediately said, that's it, no more training. That it's really dangerous and all that, like, 'I don't want to take on that responsibility because of you.'

I asked if she meant that it was dangerous because she could fall, and she clarified,

Yes, and there's also a threat of miscarriage. They were always bringing up that topic, and prescribed me all kinds of hormonal preparations, but I didn't take them. I'm the type of person where I looked it up on the internet and thought, why should I take this? As they say, if the baby is strong, he'll survive. If my body is ready— whatever happens, I don't want to ruin my body with anything, with hormones or anything else. So I decided not to assist myself at all except through correct diet, exercise, and so on. So, I think I'm strong and it'll all go as it should. Everything will be as it should be.

Given these anecdotes, I searched the Taganrog parents' forum for mentions of Duphaston and Utrogestan, another brand of prescription progesterone, and found similar stories. Here, in a thread where women post to ask for advice on different obstetricians, a writer

interprets doctors' attitude toward pregnancy medications and supplements as overprescription, although she indirectly acknowledges that others may perceive these prescriptions as a sign of attention and care:

I saw Dr. R— for my second pregnancy. No complaints. Many people complain that she's inattentive and doesn't prescribe anything. But why prescribe something for no reason? At first I went to the vaunted Dr. Ch—. He prescribed drugs that cost a fortune, Duphaston just in case, something to improve blood circulation, Curantyl [a blood thinner] for I don't even remember what. Plus vitamins for health. I didn't go to him again. I don't like to stuff myself with drugs "just in case." Dr. R—, except for vitamins, did not prescribe anything, she just reminded me to take antibodies for my Rh factor,⁶ the rest was fine." ("Re: Boltalka - po sekretu vsemu svetu - IV", 2019)

The following question and response illustrate women's caution around hormones, their skepticism of their doctors' expertise, and their practical modes of body management. Laboratory work is often privately managed in Russia, and paradoxically, for those with the means to pay for it, this makes it more accessible; anyone can go to a laboratory and ask for bloodwork or urinalysis, without the need for a prescription, and pick up the results themselves. In this context, women with some knowledge of what their medications are intended to treat can access some of the same body expertise as their doctors, eliding the distinction between expert and patient.⁷

"Girls, I need advice, the ultrasound was normal – I'm 7 weeks, but the doctor prescribed Duphaston til the 20th week. I've never tried it in my life, I don't understand how necessary it is. I read that it's hormones and I'm nervous. The doctor said the reason was that I'm 34 and I had a c-section ten years ago. I think I should consult with someone else, but who should I go to? Please advise." ("Re: UZI vo vremia beremennosti - gde?", 2018)

[Response]: "Doctors love to prescribe [Duphaston] without having checked your progesterone level. Submit a blood sample to find out. If their progesterone is normal, a lot of people opt not to take it. And in general, consult with a good doctor." (ibid.)

⁶She is likely referring to Rh immunoglobulin, taken by women with Rh-negative blood to prevent the production of antibodies to the fetus' blood, which may be Rh-positive

⁷I probably would not have fully realized this if I hadn't had to do the same – take samples to the lab myself, pick up the results, and transport them to my doctor – as part of my own routine pregnancy care. Of course, the knowledge produced by this activity is not always easy for the patient to interpret: in translating my urinalysis results to English for my obstetrician back home in California, I was alarmed to see that one of my leukocyte counts fell well outside the normal range. Only at my appointment the next day with my Russian obstetrician did I learn that the normal ranges given on lab work for blood cell counts do not apply during pregnancy, because of its drastic effects on the immune system.

Finally, in a thread asking about people's experiences with Utrogestan, another example of being prescribed progesterone "just in case," in this case not because of age or underlying conditions, but simply as a safeguard against miscarriage while doctor's offices were closed over the holidays:

"My ultrasound showed 5-6 weeks. My next appointment was at 12 weeks. Since it was my first pregnancy and it was the New Year's holidays [i.e. everything was closed], the doctor prescribed Utrogestan in order to preserve that which I had wanted for a very long time. I took it up to 12 weeks. ("Re: Dve poloski!!! A shto dal'she?", 2013)

While these quotations indicate the medical system's approval of hormonal treatments and women's cautious acceptance of them, Vasilisa, the school nurse who attributed infertility to exposure to cold, provided two stories illustrating the dangerous effects of hormones:

Here I encountered a girl, she had had sex, that is, without contraception, and she went and bought a pill that takes everything out. But it's also hormonal. And after she took it she was saying, "Somehow I feel bad, bad." And I said, "Because you mustn't take those pills, it turns out, in the woman's body— who knows what could happen. If a pregnancy has occurred, the explosion of hormones from this pill, that is— it's not clear which way the effect will go. It could be that the hormonal baseline is destroyed, and then when you want to have kids you won't be able to. Something like that. Why do they say you mustn't abort the first pregnancy? Depending on the specialist, if he does it wrong, you could not be able to have children later.

Roughly speaking, my sister-in-law couldn't get pregnant, so they were treating her— she went to the doctor and he prescribed hormonal pills to treat her. I was still in Stavropol at that time, so I went to that professor, the one I was telling you about [the head of the gynecology department]. I explained the situation to him, I said, "They found a cyst in her ovary, and said she needs to treat it with hormones." He says, "What do you mean! Under no circumstances!" He started to say, "Show me the ultrasound," all that. And as soon as she stopped taking the hormones, she got pregnant. Even with the cyst. And when she was 27 weeks, they did an ultrasound, that is, a regularly scheduled one, and she says, "It's over there." And the doctor says, "There's nothing there." It was the kind of cyst that dissolves during pregnancy. The doctor had been treating her and treating her, also with some [hormones] to normalize her cycle — "Here, take them." While you're taking them, you have no cycle, and when you stop, it begins again. Maybe it's easier for some people that way, maybe it's negligent, I can't really say.

Both of Vasilisa's stories indicate mistrust of the medical system providing hormones that cause active harm - in the first case, causing systemic disruptions and possible infertility in a young woman, and in the second, preventing her sister-in-law from getting pregnant and unnecessarily treating a cyst that turned out to resolve on its own anyway. However, neither anecdote is a wholesale rejection of medical expertise; in both cases, there are other medical professionals - Vasilisa herself in the first, and the head of the department of gynecology in the second - who are able to provide better advice and protect women's fragile health.

Vasilisa's use of the terms *explosion of hormones* and *hormonal baseline* reflect general uses of hormonal metaphors that emphasize equilibrium and its violent disruption.⁸ Several other interlocutors used these metaphors as well.

Irina, a 31-year-old mother of one school-aged child, used the metaphor of the hormonal baseline in the same way as Vasilisa - to describe a natural balance specifically disrupted by contraceptives:

Yes, for several years I took pills, but then I stopped, because suspicions arose that they- I read, actually, that they can provoke adverse changes for the body. Because after all I have my own hormonal baseline, and it turns out they're hormones that I'm constantly using. So I decided to stop.

Marina, a 29-year-old mother of a toddler, spoke of a false hormonal equilibrium lent by contraceptives, and the disruption that occurs when one stops using them. She used them in the past, but after her first birth she was no longer doing so.

But pills - they're hormonal, it turns out, and I for one am afraid. Because I often had disruptions in my cycle. It turns out that the body gets dependent on them. When you take them, your cycle is like clockwork, your face is clear, no pimples, nothing, you can wash your hair less often and it doesn't get greasy, your chest gets bigger. It sometimes happens, if you have a tendency toward weight gain, if you're bigger, you might begin to put on weight. I don't have that tendency, but my chest got a little bigger. I was satisfied with everything, with the results. But if you've taken them for a while, you have to get off them. You can't take them constantly, half a year and you have to take a break, a month or something, I already don't remember. And when you get off them, then your face breaks out, your hair gets really greasy, that is, that which was held back before appears with double force.

Like Marina, Olia discussed the effect of quitting contraceptives as a "hormone crash," here in the context of switching contraceptives due to side effects. She voiced frustration that the process of finding a suitable hormonal contraceptive is one of trial and error, rather

⁸The term I translate as "hormonal baseline" is literally "hormonal background", *gormonal'nyi fon*. I chose "baseline" as a more natural-sounding English translation that still renders the metaphor of a steady, even "layer" of hormonal activity.

than scientific analysis of the patient's body. (She assumed things were different in the U.S., and was dismayed to hear that Americans go through roughly the same process.) She also agreed with Marina that it's important to take a break from hormones for one's health.

No, it's good even [to take contraceptives], it's just that here in Russia, in order to prescribe them, it annoys me, they don't even send you to the laboratory for analyses. That is, it's "try these," the gynecologist tells you, "but if you don't feel very good, it means you'll have to switch to different ones." But your body has already begun to accept that dose, and as a result you'll have some kind of hormone crash. ... After having given birth twice, I don't take them anymore. Because on the other hand, hormones can also cause illnesses. You have to take a break after you've been taking them [for a while].

Even those among my interlocutors who were taking hormonal contraceptives expressed caution about their power and potential effects on the body. Sasha, a childless 23-year-old, takes contraceptives to treat problems with her menstrual cycle. She expressed general positivity toward contraceptives, but also indicated that a good deal of monitoring is needed to avoid any possible negative side effects.

They put me on hormones until I'm ready to have children, because when you're pregnant a big explosion of hormones happens in the body, and it's possible that that will put everything in its place. But also, this is safe contraception, that is, it's almost 100% certain that I won't have an unwanted pregnancy. You shouldn't drink alcohol [while on hormonal contraceptives], that is, you can have a maximum of two glasses of wine, but beer is completely contraindicated, because beer is itself a strong hormone. That is, women actually shouldn't drink it at all.⁹ ... You mustn't drink a lot of water, because the hormones affect your kidneys. And the more water you drink, the harder your kidneys work, and it all compounds. So you shouldn't drink a lot of water. Because of the hormones you really want to eat all the time, so you have to be careful with those desires when you want to eat. I've been taking hormones for four months and I haven't gained a kilogram. True, I haven't lost any weight, but I haven't gained either. That is, I carefully follow the instructions: everything that's allowed and everything that's forbidden.

Eva, also 23, recently married but still childless, is, like Sasha, willing to accept the pill and its risks. She displays a degree of trust in medical professionals not explicitly seen in other accounts, while asserting that many of her peers believe that hormones can permanently damage fertility.

⁹Hops contain phytoestrogens, although they are no longer present in high doses by the time hops become brewed beer. U.S. hormonal contraceptives do not caution against drinking beer.

Mostly, the people who take the pill are those who are in long relationships with a constant partner, a constant sex life. They, of course, come around to the pill sooner or later. There are certain risks and medical indications; it's a hormonal process, after all. Some people are in a state of panic about it. I myself have taken it, I don't see anything bad about it, the pill. They really do have a lot of contraindications, and they also— I know that they're not very good for women over 40, because they raise the risk of thrombosis, that is, they make your blood thicker. In my circles, I have some friends who say "The pill? But what if afterward you can't get pregnant?" But doctors thought it up and developed it, and they know something about it, more than I do. And if specialists say that it's necessary, and better to do it like this or like that, then why not? But there is an opinion, yes, that after these pills, they disrupt female processes and it's impossible to get pregnant."

Of course, hormones do not only come from contraceptives, and my interlocutors also mentioned the effect of the body's natural hormones on health. Like Sasha's account of "a big explosion of hormones" that happens during pregnancy, Antonina (44) described natural "hormonal surges" as capable of healing the body:

My friend gave birth at 40, her daughter is already school-aged, and everything was more or less fine. There is, after all, an opinion that giving birth makes a woman's body younger. Some kind of hormonal surges— they contribute to improved health. It's probably not a hundred percent certain, but nonetheless for some people it's like that.

Without mentioning hormones specifically, Galina (39) expressed a similar opinion:

It's even banal to say, comparing my photo at age 20 and now, I see that I look better now. Without cosmetics of any type — I don't do anything to my face at all. I don't know, it seems to me that some kind of renewal happens to a woman's body after birth. And many of my peers who are 39 and haven't given birth — it seems to me that I look livelier than they do. Without a doubt, calcium leaves your body [during pregnancy], you have to do a full upgrade of your teeth. There is that.

Since hormones are understood to be so important, they are also potentially powerful in rhetorically signalling good health. Inna, a 27-year-old who was married but had no children yet, and was hoping to wait until she finished her career change from law to computer programming, explained how she used hormonal analysis to put her family's minds at ease about her postponement of childbearing.

Actually, there were a lot of conversations about how there could be some problems or something. OK, I said, I'll go to the doctor. I went to the doctor, she

ordered all sorts of analyses, hormonal analyses, to understand how much— it's an exhaustible resource, your eggs. She checked everything, said that I have time, everything looks okay, no need to hurry.

Overall, the metaphors used in discussing hormones are similar to those historically used in discourses around temperature and health. The metaphor of equilibrium leads to different effects in the cases of temperature and hormones, since temperature can be directly observed and imbalances in thermal regulation easily felt. In the case of hormones, the belief in an important and fragile equilibrium lends itself to mistrust of intrusion into the body's homeostasis, especially (but not only) among those who believe that this internal equilibrium can be permanently destroyed by outside forces. This has implications for women's willingness to accept hormonal treatments during pregnancy and also for public opinion on the safety of contraceptives.

Fragility and medicine

The perception that doctors prescribe unnecessary hormonal treatments during pregnancy aligns with a broader claim about the Russian medical system often encountered in medical and public health research: that it tends to overdiagnose and overtreat, prioritizing narrowly-trained specialists over general practitioners, prescribing unnecessary and even harmful treatments for minor conditions, and requiring hospital stays for treatments that could be managed through outpatient care (see Rechel et al., 2013, for a recent summary). Determining the necessity of treatment is outside the scope of this work, but in addition to the stories above about hormones and the low threshold for clinical labeling of advanced maternal age, several anecdotes indicated that, whether women agree with the assessment or not, the medical system tends to treat maternal bodies as fragile.

Perhaps unsurprisingly, cesarean sections arose frequently as a topic connected to fragility and medical intervention. Two interlocutors, Anjelika (29) and Vera (22), mentioned that they were not supposed to give birth again for three years after their cesarean sections. Vasilisa (32) reported that her doctor told her during her first pregnancy that, regardless of delivery method, *four* years are ideal for the woman's body to recover after birth. "Three is so-so." (However, her children are three years apart in age.) Marina also explained that she was told her cesarean section would limit her childbearing:

And since my first was a cesarean, doctors recommend not to have more than two children. After all, they do the stitches, as far as I understand, along the old stitches, and they're afraid that during a third pregnancy the internal stitches could come apart. That is, there's a risk.

Given their effect on the body, not all women are willing to accept prophylactic cesareans. In explaining why she went to Rostov to give birth, Olya recounted how the doctor there asked her why she didn't want to give birth in Taganrog:

I said to him, our city— you haven't even made it to the birthing hospital and they're telling you based on your outward appearance, "you have a narrow pelvis, we'll probably do a c-section." And I say, "I don't want a c-section. You haven't even given me the possibility of trying to give birth on my own, and you've already decided at first sight that I'm probably a c-section."

Anastasia, a 34-year-old, by contrast, felt that with her second birth, delivering in Taganrog meant she missed the opportunity to have a c-section that she would have benefitted from:

As for the births themselves, nothing has changed, unfortunately, in Taganrog, and I really regret that I didn't go to Rostov for my second. It's just that both of my kids were big; my daughter was 3.85 kilos [8.5 lbs], and my son was 4.15 [9.15 lbs], and for someone of my size... I gave birth to him with great difficulty, they [the doctors] themselves clearly saw that something wasn't right, literally half the birthing hospital had gathered around me, but it was too late for a cesarean, so thank God I managed ... Now they can determine the size of the baby, and [my neighbor] said that in Rostov before the birth they give everyone an ultrasound, and if the child is more than 4 kilograms, then immediately, without further discussion, they send you for a c-section. Here it's "what are you afraid of, give birth yourself." I gave birth, but I repeat, I really regret staying here and not going to Rostov, of course.

Several interlocutors – Anjelika, Zoia (37), Evgeniia (33) and Marina (28) – also reported receiving c-sections based on the estimated size of their babies. Anjelika recounted:

And I went in, and they told me that I have a really big fetus. They actually considered that he was around 5 kilograms, plus or minus, and they operated on me right away, the next day.

Not only cesarean sections reflect beliefs about bodily fragility. The idea that birth itself is very taxing to the body, regardless of method, was reflected in Galina's explanation of part of her decision not to have any more children:

Even if I really wanted to, because of my health the doctor said it's better not to. Since I'm already 39, and... I need to take care of myself. He said, that's enough. Even though I birthed all three myself, they weren't cesareans, they were all natural births. The doctor says I shouldn't, because my body is already worn out from giving birth, and I must take care of myself.

Women's perceptions of the relationship between fragility and the medical system are diverse. As seen in Olia and Anastasia's accounts of the local hospital's orientation toward cesarean sections, some experience the medical system as too *laissez-faire*, and others as

too invasive. Broader social discourses also carry a tension between fragility caused by lack of medical care and that caused by medical malice or negligence. Although the origins of distrust in the medical system differ between the United States and Russia, the movement toward vaccine refusal has grown in tandem in both places, and shares a good deal of rhetoric, combining beliefs about bodily fragility, harmful chemicals, and a medical system with profits or secret government motives in mind (“As a nurse, I worry for every baby who hasn’t been vaccinated”, 2018). Similar conspiracy-tinged arguments also appear in popular rhetoric around birth and family planning (for an account of how this mistrust arose, see Rivkin-Fish (2005)’s work on international organizations and NGOs promoting women’s health in early post-Soviet Russia). *The Special Mission of the Anti-Christ*, a 2009 popular press anti-family planning book by two well-known psychologists, centers on the alleged plot by Western countries and international organizations to depopulate Russia through the use of contraceptives and abortion. In addition to reporting on the many alleged fertility-destroying effects of hormonal contraceptives, the book asserts that only one in ten Russian babies is “born healthy;” that ultrasounds during pregnancy lead to birth defects; and that cesarean sections are a deliberate plot to prevent Russian women from having more than two children (Medvedeva & Shishova, 2009).

My experience with the flu shot, too, illustrated the complex relationship between the health system and discourses of bodily fragility. I was determined to get the vaccine, since I was in Russia from September through December – exactly the recommended period for seasonal flu vaccination – and U.S. pregnancy care guidelines strongly recommend receiving the vaccine both in order to avoid the flu while pregnant and to pass on antibodies to the newborn, who cannot be vaccinated until 6 months of age. While official Russian state medical policy also states that pregnant women should receive the vaccine, my experience trying to obtain it indicated that this advice is not widely accepted, including by some medical professionals. On my first attempt, after a series of visits to the state clinic at various times of day and with various forms, I was on the verge of receiving permission to get the shot (the process was complicated by bureaucracy: the shot is available for free under the state medical insurance system, but as a short-term visitor, I did not have access to state medical insurance, and so the clinic could not fill out the appropriate paperwork), until I casually mentioned that I was pregnant to the hospital administrator who was writing up the order. She set down her pen, stared at me, and exclaimed, “Is this some kind of joke?” Instead of handing me the order, she sent me to a different city clinic that stocked a version of the shot without preservatives.¹⁰ After waiting at the second clinic, I was told that I could not get the shot without a note from my local obstetrician clearing me for it. The obstetrician was not surprised that I needed the note, remarking wryly that Russians take these shots very seriously.

¹⁰Later I determined that “preservatives” specifically refers to thimerosal, a mercury compound that was removed from the vaccine in the EU and is no longer used in many US preparations due to public belief that it causes autism.

Discussion

The above sections have illuminated several themes in bodily culture that may have direct effects on fertility and family planning. First, my interlocutors' discussions of aging showed a reluctance to name specific threshold ages, instead emphasizing the idea of overall health as a better heuristic; a complex relationship between bodily metaphors of organic decay, mechanical breakdown, and chronological age; a perception of tradeoffs between young motherhood and "conscious" motherhood; and different perceived effects of age on births of different parities. They also showed ambivalence about medical terms such as *starorodiashchaia*, and interpretations of aging that differed from those of the medical professionals they had had experience with.

This demonstrates considerable fluidity in the meaning of age, even as "ideal ages" for first births – both among my interlocutors and according to the government and medical establishment – remain low. As people's lives change and material circumstances tend to push births later, the countervailing effect of a bodily culture that prizes early motherhood turns out to be limited: the flexibility of the cluster of concepts that motivate early motherhood, as well as the complex relationship between aging and health, allow postponement to be reinterpreted in a more positive light.

On the other hand, the mapping of older understandings of the body as in fragile equilibrium onto the biomedical concept of hormones and hormonal balance seem more likely to slow the postponement transition in Russia. Even interlocutors who took hormonal contraceptives expressed a good deal of concern about their effects on the body. This widespread ambivalence toward contraceptives is, no doubt, partly the result of structural problems: the Soviet Union's decades of offering only poor-quality, difficult-to-access hormonal birth control (Nakachi, 2016), and the post-Soviet government's longstanding resistance to sex education in schools (Denisov et al., 2012). But it also illustrates how new bodily understandings can be incorporated into old ones and organically generate unexpected interpretations of risks and benefits of a new medicine.

Finally, the medical system's treatment of pregnancy and childbearing indicates a great deal of caution and continued fear that Russian women are weak and fragile and that childbearing demands careful treatment.¹¹ Women's reactions to the medical system are varied; many interlocutors were broadly satisfied with their medical care, while many others reported strategies for self-managing care such as gathering information online in order to make educated decisions about medications, seeking care at maternity hospitals and with obstetricians recommended by others, and simply ignoring or pushing back against medical providers who were rude or dismissive. This may not sound novel, but it represents one way in which the Russian doctor-patient relationship, long seen as mutually antagonistic

¹¹Similar criticisms have been made of the medicalization and pathologization of pregnancy and birth elsewhere, leading to "natural birth" and doula-led counter-movements in countries such as the U.S. Indeed, doulas have recently become part of the landscape of Russian birth practices as well, although there are still few outside of Moscow. To my great regret, I was unable to attend a planned doula-led breastfeeding course in Rostov before I left Russia.

and highly hierarchical, is evolving in an era when more information is available to patients. As Russia continues to try to raise birth rates, partly through continued explicit political and medical approval of early motherhood, they may find that these strategies are no longer effective.

Epilogue: Limitations and future research

Antonina's quotation, noted above, that the ideal childbearing period falls at a time when people are busy with other cares was based partly on her observation of her 24-year-old son, who was trying to build a career in the Moscow film industry and did not seem likely to marry and have children anytime soon. Prioritizing career and personal growth in one's twenties and delaying childbearing may be a generational divide, but it is also a class and a rural/urban divide. The generational aspect was easy to see: older interlocutors like Antonina and Diana, a 39-year-old with two children, stated that they had not planned their pregnancies at all, while younger, childless interlocutors laid out precise plans for milestones they wanted to achieve before starting families. The class and rural/urban gradients were more difficult to draw out from my interviews, as nearly all my interlocutors had or were studying toward a higher education, and most were natives of Taganrog. Margarita, one of only a few interlocutors who came from a rural area, had come to Taganrog to study at the pedagogical institute. She expressed the tension between her own experience of growing into adulthood and her mother's expectations for her:

I'm 20 years old now, in a month I'll be 21, and my mother is constantly after me, saying it's time to get married already, like, you have a good boy, he loves you, he's courting you! It's time to get married! She's pushing me in that direction. I say, Mom, I don't want to, and she says, you're the right age for it. I say, what do you mean, the right age, I'm only 21. I don't know. I'm not even morally prepared for all of that.

While Taganrog is certainly urban, especially compared to the small village Margarita came from, my interlocutors also emphasized that it is quite different from larger cities like Rostov. Nina, a 42-year-old self-employed English tutor who had children at 26 and 34, explained that her sister living in Rostov had had quite different goals for career, marriage timing, and childbearing than she did, and had her first child at age 35 without any concern (or, according to Nina, any outside pressure) that she was waiting too long. Several int

Thus, the account of bodily culture and its workings that I have analyzed here is in some ways highly local and class-constrained. Further work in this vein could help establish a stronger relationship between fertility patterns and bodily culture by comparing the discourses and practices of women from different socioeconomic groups, as well as from larger cities where fertility postponement has been more marked.

Chapter 4

Abortion, Crisis, and Morality

Introduction

“Since the demographic situation in the country isn’t improving, won’t take a turn for the better – all the same, the death rate is staying stable and the birth rate is still going down...”

This was how Polina Viktorovna, a college English teacher in her late fifties, explained to me her decision to apply for a grant from the Russian Orthodox Church to conduct an anti-abortion education and counseling program at the small economics institute in Taganrog, Russia, where she teaches. In my interview with her – discussed below – we covered many reasons and strategies for reducing abortion incidence, from the barbarism of underground abortions to the need for young women to understand that the fetus is a *chelovechek*, a little person. But she led with the country’s demographic woes.

The connection between abortion and population growth in the popular imagination is straightforward: more abortions mean fewer births, and fewer births mean a smaller population. Although in reality the relationship between the abortion rate and the birth rate is more complex, it’s easy to understand the allure of the numerical comparisons that this logic summons: “The babies aborted in the last 20 years could populate Moscow three times over! Meanwhile our population shrinks every year!” This type of discourse is common to anti-abortion movements in many contexts, but in Russia, with a relatively high abortion rate and a recent history of population decline, it has a special appeal.

In this sense, Polina Viktorovna’s explanation was not surprising – the striking thing about it was that it isn’t true. Russian mortality is not “staying stable” (at, it is implied, a high rate), but declining – from 2003 to 2014, Russians gained over six years of life expectancy (Human Mortality Database, 2019). Fertility, at the time of our interview, had been on the rise for over ten years, reaching a total fertility rate (TFR) of 1.78 births per woman in 2016 – comparable to the U.S. and higher than most of Europe, with the exception of France and the Nordic countries (Human Fertility Database, 2019).

Like many ethnography-adjacent research programs, this one has been built around a cultural puzzle that emerged in my fieldwork: Why does Russian anti-abortion discourse

make such prominent use of demographic arguments, even after the country's "demographic crisis" of extremely low birth rates and high death rates could reasonably be considered over? It became clear in the course of my field interviews that ordinary women, the ostensible targets of anti-abortion rhetoric, take minimal interest in these demographic arguments – not only in the sense that they reject the idea of organizing their childbearing to so overtly serve the interests of the state, but in the simpler sense that the vast majority of my participants considered the demographic crisis itself to be resolved.

A second part of the puzzle is why this demographic rhetoric is so often closely juxtaposed, seemingly incongruously, with moral and ethical arguments against abortion. Why did Polina Viktorovna's grant application, submitted to a competition called "Orthodox Initiative" run by the Russian Orthodox Church, foreground an argument about population growth, rather than one about saving babies from death or women from a grave sin? Why is an anti-abortion propaganda booklet, written by a doctor and focusing on bioethics, entitled "Empty Sandboxes"? Why does the website of the All-Russian Social Movement "Pro Life" prominently feature a clicker that counts the number of abortions averted as "children for Russia" ("Obshcherossiiskoe obshchestvennoe dvizhenie "Za zhizn'"", 2019)?

In this paper, I examine more fully the functions of demographic and moral arguments in the contemporary Russian anti-abortion movement. I make two interrelated arguments. First, the use of demographic and moral schemas together serves an extremely important purpose: to expand the scope and type of resources that can be used for biopolitical aims, and thereby generate a robust, rapidly emergent and well-funded anti-abortion movement that enjoys a great deal of attention from both the church and the state. Second, I argue that the combination of these schemas is engendered by, and partially constitutive of, a larger anti-neoliberal, post-secular political project within Russian society, which positions Russia in opposition to the West and Europe.

Data for this study comes from fieldwork conducted in Taganrog, a small city in the European south of Russia in the fall of 2017, and includes texts gathered from the library of a local anti-abortion center, ethnographic observation of the center and of daily life, and two sets of interviews. First, I interviewed the center's three main staff, Polina Viktorovna, Liudmila Valentinovna, and Ksenia Ivanovna, about their roles at and experiences with the center.

Second, I completed 41 individual oral interviews with women of childbearing age, which focused on childbearing and reproductive health, but also often touched on abortion. All interviews were conducted in Russian, and all were audio-recorded and transcribed to text. All analysis was conducted on the texts in the original Russian, and I translated them to English as needed for quoting them.

In addition to the recorded conversation, interlocutors were asked to provide a small amount of standard demographic information on paper, including their age; current marital or relationship status; number of marriages; number of children ever born; educational attainment and employment situation; and a screening question about whether they had always lived in Russia, included to screen out interlocutors who had grown up or spent a significant part of their adult life elsewhere.

The Russian context

Russia is known for its “abortion culture.” The Soviet Union, and later Russia, was long famous for its status as the world leader in rates of induced abortion (hereafter “abortion”) (Claro, 2016; Nakachi, 2016; Philipov, Andreev, Kharkova, & Shkolnikov, 2004; Zdravomyslova, 2009). In the first two decades of the 21st century, although abortion rates have fallen substantially, it has retained one of the highest rates among countries with relatively reliable statistics, though it is estimated that many countries in the developing world now have higher rates (Denisov et al., 2012; Sedgh et al., 2016).

These high abortion rates were the result of the unique history of birth control and population policy in the Soviet Union. The Russian Soviet Republic was the first country to legalize abortion upon request, in 1920. It was outlawed under Stalin in 1936 as part of a pronatalist family law; the official reason for criminalizing abortion was that under socialism, with childrearing fully supported, women no longer had need of pregnancy termination (Nakachi, 2016). The motivation was clearly also demographic, as birth rates had fallen sharply in the first two decades of Soviet rule, and the scant available data on abortions suggests that in Moscow and Leningrad they outnumbered live births by nearly 3 to 1 (Sakevich, 2001). However, the experience of legal abortion had normalized the procedure, and after the ban, women continued to seek abortions – for example, by finding doctors willing to deem them medically necessary (Issoupova, 2000).

Abortion was not re-legalized until after Stalin’s death, in 1955. World War II had been demographically devastating to the Soviet Union, resulting in an estimated 26 million deaths, and especially large losses among the male population of reproductive age (Ellman & Maksudov, 1994). This dearth of potential husbands and fathers increased the Soviet leadership’s interest in pronatalist measures, including measures to induce women to keep children conceived out of wedlock; in the late 1940s, punishment for illegal abortions, and pressure on doctors to police these abortions, became more intense and frequent than they had been before the war (Burton, 2000; Nakachi, 2016). Within a few years, though, the administration changed tactics; to officials desperate to rebuild the population, legal, accessible abortion was seen as less harmful to women’s reproductive health and ability to bear future children than widespread underground abortions (Nakachi, 2016).

With few other contraceptive options, abortion quickly became Soviet women’s main choice for fertility management. However, the procedure was by no means encouraged; in line with the pronatalist intent of legalization, the state produced materials both for popular consumption and for gynecological training that portrayed the procedure as risky and the idea of termination as contrary to women’s nature as mothers. Randall (2011) finds that Soviet texts from the 1950s to the 1970s such as health magazines cited inconsistent and frequently exaggerated statistics – for example, claiming a risk of infertility from abortion up to 35%.

As for women’s nature, motherhood as a socialist duty was an implicit part of the gender contract the Soviet state offered women from the very beginning – a contract that offered expanded rights, a role in the public sphere and (at least initially) liberation from domestic

labor in exchange for women's buy-in to the Soviet mission (Ashwin, 2000; Kay, 2007; Zdravomyslova, 2009). As the Soviet Union's demographic challenges became clearer, and as more women entered the workforce, the reproductive component of this contract became more explicit; by the Khrushchev era, a great deal of Soviet society – from medals for “hero-mothers” of multiple children to enterprise-affiliated nurseries that allowed new mothers to return to work sooner – was organized with the intent of making motherhood more appealing and compatible with labor force participation. Gender politics were also important in Soviet efforts to boost reproduction – Attwood (1990) documents the rise of Soviet sex-role socialization in schools, connecting official interest in gender and personality psychology (previously regarded as a degraded, bourgeois science) to demographic anxieties. In line with this, abortion was presented in official propaganda as irresponsible, an abdication of the duties – and the joys – of motherhood, leading to misery and regret (Heer, 1965; Randall, 2011).

Nor were women particularly enamored of abortion. Zdravomyslova (2009) calls Soviet-era abortion “a choice made under conditions of an absence of choices,” and draws on interviews from residents of St. Petersburg in the 1990s to illustrate a situation that was not viewed as morally problematic, but was frequently experienced as traumatic in other ways – for example, one interviewee recounts hosting a desperate friend's abortion (performed by a doctor) on her own kitchen table, because there was no room at the hospital. As Rivkin-Fish points out in her study of contemporary Russian feminist activists, in this context, abortion was unlikely to be seen as an assertion of bodily autonomy; indeed, she recounts noting “widespread antipathy” toward abortion in the early 1990s (Rivkin-Fish (2005), p. 23). Claro (2016), though arguing against reductive understandings of “abortion culture” as a special locus of suffering for Soviet women, discusses late-Soviet feminists' efforts to improve the conditions under which abortion was administered, in the context of larger battles for more dignity, respect and comfort in reproductive health care.

Post-Soviet abortion

The ambivalent status of abortion in the Soviet Union is crucial to understanding its crooked path in the post-Soviet period. In the early to mid-1990s, Russia's government and civil society received a great deal of interest from Western liberal democracies, as the economic project of dismantling state socialism was accompanied by a “messianic cultural project” to remake Russian society in a capitalist, neoliberal image [Hemment (2007); p. 3]. As previously restricted statistics on the country's abortion rate became publicly available, a flood of Western NGOs, donor agencies and multilateral organizations such as the UN and the World Health Organization brought to Russia the concept of – and the funding for – family planning and modern contraception (Rivkin-Fish, 2005). This effort garnered broad support from Russia's elites; in 1994, the government launched its own presidential program on family planning, focused on sex education and provision of oral contraceptives (Sakevich, 2001). In an attempt to reduce unsafe underground abortion in the difficult social and economic conditions of the

market transition, the government in 1996 loosened restrictions on abortions between 12 and 22 weeks of gestation, providing a list of 13 ‘social indicators’ allowing abortion – from incarceration of the woman or her partner, to single motherhood, the presence of three or more children in the family already, or income below the regional poverty line (“Ob utverzhdenii perechnia sotsial’nykh pokazanii dlya iskusstvennogo preryvaniia beremennosti”, 1996).

However, the mood soon shifted; the demise of state socialism was being met with a rising tide of nationalism and conservatism, with attendant anti-abortion politics, throughout Eastern Europe, and Russia was no different (Gal & Kligman, 2000). Amidst objections both to high abortion rates and low birth rates and to what was seen as population intervention on behalf of foreign powers, in 1998 the family planning program was defunded, foreign NGOs working in the family planning space were restricted, and sex education in public schools was halted by executive order (Sakevich, 2001).

Public opinion on abortions shifted in the 1990s as well; Agadjanian (2002), studying the Slavic and ethnic Kazakh populations in Kazakhstan in the late 1990s, found increasing belief in the immorality of abortion among younger women compared to older ones. Also in the 1990s, Michele Rivkin-Fish’s study of women’s health practices found that medical personnel had begun talking about abortion’s morality – modifying the abortion-shaming culture prevalent in the Soviet medical system to incorporate ethical arguments from Western anti-abortion movements (Rivkin-Fish, 2005). Rivkin-Fish also recounts encountering “gruesome photos of aborted fetuses” in the waiting room of a family planning clinic as early as 1993, placed by a clinic director who explicitly hoped to turn women against abortion (Rivkin-Fish, 2018).

Although abortion rates have fallen and birth rates have risen over the first two decades of the 21st century, Russian political culture has continued to move in a neotraditional and more overtly pronatalist direction. A new focus on anti-abortion sensibilities as a locus of “traditional” and “family” values, led by the Russian Orthodox Church, has played a key role in this (A. Agadjanian, 2017). In the year 2000, the church’s Sacred Bishops Council adopted *The Basis of the Social Concept of the Russian Orthodox Church*, a document that lays out the church’s stance on church-state and church-society relations, as well as its views on various social problems, including abortion (“*The Basis of the Social Concept*”, 2000). The inclusion of abortion in this document was one of the first signals of the importance it would take on in the church’s outward-facing work in the coming years. This outward-facing work expanded with the accession of Patriarch Kirill to the head of the church in 2009. Kirill is an advocate of the Byzantine concept of *symphonia*, encompassing equality, complementarity and mutual respect between the church and the state; he also served for decades before his election to the patriarchate as the church’s head of external relations.

The era of restrictions

It is in this context that the legality of abortion has become more restricted and the process of obtaining one more onerous. Currently, abortions before 12 weeks of gestation remain

fully legal and covered under Russia's mandatory medical insurance system, but the list of social indicators allowing abortion in weeks 12-22 has been reduced twice, in 2003 (from 13 to five items) and 2012 (from five items to one: pregnancy as a result of a criminal act), while the list of medical indications for abortion after 12 weeks has been reduced once, in 2007. In addition, a waiting period of two to seven days before abortion (depending on gestational age) was introduced in 2012, as was the right of doctors to refuse to provide abortion care.

In addition to legal restrictions, the Russian Ministry of Health has at its disposal "methodological letters," which dictate the ideal structures and normative procedures of Ministry institutions, including all state clinics and hospitals. Methodological letters are not legally binding and, in the absence of attached funding, may be impossible for many institutions to implement; nonetheless, they establish goals toward which those institutions may strive and standards against which they may be assessed. In accordance with a methodological letter from 2007, updated in 2010, it is recommended that all state obstetric/gynecological offices have psychologists and social workers on staff to assist women and families with mental, behavioral and relational needs that may arise in connection with pregnancy and childrearing ("O napravlenii metodicheskogo pis'ma "Psikhologicheskoe doabortnoe konsul'tirovanie"", 2010). The official recommendation of the Ministry of Health since 2010 has been that women receive psychological counseling from these psychologists or social workers before receiving an abortion; the methodological letter detailing the procedures of this counseling is discussed extensively below. (ibid). In a similar vein, in 2015, the Ministry of Health introduced in a methodological letter a recommendation that ultrasound technicians show pregnant women the embryo and ensure that the fetal heartbeat is audible ("Pis'mo Ministerstva zdravookhraneniia RF N 15-4/10/2-4792", 2017).

Despite the non-binding nature of these recommendations, individual doctors in Russia's highly bureaucratized health system have wide latitude to require proof of counseling before agreeing to perform an abortion. A popular press report from 2017 recounts the plight of women in Danilov, a small settlement (population 15,000) in Yaroslavl oblast, whose doctors refuse to perform abortions; the women must travel two hours each way to the city, both for psychological counseling their referring doctors prescribe, and, a week later, for the abortion itself (Nazarova, 2017). In another incident widely covered by the Russian media, a woman in Belgorod oblast was given a form requiring the signatures of a whole "commission": the director of the women's clinic, an obstetrician, a medical psychologist, a "representative of the Diocese" (that is, a priest), and a crisis pregnancy center worker, without which her doctor would not issue a referral for abortion (Zhukova, 2018).

In addition to measures to restrict women's access to, and change their experience of, abortion care, the government has enacted several restrictions aimed at abortion providers. As of 2011, a law required advertisements to devote 10% of their space to warning women of the health risks of abortion, and made it illegal to characterize it as a "safe medical procedure;" in 2013, it became illegal to advertise abortion at all (Kishkovsky, 2011; "V Rossii zapretili reklamu abortov", 2013). In 2016, changes to the law governing the licensing of medical facilities introduced stricter abortion licensing procedures ("Pravitel'stvo obiazalo kliniki poluchat' litsenzii dlia provedeniia abortov", 2016). Over the past several years, the

Duma has considered multiple times the possibility of excluding abortion from the medical insurance system, making it subject to fees for service except in cases specifically covered by medical indicators. So far legislative efforts on this measure have failed twice, in 2013 and 2015.

These changes represent both continuity with and departure from the Soviet era. On the one hand, contemporary Russian policy undoubtedly draws from the Soviet legacy of abortion as legal but not condoned. On the other, the state's strategies for discouraging abortion; its allies in its demographic mission; and the arguments it employs in service of this mission have all evolved. The next section considers this evolution.

Biopolitics and moral duty

As mentioned above, the reason given for attempting to reduce and restrict abortion in Russia is most often connected to the concept of demographic crisis. Concern with demographic crisis, and its conflation with morality, both have a long history in contemporary Russia. The term emerged in popular use in the 1990s and has been omnipresent both in everyday discourse and in the Russian media for decades, applied not only to the narrow phenomena of birth and death rates, but to a wide range of the other changes in Russian family and fertility patterns described above. Not least of all, it has motivated and/or buttressed key policy changes that have reshaped the Russian welfare state in the post-Soviet transition period.

For almost as long as it has been discussed, demographic crisis has been conflated with morality. In her dissertation, Leykin (Leykin (2013); p. 294) notes, "The conflation of the problem of underpopulation with individual morality is part of a larger social phenomenon in contemporary Russia in which moral values are often used to comment on and even determine social problems and political structures. ... Morality has also become an effective means for communicating state ideas about population interventions." Michele Rivkin-Fish, who has written extensively on demographic crisis, pronatalism and feminist politics in post-Soviet Russia (2013; 2010; 2005), contextualizes Russia's neofamilialist family policy (Mahon, 2002; Teplova, 2007) as born of "obsessive public discourses lamenting declining fertility rates, calls for strengthening the nuclear family and reviving women's 'maternal instinct'" (Rivkin-Fish (2018), p. 29).

This demographic logic, in which moral righteousness leads to population prosperity, is very old. The Reverend Thomas Malthus, one of the fathers of the "dismal science" of political economy, argued against it in his famous *Essay on the Principle of Population*, published in 1798 and revised in 1893 (Malthus & Appleman, 1976), contending that the moral virtues of early marriage and prolific childbearing would necessarily create downward pressure on wages, raising death rates, and thus could not align with population-level well-being. Malthus was writing in dialogue with, e.g., David Hume, who argued that population size corresponded to the moral goodness of a people, and the Marquis de Condorcet, who

argued for the perfectibility of man, including in terms of population size and structure. In this sense, the modern Russian synthesis of morality and demography is pre-Malthusian.

Agadjanian (A. Agadjanian (2017); pp. 43-44) elaborates a possible source for the strength of these moralizing discourses in contemporary Russian public life – a neat reappropriation and transformation of late Soviet conservative cultural values (“the rhetoric of the ‘solid Soviet family’ as the basis of a stable society, in spite of, and in contradiction with, the high rates of divorce and abortion; ... an emphasis on the priority of the ‘spiritual’ over the ‘material’; sexual (self)restraint; homophobia; and the subjugation of individual interests and expressions to the collective good”) into contemporary Russian Orthodox “traditional morality.” He notes that the alignment is not total – for example, the Russian Orthodox Church’s treatment of abortion differs substantially from late Soviet conservatism’s relatively laissez-faire attitude toward it – but that in general, the norms of late Soviet society were not as contrary to Orthodox teaching as may be generally assumed.

The conditions that led to my research on abortion themselves provide an example of the fusion of the moral and the demographic and what it can accomplish. When I arrived at the institute that hosted my research trip, I was told that they had recently won a grant through a Russia-wide competition called “Orthodox Initiative” that funds civil society projects. According to Polina Viktorovna, the grant director, Orthodox Initiative money comes from the federal government, but is distributed by the Russian Orthodox church; the initiative’s published materials are not so forthcoming about its funding, but it does present itself as a collaborative effort: “The main goal of the competition is to support civic initiatives in society, and to encourage creatively active people to practice activities aimed at the good of their neighbors and at preserving and strengthening cultural and moral traditions. This support is carried out on the basis of large-scale and diversified cooperation between the Church, society, business structures and the state” (“O konkurse ”Pravoslavnaia Initsiativa””, 2013). Most of the grants Orthodox Initiative awards are to church parishes and other explicitly religious organizations, but schools, institutions of higher learning, businesses and municipal organizations are also among the grantees.

The institute applied for and was awarded a grant of 598,000 rubles (about \$10,000) for a nine-month program running from April 2017 through January 2018 called *Sokhrani mne zhizn’* (*Preserve My Life*). This program was to involve a center within the institute that would offer material and moral support to pregnant women in difficult situations, develop educational activities for school children and institute students, and provide pre-abortion psychological counseling at the local abortion clinic.

The direction of the grant was determined primarily by Polina Viktorovna, who orchestrated the institute’s application and served as the center director. The Orthodox Initiative supports grants in four main areas: education, social services, culture, and information; according to Liudmila Valentinovna, the institute was initially interested in a special competition category within the social services category for the 2016-2017 grant year focused on shelter for pregnant women, but providing a physical shelter was determined to be too difficult and expensive a first project. Although one of the center’s ultimate goals was to set up a temporary apartment for pregnant women in need, it was decided that more limited

material support, psychological counseling and anti-abortion education would be a better focus. The grant activities – which included a wide variety of educational events, including a photo competition on the theme of family, pro-family events for school children, lectures for high school and university students given by religious leaders, and research roundtables – were designed on the basis of activities undertaken by similar centers. The anti-abortion center seems to be a familiar type of organization in contemporary Russia; during the 2016-2017 grant year, three of 54 grant winners within the “social services” category involved proposals to open similar centers, in addition to six grant winners within the special “shelter for pregnant women” subcategory. The previous year there were also three anti-abortion centers out of ninety “social services” grants, and thirteen women’s shelters (“Pravoslavnaia Initsiativa’: Projects”, 2013).

While *Preserve My Life* sounds like a moral project, in the grant application, the statement on the relevance of the project begins: “Increasing fertility is strategically important for the viability of the state. The Strategic Plan for Russian Demographic Policy-2025 indicates that since 2000 there has been an increase in the birth rate, but this growth is still insufficient to ensure population replacement. The birth rate is adversely affected by many factors, among which the Strategic Plan indicates the high number of terminated pregnancies (abortions).”

This struck me because of its seeming incongruity with a church-funded anti-abortion campaign, which I, with my American perspective, would expect to be positioned as saving babies from murder, not birth rates from oblivion. But Polina Viktorovna’s introduction to a research roundtable organized by *Preserve My Life*, entitled “Human Prenatal Development: Orthodox and Psychological Views,” was also on this theme: “Negative trends in marriage and family relations among young people have led to a worsening of the demographic situation in the country, given the role of young people in the reproduction of the social structure of society. This affects not only the economic, moral and social aspects of life in our country – the demographic structure of society reflects the national identity of Russia.” Here the linchpin is the idea of the nation, the imagined community on which crises both demographic and moral come to bear, and whose identity is threatened.

Thus, abortion is able to serve as the appropriate target for religious activism, but also for a civic-minded social project on the part of a secular institution of higher learning.

The link between religion and civics was also made clear in my interview with Liudmila Valentinovna, one of the center’s staff. She was in her early 30s, and often wore plain, dark clothing and little makeup – unusual style choices for a woman of her age that signaled her serious commitment to Orthodox religion. She did not provide pre-abortion counseling, but worked on the grant in other ways, managing social media and organizing events. In her view, Russian society did not consider abortion a social problem until the country’s demographic problems “became impossible to ignore” in the early 2000s. She asserted that it was always seen as spiritually problematic among believers, but its morality was not the subject of much social debate until the head of the Church, Patriarch Kirill, made a speech before parliament in 2015 asking that abortion be excluded from the medical insurance system. After this, there was a wave of debate about a ban on abortion, for which Liudmila Valentinovna expressed

approval: “We must develop traditional family values, first and foremost. Having no more abortions is undoubtedly a desirable goal. A society cannot be prosperous if it permits the killing of innocent babies. Therefore, we must strive to ensure that society seeks to get away from abortion.” Liudmila Valentinovna very explicitly echoes the pre-Malthusian logic of moral righteousness and population wellbeing; only a righteous society can prosper.

Official documents also couple the moral and the demographic. The Ministry of Health’s 2010 methodological letter, mentioned above in the context of its recommendation for pre-abortion psychological counseling, has been discussed in the Russian press as the first official government statement that abortion “is the murder of a living child” (“Doklad Soveta Evropy”, 2017). Later Ministry of Health materials also use this phrasing.

Crucially, this framing allows for a great deal of support between the church and the state on demographic topics, particularly given the close relationship the Russian Orthodox Church enjoys with all levels of government. Although Russia is officially a secular state, in recent years, the church has enjoyed substantial access to the government; for example, through annual Christmas meetings between Patriarch Kirill and the legislative body, the Duma, and a large annual conference of “Christmas readings” on religion, morality and society co-organized by the Russian Orthodox Church and the Russian Ministry of Education. Since the late 2000s, the Patriarch is also given legislative deference, allowed to comment on the potential impact of draft legislation on the community of believers. Patriarch Kirill’s advocacy, mentioned by Liudmila Valentinovna, of the exclusion of abortion from state medical insurance is one notable example of this. Although this campaign has failed twice, in early 2019, a Duma task force was convened to reconsider his proposal (“Volodin poruchil sozdat’ rabochuiu gruppku po izucheniiu initsiativ RPTs”, 2019). Another prominent recent example of the Patriarch’s intervention in the legislative process is his official position against a draft law introduced in November 2019 defining and criminalizing domestic violence (“Patriarkh Kirill raskritikoval zakonoproek protiv domashnego nasiliia”, 2020). Consideration of the law has been postponed.

As illustrated by the *Orthodox Initiative* project that funded *Preserve My Life*, civil society organizations also present a significant area of church-state collaboration. In addition to often-opaque financial connections between church, state, and civil society, Church-led civil society organizations such as the World Russian People’s Congress have the opportunity to influence policy, developing, for example, specifically demographic policy recommendations for “national preservation” of the Russian people at annual conferences attended and keynoted by President Putin (Latukhina, 2019).

This permeability between the state and the church operates at more local levels as well: over the past decade, several Russian regions have held officially sanctioned days or weeks “without abortion”. For example, in January 2017, the Yaroslavl oblast Russian Orthodox metropolis (mitropolia) announced that January 11 would be a “day without abortions” in memory of the infants killed by King Herod. This was not technically an abortion ban, but a recommendation that medical establishments refuse to perform abortions. It was officially supported by the oblast health department, which clarified to the press that it sent the letters out to medical establishments asking them to follow the recommendation for the

sake of good relations with the church (“V Iaroslavskoi oblasti na den’ zapretili aborty ”v pamiat’ o mladentsakh, ubiennykh tsarem Irodom.” Eto pravda?”, 2017). As discussed above, stories of women being required to consult with and receive approval from a priest before an abortion also show that local clinics and public health departments have substantial leeway in constructing their own abortion requirements (Zhukova, 2018).

Against the neoliberal

Another common theme in Russian anti-abortion literature is that abortion is not a solution to the material and logistical problems an unexpected child may present, such as lack of money, career problems, or a small apartment. This literature presents abortion not only as an unacceptable solution on the grounds that it is morally wrong, but as a non-solution on the grounds that the conception of material need as a potentially serious problem that a baby will exacerbate is false. In this sense, I consider Russian anti-abortion discourse in particular to run counter to a global trend toward neoliberal biopolitics as the main way governments attempt to manage their citizens’ reproduction. I use Susan Greenhalgh and Edwin Winckler’s relatively straightforward definition of neoliberal biopolitics as “reproductive conduct brought under rationalized conscious control,” where – in contrast with their conception of Leninist biopolitics – the locus of that control is in society, markets and individuals rather than within state structures [Greenhalgh and Winckler (2005); p.19]. By this definition, not only most governments, but also the international family-planning establishment and the entire framework of “reproductive rights” exemplify a specifically neoliberal biopolitics.¹

Moral-demographic pronatalism, on the other hand, rejects the logic of rationalized control of reproduction; private, economically-based reasons for wanting to manage fertility are portrayed as decadent, not as the hallmark of a competent neoliberal subject but as a symptom of moral disease infecting both individual and society. This is visible, for example, in the ways women who get abortions are derided as wanting to *pozhit’ dlia sebia*, “live for themselves for a while,” to achieve success in a career, or to attain physical comforts.

This was illustrated evocatively by a quotation shared on the *Preserve my Life* page on VK, a Russian Facebook-like social media site. The quotation is attributed to a priest named Aleksii Yesipov:

Decide to have children? What, like you’re getting a pet of some sort? God either grants or does not grant children. They cannot be planned at all. If God gives you a child, He will also provide for that child. This is how the Chinese, the peoples of the Caucasus, the Arabs live. And so they are populating the earth. And we are degenerating. We DECIDE to have children. And if it wasn’t in our plans, we kill them!

¹c.f. the United Nations’ assertion that women and couples have the right to “freely *and responsibly*” determine their family size (emphasis mine), language that appears in U.N. family planning literature at least as far back as the International Conference on Population and Development held in Cairo in 1994.

It is easy to assume that the anti-neoliberal is explicitly religious – as it is in the United States, where rejection of family planning is prominently represented by religious sects like the Quiverfull movement. However, in the Russian context, this alignment is imperfect. Polina Viktorovna and Ksenia Ivanovna, two psychologists providing anti-abortion counseling through the *Preserve my life* grant, represent two very different perspectives on the abortion question. Polina Viktorovna approaches the question from a secular point of view, seeing her work to stop frivolous abortions and reduce the abortion rate as a way to keep abortion legal. Ksenia Ivanovna, an Orthodox believer, sees her mission as moral – a way of keeping other believers from being led astray, and of atoning for the sins committed when Russian society did not see abortion as morally problematic.

In spite of their differing religious beliefs, Polina Viktorovna made more use of anti-neoliberal frameworks and rhetoric in her discussion of her work than did Ksenia Ivanovna. Polina Viktorovna, who wrote the grant, is in her mid-50s, a divorced mother of one adult daughter. Although her background is in psychology, she has spent most of her career teaching English. She lives with her extended family – elderly parents to young granddaughter – in a large and comfortable family home that she built partly with savings from her long and successful career as an English teacher (a career in which it is by no means easy to save money), both in Russia and, for several years in the early 2000s, in the United States. She is an extremely hard-working educator, teaching courses at two local universities and offering extra evening classes for students who wish to achieve a more advanced level of English. For several years, when the economy was stronger and more students had parents who could afford it, she organized short annual institute-sponsored trips to the United Kingdom or Malta for students to practice their English. She also has a unique sense of personal taste; she keeps two Boston terriers, as well as a terrarium housing a pair of large tropical slugs.

The dominant strand throughout Polina Viktorovna's interview was of the impossibility of a ban on abortion:

Why did I have such a desire [to do an anti-abortion campaign]? Because I looked on the websites of all these movements, these actions that want to officially ban abortions. And I think that we mustn't ban anything. And every time I argue with the representatives of the church, I say that if we ban them it will be like it was in the beginning of the last century, when in our country abortions were banned and women got them underground."

She connected this explicitly to a vivid image from literary novelist Lyudmila Ulitskaya's *The Kukotsky Enigma* (2001). Set in the late Stalin era, the novel follows Pavel Kukotsky, a high-ranking gynecologist, as he works to convince the authorities to reverse the ban on abortion. One of his attempts involves bringing them a fetus, preserved in formaldehyde, that he has had to extract from the womb of a woman who self-administered an abortion by inserting an onion into her cervix. The roots of the onion grew into her uterus and eventually enmeshed the fetus, killing it.

Polina Viktorovna returned several times, with obvious horror and relish, to the image of the onion-strangled fetus. She presented it as a real method of abortion, adding that her elderly mother – a retired doctor – had confirmed seeing such specimens during her medical studies in Leningrad in the 1950s. Avoiding these horrors was, she claimed, the main motivation for her work:

All the same, women who don't have the financial ability to give birth will get abortions, but they will be criminal abortions. That is, all the same, a certain type of person will perform abortions, in conditions far from sterility, not in an operating room, not in a hospital. The result will be infection, illness, and often, in a very large number of circumstances, death. So that's why I think, and I say this every time, that there should be education, there should be help, and not necessarily financial. It could be psychological help, moral help, it could be help in finding housing...

Curiously, Polina Viktorovna did not make explicit the mechanism by which her anti-abortion work would prevent a legal ban on the procedure. Perhaps it was self-evident to her that a reduction in the abortion rate would keep the state from feeling the need to institute a ban for population planning purposes. In this world view, then, reducing the number of abortions is a way of humanely dealing with demographic crisis, in order to keep the government from dealing with it in crueler and ultimately more disastrous ways.

She presents the role of an anti-abortion advocate as to help people grasp that the fetus is alive and human-like. The importance she ascribes to this – and specifically to the ways the fetal organism resembles a fully-developed human – is great:

We explain to [students] the value of human life, that we can't dispose of it like a piece of paper, crumpled up and discarded. That it's a little person, and at the moment of the abortion, he already has little arms and legs, and already sucks his thumb. ... Even these little dolls that we give them to hold – the students are happy to play nurse to them. They don't even imagine, they think that [the fetus is] like a little fish, a pile of slime, I don't know what else. They don't imagine that at the 12th week – at the 8th week, even, it's already a little person. And when they take this doll in their hands, they understand that it's not a piece of meat, not like a chicken leg, it's a little person.

She also describes using the concept of the fetus' humanity in her counseling at the abortion clinic:

They think that it's a little piece of slime that surgeons take out, and when I show them, when I take it out of the box – I don't keep it on the table – I take it out like a magician and say "give me your hand." They stick out their hand and I put this little person in it. Yes, a plastic person, but a little person all the same. I say: "This is what your child looks like right now."

The image of a tiny person sucking its thumb at 8 weeks of gestation, contrasted with piles of slime and pieces of meat, is intended to stir emotion. In a similar vein, Polina Viktorovna showed me with evident pride her personal contribution to the *Preserve my Life* office – a set of lifelike collectible baby dolls with realistic facial expressions and cute costumes.

In this way, Polina Viktorovna's work connects the moral and the demographic in a slightly different sense than discussed above. She seems to suggest that the moral harm of abortion can be mitigated by preventing frivolous abortions from occurring, but that ultimately, legal and accessible abortion is compatible with a morally righteous and demographically healthy Russia. She exhibits a somewhat paternalistic attitude toward her counseling clients that reflects the anti-neoliberal logic of anti-abortion activism, by ignoring the material conditions that women face in favor of interpreting their decision as stemming from a lack of empathy and human feeling. Even in her use of the argument that women will continue to seek abortion care if it is made illegal, Polina Viktorovna does not overtly acknowledge abortion as acceptable in limited circumstances.

Ksenia Ivanovna, the other psychologist offering counseling at the abortion clinic, is more religious than Polina Viktorovna, but also appeared more open to understanding abortion as a practical choice. She is a forty-two-year-old married mother of two and a psychology teacher. Teen sweethearts from two neighboring villages, she and her husband married young, at 19, but they were unable to have children until she underwent extensive fertility treatment and was finally diagnosed with endometriosis – an experience to which she attributes her faith in God.

My interview with her focused primarily on the details of her psychological counseling work. In contrast to Polina Viktorovna, she emphasizes first and foremost the difficulty of the decision women seeking abortion have to make, detailing their challenging life situations and describing how many of them cry and say they've agonized over the choice to get an abortion. This is augmented by the fact that the majority of the women she has counseled before abortion are those with two or more children; by her estimate, 50% have two children, and 20% have three or more. For her, the role of the psychologist is first and foremost to connect women to the various types of help available, including public benefits, job training, and material help from charities. In this way, she rejects the anti-neoliberal notion that material concerns are of no consequence in the decision to have children.

Only secondarily does she see the psychologist's role as changing perceptions of abortion itself – partly because other aspects of Russian abortion law take care of this. “We show them that even at five weeks there's a head, arms, legs, it's not a little worm, it's a little person. We tell them that the heart is beating. But modern Russian law has made it so that when they come to us they've already done an ultrasound, and generally they've all heard the heartbeat.” However, she does not discount the power of this type of persuasion in certain contexts.

In a few situations, when I see that we need to nudge the woman a bit, we even show her photos of aborted babies. I had a case where the girl said: “Can I go

and show this to my husband?” That is, he was making her [get the abortion]. In sum, she went and didn’t come back. Somehow she managed to convince him.

She believes that she applies this pressure judiciously, though; because she is providing counseling at the abortion clinic on the day of the procedure, she maintains an awareness that she is only likely to convince those who show evidence of having serious doubts. Ksenia Ivanovna also applies religious pressure in cases where she deems it appropriate:

If we see that the person is a believer, I look, usually they’re wearing a cross, and it’s somehow clear that the person is having second thoughts, we try from this angle as well. To remind them that it’s a sin, that the church judges it, that they should think about their child’s soul and their soul.

Religion is, in fact, the crux of Ksenia Ivanovna’s mission as an anti-abortion activist – not exactly in terms of teaching women to behave according to Orthodox teaching, but rather as a piece of a broader moral project of atonement for sins. Explaining what motivates her to continue work that is frequently depressing and emotionally draining, she describes the personal meaning she brings to it:

When they’re believers, I also ask for permission and write down their names. In Orthodoxy we give names for the priest to pray for. I want to at least support them energetically, give them this kind of strength. But besides the fact that it’s a job, you [have to] include some of your own meaning. Because in our family – my mother, my aunts – there were also all these situations [that is, abortions], and you think: it was conceived in heaven, perhaps, that these sins be forgiven. So it’s some kind of mission of mine.

The 2009 booklet *Methodological and Organizational Aspects of Counseling on the Problem of Abortions* also exemplifies the not-specifically-religious anti-neoliberal logic of Russian anti-abortion work. This manual, intended for psychologists and laypeople hoping to work or volunteer as counselors for women considering abortions, was available in hard copy in the *Preserve My Life* office/library, and was also used by the center’s two psychologists in their specialized anti-abortion training.

The manual starts from the assumption that the goal of psychological counseling is to dissuade women from abortion, and that whatever reasons a woman might have for seeking one, they are misguided. “Women who are prejudiced against the process of counseling, as a rule, get the abortion, despite their insignificant objective reasons [for doing so].” Here, the possibility of significant objective reasons is rejected out-of-hand. Later: “Thus, the best prophylaxis against abortions may be the formation of family values among teenagers and youth, and the development of the ability to find the optimal way out of a problematic situation.” While this statement admits the existence of problems, it also implies that the optimal solution is not and cannot be abortion. In a similar vein: “Often “material difficulties” is a rote phrase for the woman. In clarifying the situation – what does “material difficulties”

mean to you? – the counselor can lead the woman to conclude on her own that “if the child is born, then the means to raise it will be found.”” Here, again, the need for material resources to raise a child is not denied, but it is suggested that acquiring these resources is a problem that will solve itself, and that asking a woman to contemplate this question should lead her to the same conclusion.

Later, the manual takes a philosophical turn, quoting from the work of 18th century Russian philosopher Gregory Skovoroda and considering the meaning of life’s joys and self-love: “The more you love someone, the greater the joy you want for them – not in quantity but in quality. We wish for our loved ones the highest, the brightest, the most joyous things; we don’t wish for them to have a lot of duller, shallow joys. We must learn to love ourselves in the same way. A child is one of the great joys. And the desire to get rid of it is the desire not to give up the petty joys you have now (a relatively carefree life, a career, a casual relationship, etc. – everyone has their own).” That is, whatever a woman might value about her current life, her inability to value a child more is an indication that she does not fully love herself or want what is best for herself.

This line of argument is somewhat similar to anti-abortion advocacy elsewhere; however, there are subtle but important differences. American pro-life rhetoric, for instance, rather than rejecting neoliberal biopolitics, is often rooted in a conception of neoliberal subjectivity and ownership over one’s choices. The goal is not to convince women that their problems are trivial, but rather that they can deal with the challenges ahead. For example, from a profile of evangelical crisis pregnancy center workers: “The job is to not just say, ‘Hey, this is a real life inside of you, you need to save it.’ That’s not going to accomplish anything,” Ms. Ramsey, 31, said. “It is to get her to see that whatever she thinks is too big for her to handle, she can actually handle it” (Dias, 2019).

The anti-neoliberal also appears in official documents; text that appears to be taken directly from Methodological and organizational aspects of counseling on the problem of abortions also appears in the “Methodological Letter: Psychological Consulting of Women Planning Artificial Termination of Pregnancy” published by the Russian Ministry of Health in July 2017 (“Pis’mo Ministerstva zdravookhraneniia RF N 15-4/10/2-4792”, 2017). Two large subsections of the methodological letter, parts 5 and 6, covering problems that can emerge in the counseling process and special counseling techniques, correspond directly to the section of the booklet entitled “Counseling procedures and techniques”. The booklet is also listed in the letter’s “further reading” section.

The anti-neoliberal bent of this argument is not fully internally coherent; while the state’s stance on abortion appears intent on weakening the idea that rational control of fertility is always fully desirable, it is difficult to argue that the Russian state, or even the most reactionary elements within it, truly see no value in individualized management of life processes, and a great deal of mainstream Russian pro-natalism – not least of all Putin’s well-known speech introducing the 2007 pronatalist family policy reform, with its discussion of the housewife’s economically “degraded” position within the home as a non-producer on the labor market (Rotkirch, Temkina, & Zdravomyslova, 2007) – explicitly acknowledges the household economics of childbearing. Thus, accounts of post-Soviet family policy that label

it “socialist-inspired” miss part of the point: it is not inspired solely by socialism, but by the realization or fear that a neoliberal, privatized model of the family does not yield the demographic outcomes the government desires. In this sense, both restricted abortion access and state support of women and families operate in a framework that does not fully deny neoliberal logics, but works to change the economic calculus of childbearing.

Because of Russian society’s different relationship to neoliberal logics of personal responsibility and family planning, Russian pro-abortion rhetoric also differs from its counterpart in the U.S. It often positions itself as somewhat orthogonal to neoliberal biopolitics; as Michele Rivkin-Fish (2018) writes: “[B]y decrying the lack of state support, women defended their reproductive decisions as embedded in a moral economy of responsibilities between women and the state – responsibilities from which the state had withdrawn” (p. 29). To Rivkin-Fish’s pro-abortion activists, then, just as to Polina Viktorovna, abortion may be necessary in circumstances where women are powerless to raise their children; this powerlessness comes about as a result of the broken relationship between state and citizen. Thus, there are also echoes here of the connection between the moral and the demographic, although it is state morality, not individual morality, that leads to a flourishing population.

Ordinary women’s opinions

The way abortion came up in my interviews with regular women was quite different from the rhetoric of the three anti-abortion center workers. It was, of course, often mentioned when I asked about how people prevented pregnancy. But overall, interlocutors tended to distance themselves from it discursively; only two spoke openly about having had an abortion. Larisa, a 38-year-old who had an abortion for medical reasons, discussed it matter-of-factly, but Raisa, a 43-year-old married mother of two, had one because of an unintended pregnancy. She expresses a certain amount of regret: “Unfortunately, it has had a place in my life ... after the first, in the space between my children. I wanted it, but circumstances were such that we decided that we shouldn’t yet. A pity, but we can’t change anything now.”

Nadia, who is 40, is in many ways typical of women who came of age in the early post-Soviet era. She married young, soon after college. She had one child early on in her first marriage, in her early 20s; when he was still young, she divorced, and later remarried and had a second child who is about ten years younger than her first. However, she was visibly uncomfortable discussing abortion, saying: “This is what I think: fortunately, I don’t know what abortion is [that is, I have no experience with it], and in the circle of my closest friends, no one has ever had one. Well, one woman I know had one, but for medical reasons, because there was a big problem, the fetus had died – and that’s it. But otherwise I have nothing to say about this.” This level of discomfort was relatively uncommon, but the assertion that neither the interview subject nor her friends and acquaintances had had experience with abortion was quite common.

It was also very common to conceptualize abortion as murder; nearly half of those who discussed it mentioned this as a belief held either by themselves or by others. Yana, a 20-

year-old unmarried student from an Armenian family, says: “It seems to me that it’s not right, to kill someone.” Like many interview subjects, though, she quickly makes allowances: “If, if, let’s say, there’s a case where it threatens your health, you have to have an abortion, then okay.”

The degree and type of allowances mentioned were striking in their variety. One common idea was that abortion is understandable when a woman is single, but is not done in the context of a family – a striking contrast to the available data on abortion and to Ksenia Ivanovna’s experience at the clinic, where she estimates that nearly three-quarters of patients are married or in long-term partnerships with children. Liuba, a 31-year-old married woman with no children, initially said that “of course” a couple facing an accidental pregnancy wouldn’t get an abortion, but when I asked her to say more, she hedged; “There are different kinds of families, different fates. It can happen, of course, that someone has two, and gets pregnant with a third. And there’s no possibility to keep it.”

Galina, on the other hand, a 39-year-old mother of three, who has always used coitus interruptus as her preferred method of birth control, does not allow for this type of exception. After her latest birth, her doctor told her she shouldn’t get pregnant again, and asked her to consider contraceptives. At first she said she didn’t need them, but when the doctor pressed her on what would happen if she accidentally became pregnant, she changed her mind: “I’m categorically against abortion. I just couldn’t. I would have to give birth again. I’m a religious person, and I think, you’re an adult, you ought to have foreseen this pregnancy. So, now I have to– we take pills.”

Marina, a 29-year-old mother of one, agrees. Although she had some difficulty getting pregnant, she imagines how she would change her behavior if she felt she were at high risk of an accidental pregnancy:

The pull-out method is also dangerous, because everyone’s body is different. There are those who– there was a couple that lived in our building, in the first entryway. They used the pull-out method, weren’t planning a pregnancy, and oops, they ended up with a second kid. They aren’t in favor of abortions; I also don’t support them. If I had that kind of body, then, naturally, I would only use condoms, if I were getting pregnant all the time. In order to avoid giving birth all the time. If we plan a second, we’ll plan it at a specific time, but if it turns out we get pregnant accidentally, then we’ll have one earlier, naturally.

Often, as in Liuba’s case, the distinction was between an unplanned first or second pregnancy and an unplanned higher-order pregnancy. But Anastasia, a 34-year-old married mother of two, does not make this distinction:

We aren’t planning on another, but if there’s some kind of accident then I, of course, won’t get an abortion, because having had two children I can’t imagine going and killing the third. Abortion was unacceptable to me to begin with, and now even more so. ... If there are some medical problems, of course, that happens...but just because I don’t want it, no. Never.

In terms of exceptions to moral bans on abortion, most striking of all was the story told to me by Polina Viktorovna, as she described the difficulties of her work as a pre-abortion psychological counselor:

You see, there was a woman, 42 years old. She says “I prayed, I got treated for [infertility].” Her husband is 50, they don’t have kids, they’ve been together for a long time, and in her 42nd year of life she got pregnant. And then she got on the internet and saw that 60% of children born of these late marriages – that is, these late first pregnancies – have genetic abnormalities. And she came to get an abortion. ... And I tried for about 40 minutes to convince her, we sat hugging, we cried, I told her stories from my life, I told her that in later pregnancy they do analyses in Rostov, go ahead and get tested – they give you a shot, and take amniotic fluid and determine the genetic defects. Not on the first try – they take one, two, three shots, and they can determine it and then do an artificial birth and get rid of the child that way. But she didn’t agree to it. She went and got the abortion.

The contrast Polina Viktorovna sees between aborting a healthy child and “getting rid of” a child with a genetic abnormality via “artificial birth” is striking coming from an anti-abortion advocate, but she was not the only one to bring this up. Sasha, a 23-year-old unmarried woman with no children, describes in eugenic terms the need to keep abortion legal. She argues that banning abortion would make the nation weaker by increasing the number of disabled children who are born in a context where provisions for these children are inadequate. She describes seeing fundraising campaigns on television for sick children, where viewers are asked to send a donation via SMS, and expresses that this is an indication that the state is spending its money poorly. She is also somewhat mercenary: if the parents of a disabled child die, and the child cannot take care of himself, “who needed this life?”

Although I interviewed women up to age 45 (i.e. those born in 1971 or later), there were few representatives of the stereotypical Soviet point of view of abortion as morally unproblematic. One of the few was Evgeniia, a 33-year-old married mother of two. Her old-fashioned opinion could possibly be explained by the fact that her mother is a midwife, trained under the Soviet model. She attributed anti-abortion beliefs not to Orthodox believers, but to foreign sects:

There are some who have some religion, they can’t have abortions. It’s some kind of belief, Baptists or something like that, they can’t get abortions, they consider it child murder, so they, however often they get pregnant, they have to have all those children. But otherwise, pay your money and go have ten if you want. No one looks, no one knows, no one even says anything.”

Even those who did not explicitly frame abortion as murder tended to express disapproval for it, either in terms of physical risks, the perceived irresponsibility of relying on it as a

method of birth control, or both. Irina, a well-educated, 31-year-old divorced mother of one, describes her social circle's contraceptive practices: "No, no. They definitely don't do that. Everyone knows that that's harmful, and it's easier to prevent pregnancy than to liquidate the consequences." Eva, who is 23, childless and recently married, was one of the most pro-abortion of my interlocutors, actively criticizing the role of the church in current political debates. But she elaborates:

I'm not a fan of abortions; I think that it's better for it to not come to that. There are modern methods of contraception, and it isn't hard at all to sort things out with those pills. I dislike abortion and its consequences from a medical point of view. ... It's just that it often leads to infertility. Because these kinds of disturbances in the delicate reproductive system – they don't lead to anything good, and such poorly thought-out actions can harm a woman, that is, I think it's not worth it to forbid her from having abortions, it's worth it to explain to her what the consequences can be, that some kind of slip of the knife can destroy... can lead to infertility.

Anjelika, a married mother with an infant son, is a somewhat unusual figure among my informants. A tall twenty-nine-year-old, she has for several years cultivated a large Instagram following, posting photos of herself in stylish clothing taken by photographer friends. She owns an automated photo booth at the local mall, and when I spoke to her, she had also recently started a business selling small-batch natural beauty products. Her husband owns and manages a fashionable bar in town.

Besides being a person with a keen sense of the opportunities available to someone who can bring novel trends to Taganrog, she lived alone before she met her husband – a rarity for young single women. At the time of our conversation, she was on maternity leave from her day job as a manager at an insurance company, but hoped to avoid returning to that position and instead continue building a more flexible career working from home as an independent entrepreneur.

Although her marriage was precipitated by an unintended pregnancy rather early in her relationship with her now-husband, Anjelika reflects on the strategy and reproductive planning required to maintain her lifestyle, drawing a link between abortion and what she calls asocial ways of life:

Here [abortion] is strongly connected to social strata. It seems to me that the people who get abortions are often those who are poorly educated, who drink and so on, who don't work. So, I have a career. I have a pretty good job for a provincial city, I have a group of insurance agents I manage, almost 20 people. For a large insurance company with branches in every city. And naturally I know that if I get pregnant once, twice, three times, and I'm eternally giving birth, living my life carelessly, then of course I won't have any of that. Not to mention my apartment, which I had to earn the money for, back when I was single and

living by myself. But those who lead a more asocial way of life, they get pregnant frequently, and often they keep it – it’s not that they’re always necessarily getting abortions. There are families like that with 4 or 5 kids. They somehow take it all lightly, I don’t know. It’s just that the higher your quality of life, the more scrupulously you relate to everything and pay attention to everything. So, contraception... I’m saying that probably those who use contraception are those who have something to lose. Those who don’t want kids.

Anjelika’s explanation begins with the idea of abortion, but she quickly pivots to another behavior she considers low-class – unplanned, “careless” pregnancy. Both abortion and frequent pregnancy, to her, are instances of mismanaged fertility – symptoms of a lack of attention and scrupulousness, of having nothing to lose. Whether people who have had four or five pregnancies manage them with abortion or not, to Anjelika, their avoidance of contraception indicate something about their life.

This attitude toward women with many children was also expressed – from the other side – in a story told by Vasilisa, a 32-year-old nurse who is married with two children of her own:

I was sitting at the gynecologist’s office when I was pregnant with my younger child, and she chased a woman out. It was not very nice on the doctor’s part. This woman had come in; she was 12 weeks pregnant. It was either her third or fourth child. And she came in with her lab results to get registered [that is, to begin regular prenatal care]. The doctor started in: “Go get an abortion, what do you need this child for?” That is, she tried to talk her out of it. The woman left, but she stood her ground that she was going to give birth. And I go in next and the doctor says “Look at that, poverty...” The woman was from some village. “They’re birthing poverty! What’s it for, the third, the fourth? They come in here when they themselves are dirty.” But, what’s it to you? If she wants to give birth, she knows what she’s doing. And furthermore this woman came knowing that before 12 weeks you can get an abortion and after 12 you can’t. And she came after 12, with her lab results, goal-oriented, intending to keep the child.

Vasilisa’s story is clearly a rejection of this attitude, meant to illustrate a case of a physician overstepping her bounds. This rejection was also reflected in a passionate defense of multi-child (*mnogodetnaya*) families I witnessed from Ksenia Ivanovna at the roundtable on prenatal psychology. In her view, Russians need a reeducation about the status and desirability of large families. Her paper, discussed above, focused on changing social stigma around large families: “For example, a series of [TV] programs about the families of outstanding people who were their parents’ third or subsequent child could dissolve the myth that children in multi-child families are poorly educated and uncultured.” Her roundtable presentation expanded the idea of lack of education and culture from the children to the parents of multi-child families – that women with multiple children who find themselves pregnant worry about keeping the pregnancy because of how they will be perceived. She

also moved on to the idea that modern people need to understand that giving their children “the best” doesn’t mean the latest iPhone and a lot of new clothes. In her view, the concept of rural poverty expressed by the doctor in Vasilisa’s story, or Anjelika’s idea that those who have a lot of kids “don’t take life seriously”, exist in the collective consciousness and are major barriers to allowing women who have several children already to consider keeping their pregnancies.

Curiously, despite the pervasiveness of crisis in anti-abortion and pro-natalist advocacy, the idea of “demographic crisis” was of little interest to most of my interlocutors. Almost no one brought it up spontaneously, but I asked most people about it: “Have you heard the term ‘demographic crisis’? What does it mean?” Many were aware of the relevance of crisis to the state; in a large number of cases, interlocutors immediately brought up maternity capital, the cornerstone of Putin’s 2007 pronatalist reforms. Kira, 29 and a mother of one, gives a typical response:

I can’t say that there’s a demographic crisis now. Maybe somehow according to statistics it’s going away. Demographic crisis is a fall in birth rates, when people refuse, generally, to give birth, and you end up with very few new little people. ... I can’t say there’s a crisis now, I don’t know– in my opinion, you go outside and one person’s pregnant, another already has a baby carriage, in general people are having a second kid, probably because of maternity capital.”

Inna, 27, married and childless, was one of several interlocutors who connected demographic improvements to maternity capital and general economic improvement:

Well... I’ve heard of [the demographic crisis], but lately there has been information that it’s normalizing, it seems to be going away ... It turns out that about 9 or 10 years ago maternity capital was established, and it really helped at a certain point. Maybe, in general, the fact that the situation in the country is normalizing helps. It’s just that the economy has stabilized a little since that moment, and it helps, but maternity capital has also contributed, and it turns out that a lot of people – this isn’t the determining factor, of course, people aren’t having a child simply because they will give you 500 thousand rubles – but still it does help, because for many parents who think: “let’s have second child,” but there’s no room, and they think, “This will just be extra money, we can expand our housing...”

Diana, 39 and a mother of two, also observes that there are many more children now than there used to be:

[My daughter] finished school this year, and there were two groups of 18 kids in her graduating class. And of course it’s noticeable when the graduating 11th-graders take the first-graders’ hands on stage, and there are three or four first-graders for each 11th-grader. Of course, it’s very noticeable.

The way my interlocutors talked about abortion tended to involve discursive distancing, as most recognized it either as a subject of moral debate or overtly as murder. This is perhaps unsurprising, given that abortion has become a fraught topic in recent years and that they were talking to a stranger whose stance on the issue they did not know. Several interlocutors' comments also focused on the class markedness of certain types of sexuality and childbearing. What was conspicuously absent in their discussions of abortion was any attempt to construe it as a crisis, or to see it as constituting a threat to society (demographic or moral).

Conclusions

As in the Soviet era, abortion in Russia today is seen as an act that has potentially grave physical consequences; but, in contrast to Soviet anti-abortion sentiment, which emphasized consequences such as infertility and marital unhappiness, anti-abortion rhetoric now much more often emphasizes the moral and demographic aspects of abortion. The Russian anti-abortion movement tends to marry these two types of consequences, subtly or overtly implying that the demographic health of the nation is a moral responsibility borne by women. The moral and demographic are woven together in religious discourses, but also found in official state documents such as Ministry of Health directives. This is what makes moral-demographic discourse so powerful; not only is it a straightforward way to legitimize state interest in lowering abortion rates, but it expands the potential set of stakeholders beyond the state, by melding two goals that are attractive to a range of actors, from ethnonationalists to civil society organizations to, most importantly, the powerful Russian Orthodox Church. The grant that the institute in Taganrog won is an excellent example of this: as an Orthodox Church-funded grant, targeting abortion as a moral wrong was an appealing proposal, while the civic aspect of the project - improving the country's demographic situation - made the project appropriate for a secular institution to carry out, and provided justification for the project's impact.

However, the demographic component of abortion is not usually mentioned by women discussing the procedure. My interlocutors' rejection of the notion of demographic crisis is itself important. It suggests a limit to the rhetoric of neotraditionalism: while many of my interlocutors have fully or partially accepted the equation of abortion with murder, anti-abortion activists have clearly had less success translating the Soviet-era concept of duty to the state (or, in Zdravomyslova's terms (2009), a gendered contract of citizenship) into a moralizing framework that people find relevant to their daily lives. However, this may be beside the point; whether the notion of crisis is relevant to individuals or not, it remains a powerful rhetorical tool for justifying state intervention into abortion care and, through the Russian Orthodox Church's role as representing Russian ethnic interests, increases the urgency of church intervention into what would otherwise be a purely moral concern.

Chapter 5

Conclusion

In this dissertation project, I have attempted to characterize and explain the immense changes in fertility observed over the last thirty years in the Russian Federation. I use both quantitative and qualitative methods to consider these changes.

In Chapter 2, I disentangle tempo and quantum effects, and differential patterns by parity, on period fertility rates over the past 30 years. I have examined how much of the large swings in period fertility are accounted for by tempo effects, and how those effects differ by parity. I find that tempo shifts, particularly at higher-order births, were responsible for approximately 60% of the fall in fertility in the 1990s, and 20% of the subsequent increase. Several characteristics of the fertility increase, including increases in second- and third-order births and flattening mean ages at birth at higher parities, indicate at least temporary effects of the changing policy environment under Vladimir Putin, which incentivizes families with two or more children. The quantum gain observed from 1999-2015 is partly driven by cohort-driven recuperation of previously delayed births. However, the pattern of stable mean age at second birth and declining age at higher birth orders since 2010; the inflection point in cohort fertility schedules at 2006-2007; and parity-specific period schedules that show a large increase for second and third births, together give strong evidence for the influence of the changing policy environment, and specifically the maternity capital program offering benefits for second and higher-order births. General economic improvement over the course of the Putin era has likely also played a role, as seen by the procyclicality of fertility as Russia's economic situation has worsened in recent years.

It is, perhaps, unusual for a demographic work to focus so specifically on one country and one small slice of demographic history, but Russia in some ways demands this, not only because of the unique characteristics of the deep civilizational crisis that launched its fertility postponement transition, but because of the immense rhetorical weight its fertility (and mortality) patterns are given - both by its own politicians, religious leaders and intellectuals, and by outside observers. As the writing of this dissertation has corresponded with an era of tension between the United States and Russia - starting with the Ukrainian *Maidan* movement and Russian annexation of the Crimean peninsula just months before I began graduate school and continuing through to the ongoing "Russiagate" scandal of Donald

Trump's presidency – I have seen frequent examples of this tendency, as U.S. intellectuals strive to interpret Russia's population dynamics as a straightforward indictment of Putin's rule. Therefore, in addition to contributing to the literature on postponement transitions and lowest-low fertility, I hope this chapter serves as a reminder of the complexities of describing and understanding fertility change, even in authoritarian regimes.

Chapter 3 contributes to smaller literatures on women's health in contemporary Russia and on the cultural dynamics of childbearing in low-fertility societies. I propose a concept of "bodily culture" that considers both health systems and other understandings of bodies and how they work. The paper elaborates several themes in bodily culture that may have direct effects on fertility and family planning. First, Russian women's discussions of aging showed a reluctance to name specific threshold ages, instead emphasizing health as a heuristic for appropriate fertility; a complex relationship between bodily metaphors of organic decay, mechanical breakdown, and chronological age; a perception of tradeoffs between young motherhood and older, "conscious" motherhood; and different perceived effects of age on births of different parities. They also showed ambivalence about medical terms such as *starorodiashchaia*, and, often, interpretations of aging that differed from those of the medical professionals they had had experience with.

Second, I showed the mapping of older understandings of the body as in fragile equilibrium – most frequently understood as a temperature equilibrium – onto the biomedical concept of hormones and hormonal balance to be important elements of women's understanding of sexual health. Even interlocutors who took hormonal contraceptives expressed a good deal of concern about their effects on the body and described beliefs in their potency and many potential side effects. This illustrates how new bodily understandings can be incorporated into old ones and organically generate unexpected interpretations of risks and benefits of a new medicine.

Finally, I discussed how the medical system's treatment of pregnancy and childbearing indicates a great deal of caution and continued fear that Russian women are weak and fragile and that childbearing demands careful treatment. Examples of this included prophylactic use of progesterone in early pregnancy, use of c-section in cases where the fetus was estimated to be large, the mother's pelvis was small, or the mother was older; and general warnings against too much or too-frequent childbearing. Women's reactions to the medical system were varied; many interlocutors were broadly satisfied with their medical care, while many others reported strategies for self-managing care, either to limit intervention or to advocate for more intervention. These strategies included gathering information online in order to make educated decisions about medications, seeking care at maternity hospitals and with obstetricians recommended by others, and simply ignoring or pushing back against medical providers who were rude or dismissive. This represents one way in which the Russian doctor-patient relationship, long seen as mutually antagonistic and highly hierarchical, is evolving in an era when more information is available to patients. As Russia continues to try to raise birth rates, partly through continued explicit political and medical approval of early motherhood, they may find that these strategies are no longer effective.

Chapter 4 turns to consideration of the Russian anti-abortion movement. Using interview

data and texts from the local anti-abortion center, I show that, in contrast to Soviet anti-abortion sentiment, which emphasized consequences such as infertility and marital unhappiness, anti-abortion rhetoric now much more often emphasizes the moral and demographic aspects of abortion. The Russian anti-abortion movement tends to marry these two types of consequences, subtly or overtly implying that the demographic health of the nation is a moral responsibility borne by women. The moral and demographic are woven together in religious discourses, but also found in official state documents such as Ministry of Health directives. This is what makes moral-demographic discourse so powerful; not only is it a straightforward way to legitimize state interest in lowering abortion rates, but it expands the potential set of stakeholders beyond the state, by melding two goals that are attractive to a range of actors, from ethnonationalists to civil society organizations to, most importantly, the powerful Russian Orthodox Church. The grant that the institute in Taganrog won is an excellent example of this: as an Orthodox Church-funded grant, targeting abortion as a moral wrong was an appealing proposal, while the civic aspect of the project - improving the country's demographic situation - made the project appropriate for a secular institution to carry out, and provided justification for the project's impact.

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Where to from here?

This research program may be expanded and elaborated upon in several ways; here, I suggest what I see as two fruitful avenues for future work.

Gender and low fertility

As I argue in Chapter 2, not all of Russia's recent fertility increase is attributable to tempo effects. I give several arguments accounting for the increase in quantum, including cohort-

driven recuperation of delayed births, the policy environment and especially the policy of payouts for second and higher-order births, and general economic improvement. However, explanations “further back in the chain of causation” (Bongaarts & Sobotka, 2012, p.83) are desirable, especially given that economic improvement does not always have a straightforward relationship to higher fertility; that Russian demographers have found evidence of a one-child norm in Russian culture dating back to the Brezhnev era; and that, as mentioned above, evidence from other work indicating the effectiveness of the maternity capital policy has been mixed to weak. Even if the births gained are “merely” those that were intended all along, what contextual factors allowed women to make good on those intentions?

While many aspects of the theory of the Second Demographic Transition (Van De Kaa, 1987), such as increasing non-marital childbearing, apply to Russia, the theory’s account of fertility increases through generational ideational cycles is not likely to apply; indeed, Zakharov (2008) has noted that the generation currently of childbearing age is most likely to experience shifts toward individuation and delayed family formation, not back in the other direction.

Gender, on the other hand, presents a theory of low fertility that could potentially identify changes within Russian society that have influenced fertility. Much work on gender and fertility departs from the work of Peter McDonald, whose 2000 article in *Population and Development Review* introduced the concept of a mismatch between gender equality in individual-oriented institutions and in family-oriented institutions. Rising opportunities for women in the labor market facilitate the initial drop in fertility in the demographic transition, but those opportunities will eventually come into conflict with women’s duties within the family, causing very low fertility until gender equality within the family increases and lowers the opportunity cost of childbearing (McDonald, 2000).

Along similar lines, Myrskylä, Kohler, and Billari (2009) find that in both cross-national and within-country comparison, the relationship between fertility and economic development is J-shaped, with fertility rising in the most advanced countries. They suggest a gender aspect to this, particularly in the realm of work-family balance policies and gender norms that encourage compatibility between female labor-force participation and child care.

Brinton & Lee (Brinton & Lee, 2016) contrast societies that advocate both female labor force participation and gender-essentialist norms of family life with those that advocate a male breadwinner model; they find that the former is negatively associated with total fertility (*vis-à-vis* “full egalitarianism”), while the latter is not. This aligns with McDonald’s proposal that it is disparate levels of gender equality in different institutions, not overall equality, that reduces fertility to lowest-low levels.

Finally, Anderson and Kohler (2015) extend McDonald’s work theoretically, proposing that gender equality in the public institutions occurs in the course of economic development, and gender equity in private institutions such as the family follows because of a “gender equity dividend” that arises when women’s labor force participation lowers fertility rates and sub-replacement fertility leads to a marriage squeeze that raises women’s bargaining power in the marriage market. The rise in family gender equality leads to a recovery of fertility. Among “second-wave developers,” including East Asia, Southern and Eastern Europe, the

public gender equity transition happened so quickly that family roles have not had time to catch up, causing long periods of very low fertility.

On some indicators, such as female labor force participation, Russia is a world leader, and many Russians maintain a strong belief in the Soviet legacy of legal equality for men and women (Ashwin, 2000). At the same time, the Soviet social structure assigned a special role to women as both producers and reproducers, enshrining the double burden as women's duty (Ashwin, 2000; Kay, 2007; Utrata, 2015). Furthermore, a belief in substantial sex differences in abilities and personality traits rose in prominence in the late Soviet era, permeating school curricula, popular journalism, sociological and demographic research, and official policy (Ashwin, 2000; Attwood, 1990; Bridger, 2007). This "gender backlash" emphasized women's primacy in the domestic sphere and their "natural" ability to work tirelessly (Vinnokurova, 2007). It recast balancing the double burden not only as women's duty to Soviet society, but as their unique strength as women; perhaps this naturalization of gendered care work allowed it to persist after the collapse of Soviet power.

However, post-Soviet women show some indications of wanting a return to more "traditional" family structures; Ashwin (2000) found, in survey research, that both men and women expressed a desire for this, although their conceptions of the content of such a return differed greatly, and women were more likely to express desire for a version of it in which they still worked, but their husbands earned more money. A comparative study of Sweden and Russia shows that the similar family policy structures and female labor force participation rates of the two countries does not equate to similar beliefs about gender roles; although Russia had higher proportions of both female-led and dual-income households, Russians were more likely to express a preference for the single-breadwinner model (Motiejunaite & Kravchenko, 2008).

Recent survey research suggests that these beliefs still hold – in a 2017 survey on gender equality and feminism, only 12% of Russian women surveyed indicate that they feel they lack equality with men. At the same time, 54% of Russians agreed with the assertion that men are more capable than women of doing things "such as working, earning money, and being educated" ("Three in four women around the world believe there are unequal rights in their country", 2017). Of 24 countries surveyed, Russia ranked second to India in the percentage of respondents (30%) who agreed that women should not aspire to do more than stay at home and care for the family (*ibid.*). Russian women's experience in the labor force – where low wages, lack of advancement opportunities for women, and discrimination against those who may become pregnant are the norm – reflect these attitudes (Utrata, 2015).

Family structure also creates a more complicated picture for Russians; while on the surface, Russia could be conceptualized as a country where both gendered care work and female labor force participation are norms, the reality of high divorce rates, single parenthood, and use of extended family networks may cause these two norms to interact in unexpected ways. Utrata (2015), writing on single mothers, theorizes motherhood in post-Soviet Russia as "compulsory and compensatory;" compulsory because it is viewed as an, or perhaps the, essential component of gendered female adulthood, and compensatory in that it makes up for what is felt to be the lack of possibilities for other kinds of achievement – for example,

a “successful” marriage, wealth, or an upward career trajectory – in women’s lives. She argues that, for contemporary Russian women, single working motherhood is experienced as a way of construing oneself as a successful subject in neoliberal free-market conditions. She also highlights the extensive help that mothers often receive from their extended families, particularly their own mothers.

All of this contributes to a considerably more complex picture of gender as an input to fertility decision-making than allowed for by current models of gender and fertility. Much demographic literature on gender and fertility in advanced societies assumes a somewhat developmentalist stance, not unlike the developmentalist stance of demographic transition theory –it is desirable for fertility to be on the higher end of sub-replacement, and advancement toward equality is conveniently found to raise fertility away from lowest-low levels. However, as more of the world converges toward sub-replacement fertility, it seems unlikely to me that this straightforward gender model, which comes with unspoken assumptions about the content of the gender paradigm and the meanings of and conflicts between labor force participation and domestic labor, will be found to hold in all cases.

For instance, as discussed above, Russian society is not highly egalitarian, but many women construe their legal equality, special social role as mothers, and ability to balance work and family as a form of level playing field. Persistently elevated male mortality at young adult ages means no marriage squeeze has materialized to strengthen women’s bargaining power within the family, and many women still claim to prefer a male breadwinner model. And yet, fertility has remained relatively high and stable from cohort to cohort, and the share of women who are having second and third children is increasing. Further work is needed to explore this idea.

Russian and global anti-abortion movements

This work focused on the unique characteristics of the Russian anti-abortion movement, but it also shares many commonalities with anti-abortion movements in other contexts. Examining the ways that American anti-abortion rhetoric and materials – from the 1984 anti-abortion propaganda film *The Silent Scream* to concepts like “the right to life” – have been adapted and deployed in Russia would further enrich our understanding of the diversity of global perspectives on abortion. Further research is also needed to fully document and understand the international networks of conservative money and power that make possible international movement-building around conservative approaches to gender, sexuality and reproductive health. One such network that has received some attention is the World Congress of Families, a project of U.S. activists on the Christian Right which has since 1997 brought U.S. activists on the Christian right together with leading Russian conservative businessmen, philanthropists, religious leaders and government representatives to discuss and strategize on topics such as LGBTQ rights, abortion and contraception, and marriage (“World Congress of Families”, n.d.).¹ As right and far-right movements gain and entrench power in both

¹Although it now has a wider reach, WCF was originally founded as a Russian-American venture, with the participation of conservative Russian demographer Anatoly Antonov, and Russians and Americans still

Europe and North America, research examining the connections between them and the legal, rhetorical and organizational strategies they use to advance pronatalism, restrictions on LGBTQ rights, and restrictive reproductive health policies becomes ever more important, both to demography and to the social sciences as a whole.

make up a large proportion of its membership.

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