© T.L. Kuksa

PARTNER-ACCOMPANIED CHILDBIRTH AND INDIVIDUAL CARE PROVIDERS IN THE SETTING OF COVID-19 PANDEMIC: POWER DECISIONS, PRACTICES AND DISCOURSES

Keywords: Partner-accompanied childbirth, individual midwife, doula, patient choice, informed consent, patient rights, medicalization, COVID-19, restrictive measures, quarantine, emergency government regulation

The article analyzes field materials and regulatory documents representing childbirth with support of a partner, individual midwife and doula accompaniment since the beginning of the COVID-19 pandemic, as well as strategies for interaction of patients, their families and personal assistants with maternity hospitals in the context of anti-epidemic restrictions of the Rospotrebnadzor and recommendations of the Ministry of Health of the Russian Federation. In larger Russian cities, the possibility of extraterritorial choice of an obstetric hospital has been limited. Physicians are forced to act on the basis of the presumption of COVID-positive status in pregnant women, women in labor, infants and other caregivers. In maternity hospitals, the practice of family- / partner- and doula-provided assistance was temporarily suspended, and physical separation of the mother from the newborn was recommended, including that in children's intensive care. However, the conspiracy and eschatological discourses of the lay people and the academic establishment, fears of asceticism and of "canceling thy neighbor," a return to "bare life," the supremacy of biopower, loss of rituals of childbirth and funeral were overcome by individual specialists and practices of continuing life itself. Epidemic-control restrictions forced them to transfer interactions with women into forms uncontrollable and invisible to the state and provide support for home births, online support in maternity hospitals, (un)paid prenatal and postnatal counseling and rehabilitation.

This article is a translation of: Т.Л. Кукса. Партнерские роды и индивидуальные сопровождения в условиях COVID-19: властные решения, практики и дискурсы // Etnograficheskoe Obozrenie. 2021. No 6. P. 39–61. DOI: 10.31857/S086954150017932-5

Theoretical framework, sources and methods

Conventional, media and academic interpretation of COVID-19's effect on people are dwelled upon in many a recent anthropological work (*Bakhmatova* 2020; *Kirziuk* 2021; *Manichkin* 2021; *Kharitonova* 2020). In these papers, the researchers interpret the initial response to newly introduced anti-pandemic measures either from the perspective characteristic of European establishment, operating on concepts introduced by Agamben and Foucault (*Manichkin* 2021), or from the point of view held by ordinary Petersburgers prone to "moderate" or "radical" COVID-19 dissent (*Kirziuk* 2021). Nestor Manichkin mostly dwells on the European academic media dispute concerning Giorgio Agamben's

Tatiana Kuksa | https://orcid.org/0000-0002-8696-7284 | tkuksa@hse.ru | HSE University, Russian Federation (11 Pokrovsky Bulvar, Moscow, 109028, Russia) Institute of Ethnology and Anthropology RAS

Etnograficheskoe Obozrenie. 2021. № 6. P. 294–313. https://doi.org/10.31857/S086954150017611-2

ISSN 0869-5415 | http://journal.iea.ras.ru

radically critical views of emergency regulations imposed by the states[1], the consequences of the newly introduced "biosafety" requirements and the "sanitary terror"[2] that led to a "religious cult of medicine"[3], social distancing[4], "canceling thy neighbor"[5] and "facelessness"[6], "technical barbarity" of studying from home[7], giving up culture, rights and values in favor of physical survival and "bare life"[8] (*Manichkin* 2021; *Agamben* 1998). Anna Kirziuk places dissent into a conspiracy frame and examines semi-structured interviews with the denizens of St. Petersburg concerning their disregard of the restrictive measures. Employing the concepts of "stigmatized knowledge" (*Barkun* 2015) and "agency panic" (*Melley* 2000, 2008), Kirziuk portrays both the "moderate" and the "radical" COVID-19 denier in Russia, explaining the "pessimistic" roots of anti-"system" resistance via insufficient agency and pre-pandemic fondness of "alternative", paramedical and other "stigmatized" conspiracy theories (*Kirziuk* 2021; *Barkun* 2015; *Melley* 2000, 2008).

Nevetheless, the abovementioned works leave aside the normative content, legal sufficiency and the logics of implementation of emergency epidemic-control measures and the multitude of personae who adopt the controversial governmental decrees (for example, see more on this in: *Kuksa* 2020a, 2020b), as well as the analysis of the legislative and regulatory compliance practices (aside from discursive practices) and scenarios of medical and patient decision-making during the COVID-19 pandemic. With few exceptions (see, for example: *Kuksa* 2020a, *Kharitonova* 2020), Russian scholarly literature on the matter tends to leave aside anthropological analysis of how Russian professional communities and human rights advocacy groups react to massive epidemic-control measures that involve restrictions on the rights of both medical professionals and patients, including obstetric patients and their families. On the contrary, some recent works by Western medical anthropologists explore the specifics of limiting the agency of pregnant women and new mothers as a result of state policies of health preservation and of epidemic-control measures implemented by governments and hospitals (*Barata et al.* 2020; *Castaneda, Searcy* 2020; *Declan et al.* 2020; *Quagliariello, Grotti* 2020; *Rivera* 2020; *Rocca-Ihenacho, Alonso* 2020; *Varley, Strong* 2020; *Yuill et al.* 2020).

This article focuses on field materials and regulations concerning partner-accompanied births, midwifery and doula-assisted support since the outbreak of the coronavirus pandemic, as well as the bureaucratic and communicative contexts and strategies of interaction between obstetric patients, their family members and trained companions with maternity clinics under the epidemic-control measures implemented by the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (Rospotrebnadzor) and the Ministry of Health of the Russian Federation.

The specifics of the functioning of maternity wards during the pandemic, partner- and doula-accompanied births temporarily put on hold and then selectively reinstalled in larger Russian cities, bodily restraints and legal restrictions, the discursive reaction of medical, obstetric, doula and patient networks towards the medicalization cannot, in my opinion, be properly explored apart of the content of policies of health preservation, restrictive epidemic-control measures and "punishment" forms of administrative and judicial control. Therefore, an analysis of normative legal and administrative documents and guidance materials related

[1] https://centerforpoliticsanalysis.ru/position/read/id/iskljuchitelnoe-polozhenie-i-polozhenie-chrezvychajnoe
[2] https://centerforpoliticsanalysis.ru/position/read/id/biobezopasnost-i-politika
[3] https://centerforpoliticsanalysis.ru/position/read/id/meditsina-kak-religija
[4] https://centerforpoliticsanalysis.ru/position/read/id/sotsialnoe-distantsirovanie
[5] https://centerforpoliticsanalysis.ru/position/read/id/zaraza
[6] https://centerforpoliticsanalysis.ru/position/read/id/litso-i-smert
[7] https://centerforpoliticsanalysis.ru/position/read/id/rekviem-po-studentam
[8] https://centerforpoliticsanalysis.ru/position/read/id/golaja-zhizn-i-vaktsina

to reproductive and/or patient choice precedes my further elaborations, as further filling of the gaps in the interpretation of numerous (and often contradicting) bureaucratic logics of the government authorities adopting extraordinary anti-COVID resolutions is in order (*Kuksa* 2020a, 2020b, 2021). Accordingly, five relevant federal laws have been analyzed in this article along with the four versions of the guidelines that have been issued by the Ministry of Health since the start of the pandemic, 14 resolutions, 26 mandatory guidelines and more than 100 non-regulatory documents issued by the Rospotrebnadzor, all aimed at 2019-nCoV contagion prevention.

I address the discourses and narratives representing partner-, midwife- and doula-accompanied births from the perspective of the Harvard school of medical anthropology and its approach to culturally determined *health care systems.* Such systems, not unlike other symbolic systems, e.g. kinship systems and religion systems), emerge from "meanings, values, behavioral norms" and are supported by communities, agencies and their representatives – *agents of care* (*Kleinman* 1978, 1988). Both Arthur Kleinman, the lead developer of this theoretical paradigm, and his followers view local explanatory models as systems of knowledge and values as valuable as the legitimate "biomedical model" (*popular or folk illness models vs biomedical disease model*), along with describing the distinction between popular/lay and professional *illness and disease narratives and experiences* (*Eisenberg* 1977; *Kleinman* 1978, 1988, 1992, 1994, 2019; *Mikhel* 2017). This approach allows to discard negative evaluativity and reductive unambiguity resulting from categorizing popular interpretations and actions as "stigmatized", "alternative" conspiracy theories and "anxieties", "panics" compensating for the lack of agency of the "late modern subject" (*Barkun* 2015; *Melley* 2000, 2008; *Kirziuk* 2021).

Partner-accompanied births. Upon applying Kleinman's theoretical frame to field materials, it is safe to assume that partner-accompanied births in the company of family members fall into the "popular sector" that includes, according to Kleinman, individual, family and community levels of health care: since 2011, the husband or any other family member is legally allowed to be present at births taking place in a medical facility, free of charge, provided certain requirements are fulfilled (*Kuksa* 2021).

Individual midwife-provided support. Individual midwife-provided support was legalized in 2006 and is still possible provided that the certified midwife works full-time at a private clinic and part-time – at the obstetric hospital. In this case, the personal assistant is considered a *professional agent of care,* while remaining relatively independent from the healthcare facility.

Doula-accompanied birth. Paid doula-provided support in an obstetric hospital is not legally recognized yet despite activism in doula community, lobbying the legality of the doula'' presence during birth (as the "birth assistant", with inclusion of the profession into the official register[9]). Nevertheless, it is very popular with women and is often used during births by contract basis and, although informally, under obligatory medical insurance at more permissive healthcare facilities in larger Russian cities (*Kuksa* 2021). In this latter case the specialists try to move from the "popular sector" (namely, quasi-family), where birth assistants are forced to pretend that they are members of the client's family and introduce themselves as such, into the "professional sector" of female health care. During births by contract basis, as healthcare facilities are interested in said contracts, doulas do not have to disguise themselves as quasi-partners to be allowed to participate in the birth at all. The demand for private education programs for the training of "professional" doulas and the growth in the number of "certified" (trained) specialists is forcing program managers to organize volunteer projects in friendly maternity hospitals (for graduates of doulas

[9] See the aims and purposes of the Russian Association of Professional Doulas: https://doularussia.ru/about

to undergo internship and free support of women in childbirth). In any case, doulas address their ethical code and highlight the non-medical nature of the assistance they provide, trying to steer clear of competition with qualified medical professionals at the healthcare facilities (*professional agents of care*), who are, as of today, monopolists in the sphere and have legal and fiscal responsibility for obstetric care (*Kuksa* 2021; *Kuksa, Shnyrova* 2021).

At the same time, both prenatal and postpartum doula support of women is becoming more and more popular in the "folk sector" of health care (in this case, the quasi-traditional sector). In this environment, self-employed providers of perinatal care do not have to protect their status in the minimally regulated and, therefore, competitive markets of advisory, education, psychological and massage services demanded by families in the perinatal and postnatal periods. These care providers, who usually act as freelance workers, are often mothers with multiple children themselves, and act either as doulas or as individual midwives.

The history of grassroots doula movement (following the professionalization and legitimization of the individual midwifery project in Moscow), the authentic interpretations of "non-medical psychological, informational and physical support" during childbirth and the characteristics of the informal and precarious position of doulas as independent agents of perinatal care at healthcare facilities are unveiled upon in proper detail in the following research papers published in 2021 (*Kuksa* 2021; *Kuksa, Shnyrova* 2021).

The Harvard school focuses on the language of experience of suffering and sickness. Personal beliefs and stories of the patients are explored along with the popular and medical "explanatory models" to make the health care provided by professional agents of care more efficient (*Good* 1994; *Good et al.* 1994, 2010; *Kleinman* 1978, 1988, 1992, 1994, 2019).

Therefore, the ethnographic section of my research is primarily based on participant observation of discursive practices and on the analysis of personal narratives recorded during semi-structured in-depth interviews of women and independent perinatal specialists, mostly from Moscow and Moscow suburbs, but from other cities of Russia as well. Another source is the storytelling borrowed from themed message boards and groups on social networks, as well as from recordings of midwifery and doula conferences, lectures and training courses that took place both online and offline before and during the pandemic. I have also conducted a remote polling of specialists during the lockdown in the Spring/Summer of 2020.

These patient, midwife and doula narratives allow to examine obstetric hospitals and COVID-related restrictions from the engaged perspective of many participants and observants of the process of childbirth: mothers-to-be, their families and independent (for the purposes of our discussion) specialists. In-depth analysis of the content of the policies of health preservation and the logic of carrying out restrictive decisions by the authorities, as well as the deciphering of bureaucratic contexts from both the legal and the anthropological points of view, allows for relevant understanding of interaction practices and for thick description of the authentic terminology and interpretations characteristic of the medical, patient, midwifery and doula networks.

Extraordinarily resolutions of the authorities during the lockdown in the Spring/Summer of 2020

Among the many restrictive measures implemented by various Russian authorities in the start of the pandemic I will mostly concentrate on those carried out by the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (hereinafter referred to as Rospotrebnadzor) – the key government actor responsible for "making rules and standards", "monitoring health and hygiene", "conducting sanitary and epidemiological

control on the federal level" and the key decision maker concerning the "sanitary and epidemiological welfare of the population"[10].

The Rospotrebnadzor epidemic-prevention regulations during the spring / summer lockdown in 2020 were implemented via 14 regulatory (binding) resolutions signed by the Chief State Sanitary Officer of the Russian Federation A.Yu. Popova[11], along with 145 formally "non-binding" acts[12], relegated for implementation to both legal and natural persons along with branches and institutions of the Federal Service, state authorities and healthcare facilities[13].

The regulatory authority first and foremost increases the sanitary and epidemiological rules and regulations and tightens the pandemic-prevention restrictions related to sanitary

---

[10] The massive branched administrative infrastructure of the Rospotrebnadzor ensured "sanitary and epidemiological welfare of the population" and prevention of infectious diseases since the Soviet era. At the start of the pandemic, it counted: "84 territorial branches, 84 centers for hygiene and epidemiology in constituent territories of the RF, 29 research institutes, 12 Plague Control Stations, over 100 disinfection organizations. Overall, more than 110 thousands professionals are employed in various branches and offices of the service." (https://www.rospotrebnadzor.ru/region/about.php)

[11] The (regulatory) binding resolutions issued by the Chief State Sanitary Officer of Russian Federation: No. 2 "On measures aimed at prevention of the spread of the new 2019-nCOV-induced coronavirus infection" (January 24, 2020); No. 3 "On additional sanitary and epidemiological (preventative) measures aimed at prevention of import and spread of the new 2019-nCOV-induced coronavirus infection" (January 31, 2020); No. 5 "On additional measures of risk reduction concerning the import and spread of the new 2019-nCOV-induced coronavirus infection" (March 02, 2020); No. 6 "On additional measures of risk reduction concerning the spread of COVID-2019" (March 13, 2020; enacted all over the Russian Federation except Moscow); No. 7 "On isolation mode aimed at prevention of the spread of COVID-19" (March 18, 2020); No. 9 "On additional measures aimed at prevention of the spread of COVID-19" (March 30, 2020); No. 10 "On amendments being made to the resolution of the Chief State Sanitary Officer of Russian Federation No. 9 (March 30, 2020) 'On additional measures aimed at prevention of the spread of COVID-19'" (April 03, 2020); No. 11 "On amendments being made to the resolution of the Chief State Sanitary Officer of Russian Federation No. 9 (March 30, 2020) 'On additional measures aimed at prevention of the spread of COVID-19'" (April 13, 2020); No. 15 "On approval of sanitary and epidemiological regulations SR 3.1.3597-20 'Prevention of the new coronavirus infection (COVID-19'" (May 22, 2020); No. 8 "Sanitary and epidemiologic safety when transporting organized groups of children by train in Summer 2020 in the setting of persisting risks of contracting the COVID-19 infection" (June 05, 2020); No. 16 "On approval of sanitary and epidemiological regulations SR 3.1/2.4.3598-20 'Sanitary and epidemiological requirements concerning arrangement, scope and organization of work of educational facilities and other objects of social infrastructure intended for children and the young in the setting of the spread of the new coronavirus infection (COVID-19)'" (June 30, 2020); No. 18 "On amendments being made to the resolution of the Chief State Sanitary Officer of Russian Federation No. 7 (March 18, 2020) 'On isolation mode aimed at prevention of the spread of COVID-19'" (July 07, 2020).

[12] From January to July 2020 the central administrative office of the Rospotrebnadzor, backed by subordinate authorities, had issued up to 200 coronavirus-related documents alone. Of these, 14 regulations are binding and registered with the Ministry of Justice of the Russian Federation. Other 145 documents were drafted and issued as methodical guidelines (about 26 as of June 10, 2020), (simple) guidelines, memorandums, explanatory statements, restrictions and requirements implementation briefs. In fact, they were both non-binding and binding (at least for regulated legal persons and self-employed entrepreneurs). The documents warned against fraud and listed "recommendations" concerning disease prevention, disinfection, diagnostics, testing, face masks and PPE use, healthy eating in the setting of the spread of the coronavirus infection (2019-nCoV). These documents normally list specific addressees of non-binding requirements: parents, elderly people, buyers of food, medication, tobacco and alcohol, gadget users, consumers of other goods and services, as well as educational and healthcare facilities, specific business spheres (public transport, tourism and hospitality, the agricultural sector, catering and retail industries, cinemas, service trades, balnearies and saunas).

[13] The documented rulings and regulations were undoubtedly based on a decades-old traditional of total and unlimited implementation of Federal Law No. 52 and numerous excessive sanitary regulations (without actual emergency), as well on the established practice of interaction with regulated subjects (mostly legal persons). Nevertheless, since the start of the pandemic most of the Rospotrebnadzor documents hereby analyzed became mandatory not only for legal persons and subordinate facilities, but also for federal and local authorities, state-funded healthcare facilities and, eventually, even for natural persons.

and hygienic treatment, disinfection of premises and objects, disinfection of air in the entire territory of a facility. Mandatory use of personal protective equipment (hereinafter referred to as PPE), such as face masks and respirators, in medical facilities and public spaces is also introduced.

Yet from the point of view of independent midwives certified to perform delivery, these measures could not be implemented in full and were often observed formally. Western anthropologists of reproduction and motherhood also note the insufficient supply of PPE in Portuguese, U.S., Canadian and Irish hospitals to provide those to personal assistants and even to medical staff as required (*Barata et al.* 2020; *Castaneda, Searcy* 2020; *Declan et al.* 2020; *Rivera* 2020; *Rocca-Ihenacho, Alonso* 2020). According to my Moscow informants, the situation in Moscow hospitals was the same:

> ***Inf. 1***: On top of that, they don't provide you with personal protection equipment – they have to buy those themselves; each does what they can. It's like you arrive there, and there are no masks. And you have to change the mask every two hours. <...>
> ***T.K.***: There were no PPE in the obstetric hospital? The medics had to buy those?
> ***Inf. 1***: Well, they bought these respirators, the kind that goes into dry-air sterilizers. And what is left of that respirator afterwards? The valves, they don't work anymore after that. So why does anyone even wear those? No idea. It's all nonsense. It's like we're doing something – just to put on the show. "You see, all the staff are wearing this all." But it's not even any sort of PPE! Totally not.
> ***Inf. 2***: It's like the usual over here: they did it in the form but not in the content.
> ***Inf. 1***: Just signed the papers to be through with it.
> ***Inf. 2***: Totally meaningless (Informants 1 and 2 are individual midwives from Moscow, mothers of multiple children; May 31, 2020).

Initially, the Rospotrebnadzor could not cope with state record-keeping, monitoring and sanitary and quarantine control of people returning from overseas at the border checkpoints.[14] Because of that, the service had to improvise with the help of its local offices, subordinate organizations and medical providers, urging the citizens, among other things, to inform the authorities about their returns from overseas and transit routes (*Kuksa* 2020a).

After the WHO officially declared the pandemic on March 11, 2020[15], Russia didn't use the designed algorithms and administrative procedures of emergency decision-making as it is necessary under the legislation concerning the sanitary and epidemiological welfare of the population and under the sanitary guidelines. On top of that, the 2019-nCov infection has yet to be included in the list of the 26 diseases requiring the federal service to introduce "quarantine" and "public health measures" according to the Federal Law "On sanitary and epidemiological welfare of the population" (hereinafter referred to as Federal Law No. 52).[16] (In fact, Moscow City Government takes the lead here because of the COVID-19 crisis in

---

[14] At the start of the pandemic Rospotrebnadzor employees "execute sanitary and quarantine control in 285 checkpoints, including 102 route checkpoints, 67 airport checkpoints, 64 sea checkpoints, 13 river checkpoints, 39 railroad border checkpoints" (https://www.rospotrebnadzor.ru/region/about.php).

[15] See "WHO Director General's opening remarks at the media briefing on COVID-19, 11 March 2020": https://www.who.int/ru/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

[16] According to point 3 of article 31 of Federal Law No. 52, "the list of infectious diseases" and the procedure for executing "restrictive measures (quarantine)" are outlined in sanitary guidelines. With emergencies of this nature in mind, the "List of infectious (parasitic) diseases calling for implementation of public health measures on the territory of the Russian Federation" and sanitary and epidemiological regulations "Public health measures on the territory of the Russian Federation. SR 3.4.2318-08" were both adopted by the Chief State Sanitary Officer back in 2008. At the same time, before the pandemic was even declared, the Government of the Russian Federation updated another list of dangerous diseases – RF Government Decree No. 715 (December 01, 2004) [edition of January 31, 2020] "On adoption of the list of socially significant diseases and of the list of diseases constituting a danger to the public" (*Kuksa* 2020a).

the capital, enacting regulations that should have normally been suggested by the local Rospotrebnadzor office, which will be elaborated upon further.)

The specific Federal Law No. 52 and ministerial rulemaking are not consistent with the wording of the International Health Regulations adopted by the WHO in 2005[17]: the pre-COVID documents employ an extensive interpretation of both the competencies of the "responsible authorities" and the definition of "quarantine" (which means any restrictions, not differentiating according to the level of danger). From both the mandatory regulations and "non-binding" guidelines issued by the Rospotrebnadzor since the start of the pandemic, one may conclude that the federal service, in line with the traditional post-Soviet logic of total sanitary and epidemic regulation and control, *de facto* equates restrictive (quarantine) measures to sanitary epidemic-control (preventative) measures and does not distinguish between administrative modes of quarantine, observation, isolation and medical supervision. While making sanitary and epidemiological rules and regulations, the federal service overlooks both the excess financial burden that falls on legal and natural persons alike and the speed and effectiveness of distribution and spending of budget funds – especially during a pandemic. Nevertheless, the Rospotrebnadzor explicitly declares the introduced mode as "preventative", which (judging by the interviews) is interpreted as a "quarantine" at the local level, but with limited organizational and financial resources for its actual implementation.

> ***Inf. 1***: Now since COVID-19 started, they've taped up all the vents with plastic garbage bags. That's ridiculous! The plastic bags, they are a membrane. It's penetrable. Still, they taped everything up with them. And called it an Meltzer's individual box (it does not connect to the box next door). And the orderly is going to and from in the very same freaking uniform. But that's how it always is with us: here's the form, and here's the actual content made from mud and straw.
> ***Inf. 2***: We've made a whole bunch of journals and all the reports for the show. All is well, isn't it? Look, we've all got PPEs in the dry-air sterilizer even. So what? This PPE will be processing in the sterilizer for a month. And is it even effective? Ridiculous. That's why it is how it is... (Informants 1 and 2 are individual midwives from Moscow, mothers of multiple children; May 31, 2020).

The only independent witnesses to the functioning of Moscow maternity wards during the lockdowns were personal assistants, and their descriptions are vastly critical of excessively formalistic implementation of the tightened sanitary and hygienic restrictions, preferring bureaucratic records to the prejudice of safety. From the midwives' point of view, an expensive ventilation system with air-sanitation filters built-in during the construction of the maternity ward (like those in European hospitals or a private Moscow obstetric hospital) is the only effective means of fully preventing contagion.

The Rospotrebnadzor was commissioned by the Government of Russian Federation to account for and distribute expended supplies, as well as to perform testing for COVID-19, which was fulfilled by the federal service's own hygiene and epidemiology centers. Nevertheless, the resources for and effectiveness of COVID-19 testing were limited since the very start of the pandemic (*Kharitonova* 2020), hence problems with confirmation of the recently introduced diagnosis (B-34.2. according to the ICD-10) and, therefore, with choosing of appropriate tactics, be it temporary observation, (self)-isolation at home or hospitalization.

Therefore, judging from the decisions made, the Rospotrebnadzor was neither interested in nor capable of differentiating between sanitary legal modes in a real-life emergency during the pandemic – based on the level of threat with regard to certain mandatory regulations,

---

[17] "The International health Regulations of the WHO (2005)", revised five times, list six diseases as last revised.

their effectiveness, feasibility and costs, including monetized assessment of regulation effects.[18]

Nevertheless, the Rospotrebnadzor is unable to ensure compliance with sanitary and epidemic-control restrictions introduced, unless legal sanctions are selectively instituted against citizens, specifically through Moscow "social monitoring" system (tracking the infected and those who had been in contact with them through a smartphone app since April 10, 2020) (*Kuksa* 2020b).

In the early March 2020, before the federal service enforced a quarantine, the mayor of Moscow introduced new administrative regulation *ultra vires*[19]: the "high-alert mode" under the Federal Law "On protection of the population and the territories from natural and man-made emergencies" (hereinafter referred to as Federal Law No. 68) and the ultimate pinnacle of bureaucratic logic – the mandatory "self-isolation" of citizens at the expense of the citizens themselves and a ban on traveling within city borders. These Moscow regulatory novelties were extrapolated to other constituent territories of the Russian Federation by their regional authorities. The Moscow mayor's emergency powers were legalized[20] by the Federal Assembly of Russian Federation on April 01, 2020, along with new and reviewed corpora delicti[21] criminalizing the behavior that was previously considered normal as well as raising legal and natural persons' fines for incompliance with the new anti-COVID regulations (*Kuksa* 2020b).

Throughout the lockdown of the Spring/Summer 2020 that lasted almost until the voting day for the new Constitution in July, most of citizens, even those who neither exhibited any symptoms of the coronavirus infection nor were diagnosed with such, were required to minimize their traveling around their city and to self-isolate. These restrictions, supported by administrative fines, caused the first wave of negative reaction from human rights groups (*Kuksa* 2020a). Wearing of gloves and face masks, "social distancing" (of varying actual distance according to the regulatory authority: from 1 meter according to the Rospotrebnadzor to 1,5 meters as required by Moscow authorities), daily temperature measurements, regular testing for COVID-19[22] and mandatory vaccinations for certain professions (since Russian vaccines were registered and introduced to the population) are still required as of now.

It should be noted that as far as various forms of medical aid, including obstetrics, are concerned, the abovementioned epidemic-control regulations issued by the Rospotrebnadzor along with emergency measures implemented *ad hoc* by Moscow authorities have, in fact, paralyzed the implementation of some norms of the Federal Law "On the basics of health care" (hereinafter referred to as Federal Law No. 323) – namely, those that guarantee the

---

[18] Under the "regulatory guillotine" the Rospotrebnadzor regularly cancels mandatory sanitary and epidemiological regulations of business listed in obsolete documents such as SRs, SanRaNs and appendixes.

[19] Moscow City Government Decree No. 12-UM (March 05, 2020) "On introduction of high-alert mode" (as amended and supplemented).

[20] Federal Law No. 98 of April 01, 2020 "On amendments being made to some legislative acts of the Russian Federation concerning emergency prevention and recovery" (hereinafter referred to as Federal Law No. 98) expanded the scope of Federal Law No. 68 in one day and six articles. Moreover, Federal Law No. 98 establishes the Government's power to adopt mandatory rules and regulations over the behavior of citizens and organizations "under emergency and high-alert modes" (amendments to Art. 10 of Federal Law No. 68), as well as the power of constituent territories of the Russian Federation to adopt additional mandatory regulations provided their compliance with the regulations adopted by the Government (amendments to Art. 11 of Federal Law No. 68).

[21] Federal Law No. 99 of April 01, 2020 "On amendments being made to the Administrative Offences Code of the Russian Federation"; Federal Law No. 100 of April 01, 2020 "On amendments being made to the Criminal Code of the Russian Federation and to the Articles of 31 and 151 of the Russian Federation Code of Criminal Procedure".

[22] To cross the state border and to visit state-funded educational and healthcare facilities, negative tests for COVID-19 were required in certain cases. Due to their urgency, they had to be performed in private labs and were paid for.

free-of-charge provision of basic (pre-COVID) medical aid to healthy/asymptomatic and sick people under the basic program of obligatory medical insurance. Introduction of new regulations and modes has, in fact, cancelled the norms ensuring patient's choice, informed consent and (family) assistance. In some cases, informed refusals of medical intervention and visits to the patients in hospital wards and intensive care were effectively put on hold, and partner-accompanied births were unavailable for a long time.

At the same time, thanks to the regulatory policies of the Government of Russia, the Ministry of Health and the stimulating budgetary provisions (payoffs to medical professionals and compensating the costs of treating COVID-19 patients to healthcare facilities[23]), medical facilities were rapidly transforming to comply with new priorities: actual testing for COVID-19 ramped up, patient capacity of the "red zone" increased, a new system of routing and hospitalization of COVID-19 patients was developed as well as new and reviewed methodological guidelines and manuals for medics and medical superintendents.

Non-public and "avoidance" nature of resolutions made by local Rospotrebnadzor offices (as exemplified by "preventative mode" and "ban on hospital ward visitations" in Moscow)

On March 12, 2020, E.E. Andreeva, the Chief State Sanitary Officer of Moscow, issued an administrative ruling No. 1 "On additional sanitary and epidemiological (preventative) measures aimed at prevention of the spread of the new 2019-nCOV-induced coronavirus infection in the city of Moscow", addressed to medical superintendents regardless of the type of the facility, the head of Moscow Healthcare Department (hereinafter referred to as MHD), as well as other organizations and self-employed entrepreneurs.

On the one hand, the local office reiterated the regulations issued by the central administrative office of the Rospotrebnadzor, and made regulated subjects implement epidemic-control (preventative) measures on their premises and respective territories. At the same time, the ruling did not require Moscow authorities to enforce, either citywide or at individual medical facilities, any "restrictive measures" otherwise known as "quarantine". On the other hand, on March 05, 2020, Moscow City Government outran the Rospotrebnadzor's decision and did enforce similarly restrictive "high-alert mode" and "self-isolation". This too provoked negative reaction both from human rights activists and from lay people, not only in Moscow but in other regions as well (*Kirziuk* 2021; *Kuksa* 2020a; *Manichkin* 2021). And, last but not least, the only thing lacking was the legal and statistical fact that normally served as the basis for state sanitary officers to enforce a quarantine: the burden of disease exceeding a threshold of 15-20% of a territory's (premises) overall population, as prescribed by sanitary regulations for enforcement local quarantines, e.g., in schools or hospitals, in the case of certain diseases.

Among other things, the ruling No. 1 required to "revoke permission for patient visitation in hospital wards" from March 12, 2020, and until further notice.[24]

The Chief State Sanitary Officer of Moscow did not explicitly mention a "quarantine". Nevertheless, an order of Moscow Healthcare Department, issued on March 13, 2020[25], was

---

[23] The cost of treatment per one COVID-19 patient under the OMI is established according to a regional tariff. E.g., in Moscow it estimates 200-205 thousand roubles. (Federal Mandatory Health Insurance Fund, May 06, 2020: http://www.ffoms.gov.ru/news/monitoring-smi/skolko-stoit-lechenie-bolnogo-koronavirusom-v-rossii)

[24] Similar requirements concerning the ban on hospital ward visitations could be found in later letters (of March 26, 2020) from the central administrative office of the Rospotrebnadzor to federal bodies of executive power and their subordinate authorities. In those letters, the Chief State Sanitary Officer of the Russian Federation elaborated on how complex disinfection should have been performed.

[25] Moscow Healthcare Department Decree No. 201 of March 13, 2020 "On additional sanitary and epidemiological (preventative) measures aimed at prevention of import and spread of the new coronavirus infection caused by COVID-19" (p. 2.1.).

forwarded to "medical superintendents of state hospital wards of Moscow" with an instruction to "implement restrictions and cease visitations of patients in hospital wards". All medical facilities in the city regulated by this order were forced to comply with the "quarantine" instructions issued by the other service (not Rospotrebnadzor in accordance with Federal Law No. 52). Thus, in compliance with multiple normative legal documents[26], Moscow medical superintendents ensured implementation of both "restrictive" and "preventative" measures, including bans on hospital ward visitations.

Moscow maternity wards interpreted the bans by E.E. Andreeva and A.I. Khripun extensively, using those as a normative basis for putting partner-accompanied births and other family-oriented technologies (such as open maternity wards and children's intensive therapy wards) on hold. In 2019, A.S. Olenev, MHD's chief external expert in obstetrics and gynecology, medical superintendent for the perinatal center of MHD State Budgetary Healthcare Institution "City Clinical Hospital No. 24", Cand. Sci. in Medicine, was giving talks on various media platforms on how a loved one's presence during childbirth had positive effects[27]. But on March 21, 2020, Olenev confirmed that partner-accompanied births and hospital ward visitations in Moscow were now prohibited.[28]

It should be noted that while the ruling No. 1 was forwarded to medical facilities, it never appeared on the official website of the local Rospotrebnadzor branch. Moreover, there were no scans of these documents on the websites of most of the "addressees", therefore, an ordinary patient / seeker of medical aid could not understand what restrictive and/or preventative measures were being undertaken exactly.

Thus, these regulations did not have the publicity, unambiguity and legal sufficiency required by the law. Therefore, a wide range of concerned citizens (first and foremost, the patients, their relatives, legal representatives and visitors) had no access to the documents imposing limitations on their rights guaranteed by Federal Law No. 323 for quite some time. Pregnant women and personal assistants were first informing each other of the restrictions by word of mouth, and after a scan of the document was found on the website of a private obstetric hospital (this hospital offered both women in labor and their partners express PCR-testing for a price of 11 thousand roubles instead of a ban on visitations), they started sharing it online.

Scope change of specialized medical aid during childbirth and limitations on patient choice of women in labor during the COVID-19 pandemic

The earliest federal-level guidelines on specialized medical aid provided to pregnant women and women in labor appeared only in late April 2020. Despite that, a new system of routing and hospitalization for this category of patients was already underway in Moscow since March[29], a scheme of checking patients' contacts was being tried out, and outpatient observation was going online. (Use of telemedicine and online consultations in prenatal care was also noted in Portugal, Ireland, Italy and the U.S. [*Barata et al.* 2020; *Declan et al.* 2020; *Quagliariello, Grotti* 2020; *Rocca-Ihenacho, Alonso* 2020].)

The number of Moscow obstetric hospitals admitting non-infected pregnant women plummeted. Namely, obstetric hospital No. 8 (State Budgetary Healthcare Institution

[26] The documents adopted by the central administrative office of the Rospotrebnadzor since January 2020; the ruling adopted by the Chief State Sanitary Officer of Moscow No. 1 of March 12, 2020; the Moscow Healthcare Department Decree No. 201 of March 13, 2020.

[27] "Childbirth with a loved one makes the process of giving birth to a baby a deep joint experience for both parents. According to doctors, the presence of a partner increases the likelihood of a successful delivery." (https://navigator.mosgorzdrav.ru/columns/ ginekologiya/partnerskie_rody_v_moskve_ stolichnye_vrachi_vystupayut_za_soprovozhdenie_ rozhenitsy_blizkim_chelovek/).

[28] https://mosgorzdrav.ru/professional/covid-19; https://youtu.be/nayEqHM2JeE

[29] https://mosgorzdrav.ru/professional/covid-19; https://youtu.be/nayEqHM2JeE

"MHD V.P. Demikhov's City Clinical Hospital"), the maternity ward of the State Budgetary Healthcare Institution "MHD O.M. Filatov's City Clinical Hospital No. 15", obstetric hospital No. 36 (State Budgetary Healthcare Institution "MHD F.I. Inozemtsev's City Clinical Hospital" and the private clinic "Lapino" (company group "Mother and child") were repurposed as COVID clinics, according both to my informants and the media. Most of the facilities had worked in the "red zone" until mid-Summer / late Summer 2020. Women in labor of unknown COVID status are currently treated in the maternity ward of the State Budgetary Healthcare Institution "MHD O.M. Filatov's City Clinical Hospital No. 15", which stands at a distance from other hospital buildings. This clinic has delivered more than 800 children in a year since the start of the pandemic[30]. In January 2021, the private clinic "Lapino" opened a separate pavilion known as "Lapino-4", counting 100 hospital beds including 12 beds in the intensive care ward, where high-skilled paid medical aid is provided to patients with surgical pathology aggravated by the COVID-19 infection as well as to pregnant women and women in labor.[31]

Previously a pregnant woman could choose a maternity ward of her liking under her obligatory medical insurance free of charge, regardless of her abiding place (the so called "residence registration"). The costs were covered from budgetary insurance wrap on the basis of a childbirth certificate. But since the pandemic started, exterritorial choice of obstetric facility was available no more – first and foremost for COVID-positive patients or patients exhibiting symptoms of a cold or a respiratory infection. Thanks to the pre-COVID option of choosing the medical facility, popular gift kits for the newborns, "family-oriented" births covered by the obligatory medical insurance and paid programs with water or quasi-home births, Moscow became a destination for fertility/medical tourism, when women from other regions of Russia came to give birth in Moscow obstetric hospitals and perinatal centers.

Non-quarantine yet restrictive, non-public yet mandatory regulations introduced by Moscow Rospotrebnadzor on March 12, 2020, and MHD on March 13, 2020, effectively banning patient visitations in hospital wards, led to a total prohibition of family-oriented, or partner-accompanied, births from late March to mid-August 2020 in Moscow[32], while pre-COVID such births amounted for 30% of all deliveries (according to MHD's chief external expert in obstetrics and gynecology A.S. Olenev). At the same time, in late May 2020 Russia's Chief State Sanitary Officer A.Yu. Popova was already encouraging healthcare facilities returning to regular working mode to decide themselves, whether visitors should have been allowed into hospital wards.[33]

> So during that week when the prohibitions of everything started piling up, our chat looked like everyone was waiting for "death notices". And so, it went on like: "Oh, I came there, and they had been letting people in the day before, but now they weren't", "See, girls, I came here, they're letting visitors in and they said they would be in the upcoming days, so let's bring our women there!" "And us, we've terminated the contract there and signed a new one here, because in the 29th obstetric hospital they're definitely don't allow visitors, see, and they swear they won't for another month" (The informant is a doula from Moscow, a lawyer and a mother of three; March 31, 2020).

---

[30] https://www.mos.ru/news/item/87369073/?utm_source=search&utm_term=serp

[31] On the opening of the pavilion see more on the website of the company group "Mother and child": https://mamadeti.ru/news/covid

[32] See info on the MHD website from August 14, 2020: https://mosgorzdrav.ru/ru-RU/news/default/card/4507.html

[33] Methodical guidelines "MG 3.1/2.1.0186-20 Guidelines on implementation of preventative measures aimed at prevention of the spread of the new coronavirus infection (COVID-19) in the setting of healthcare facilities' specialized work recovery" adopted by the Chief State Sanitary Officer of Russian Federation on May 25, 2020.

Women were hurrying to find new doctors and obstetric hospitals allowing hospitalization in the company of family members and/or personal assistants. The interviewees mentioned that pregnant women were not allowed to bring their partners even to paid, contractual childbirths; only individual midwives officially employed on a part-time basis in maternity wards promoting "soft births" continued working. These midwives informed the women of the environment in the "COVID-free" obstetric hospitals and their capacity.

T.K.: What about contracts? What if it's a paid birth? If it's been paid for specifically to provide a midwife, a doula, what's to do then?
Inf.: Well, the officially employed midwives, they still sign up for contracts and provide care. If it's an individual midwife. You see, doulas are illegal. There's no such profession – a doula. There are no women officially employed as doulas in obstetric hospitals. If that was possible, there might have been no problems at all (The informant is a doula from Moscow suburbs, a psychologist and a mother of five; April 5, 2020).

Along with partner-accompanied births, doula support was *a priori* banned as well (which, as I have already mentioned, was previously executed within the "everyday sector" [quasi-family] of health care), as due to the ambiguous status of doulas in healthcare system they used to introduce themselves as the woman in labor's family members.

I was crying almost every single night during those first days when partner-accompanied births were getting botched up. The fact that I still had partner-accompanied births was the only reason I was not getting drunk on wine. So I went to the maternity wards that had not shut down partner-accompanied births yet. Generally speaking, I was not allowed to despair. But it all looked very sad. There was that feeling that the exits are getting closed one by one. I mean, first they shut off the 29th maternity ward (they don't really like visitors in there regardless). Then another, then yet another, the Family Planning and Reproduction Center on Sevastopolsky Ave. The 20th, the 24th, the 70th held out for quite a long time. Zelenograd went into lockdown pretty quickly. Then the 24 was closed – Anton Sergeevich could not take it. So there were the 20th and the 70th left, then only the 70th. And it's only some maternity wards in the suburbs of Moscow as of now, a few. And you know, it all went like "Ten little Soldier Boys went out to dine; One choked his little self and then there were nine". It felt really creepy (The informant is a doula from Moscow, a lawyer and a mother of three; March 31, 2020).

As has been noted above, the cancellation of family-oriented births did not effect individual midwives, but caused a negative reaction from them nevertheless. Achieving epidemiological safety through total and mandatory isolation of women and newborns from their families was typical of Russian birth delivery systems in the pre-COVID times as well, but, according to perinatal medical experts who visit European obstetric hospitals for learning exchange and advanced training on a regular basis, this approach falls below flagship Western standards and practices.

T.K..: So, the midwives are always let in. The doulas are always banned from entering. The husbands are the question. How do you think, in all fairness, is it right or wrong to let the husband in or not?
Inf. 2: Of course it's wrong, elsewhere in the world...
Inf. 1: If the woman's just parted with him. If this husband is taking this very woman back in three days. Then what's the point? If you're telling us that face masks are all so effective, if you've turned every ward into Meltzer's individual boxes, whom is he going to even make contact with? What are we afraid of?
T.K.: So is it all for no good reason?
Inf. 1: He's going to have the woman and the baby back with him in three days, and everything's going to be alright. But three days earlier – isn't it going to be alright then? So when he used to live together with them both, it was also no problem. I mean, it's a load of nonsense. Ridiculous as always! (Informants 1 and 2 are individual midwives from Moscow, mothers of multiple children; May 31, 2020).

As a result, by the end of March 2020, each and every obstetric hospital in Moscow, except the private clinical hospital belonging to the company group "Mother and child" on Sevastopolsky Ave, had banned partner-accompanied births with husbands, family members and doulas – invoking either the quarantine or the ban on hospital visitations. Some perinatal medical experts showed understanding concerning the restrictions and the isolation of the mothers-to-be from their families:

> ***Inf.***: Accompaniment is not allowed. It's a quarantine restriction. And they are not allowed in each and every maternity ward in Moscow. <...>
> ***T.K.***: The fathers are banned from accompaniment as well, aren't they?
> ***Inf.***: Yes. Everyone's banned. Partner-accompanied births in general are banned. You see, it's a quarantine restriction. This is an emergency. I mean, we should understand that it's not happening because the doctors have decided that they don't want partners assisting in childbirth anymore. It's happening because we need to prevent the contagion. Yes, I can understand that it's problematic. Nevertheless, it's the sanitary officer, the Chief Sanitary Officer who'd issued this ruling. All obstetric hospitals are in lockdown until further notice. Actually, that's pretty normal. It's just like the seasonal flu quarantine, yeah, where every maternity ward decides for themselves. <...>
> ***T.K.***: So, you think this is justified, legitimate and reasonable?
> ***Inf.***: Look, I know about the experience of the doulas who're currently working in the other countries. The restrictions are everywhere, just everywhere. Take Israel, for example; you used to be able to take however many people you pleased to a childbirth: the husband was allowed to be present there, a doula, one's mother, one's father, aunties, uncles, sisters – whoever you please. They used to gather in crowds there... And now they've got the restriction – one person max. So now women have to choose, whether it will be the husband or the doula, for example. This is what my Israeli colleagues are telling me. Some hospitals have banned that whatsoever. That's basically about the women who are admitted when exhibiting symptoms of a respiratory infection. But I think, I believe, it's normal and it's perfectly understandable, why it's happening. And still, some restrictions were imposed right away. Our New York City colleagues are telling us... Well, you do know the story, don't you?
> ***T.K.***: I've read about it.
> ***Inf.***: That women basically fought for it. And that was why they were allowed it. Unfortunately, the woman over here is very passive. And I think it's very difficult to incite a mass initiative like that. I don't think it is impossible, but it calls for a real movement. We've also got that thing, like, if you're told no, then it's a no. And another one: "People used to give birth without assistance all the time, well, I'll manage as well somehow". So, the women are the authors of their own... (The informant is a doula from the suburbs of Moscow, a psychologist, a doctor and a mother of five; April 05, 2020).

Juristically competent doulas were very vocal in their belief that the legal norms established by Federal Law No. 323 could not be reversed under ministerial documents that have been issued by the key regulatory authorities since the start of the pandemic:

> This regulation does not have a word in it about partner-accompanied births, it only goes on about hospital ward visitations. Visitations are not guaranteed by law. And partner-accompanied births, at least when the father, a family member is present, are guaranteed by law. And thanks to that, we used to manage, dead or alive, to make it into maternity wards till the very end – the dads used the declaration I drafted for them. I was getting inside myself, the last time I was to a maternity hospital was on March 27 – in the 70th hospital, in Novogireevo. But now Moscow is done with that for good. They said: "Enough is enough, we're afraid, so we're not going to let anybody in, except for maybe the most insistent of the dads." So, partner-accompanied births are only possible in the suburbs as of now. Just recently, I very much hope that... Won't they put Moscow on total lockdown? They shouldn't, actually – they have no legal basis for that... I hope to travel with my girl there, she's got a broken back, and this is her first pregnancy, she does not need any epidural, she needs natural methods of care. We are very much hoping for a possibility to have

a "partner-accompanied birth" in the end (The informant is a doula from Moscow, a lawyer and a mother of three; March 31, 2020).

The doula community expressed almost unanimous surprise over the fact that, despite "quarantine" restrictions and bans on hospital ward visitations, the private clinical hospital on Sevastopolsky Ave continued with paid partner-accompanied VIP-births. "Doulawyers" and medical lawyers used to write to the public prosecution offices of Moscow and Moscow suburbs for a clarification concerning the legal basis for the ban on partner-accompanied births and for the limitations of patient rights guaranteed by Federal Law No. 323 (without any declaration of an emergency, which was the only mode under which, in their opinion, such restrictions would have been legally justified).

Maria and I <...> submitted filings both to the Rospotrebnadzor and to the public prosecution office. They sent us a pat answer that the response was to be expected within a month. That was on March 18 and 19, when maternity wards started banning partners en masse. And some of my women filed complaints. But some decided to roll with it... (The informant is a doula from Moscow, a lawyer and a mother of three; March 31, 2020).

Anthropologists of childbirth have noted active protests from Portuguese, Irish and English midwives and doulas concerning restrictions on individual assistance in childbirth (namely, the cancellation of partner-accompanied births and lockdowns in obstetric centers). Sometimes petitions, complaints and talks between these professional communities and regulatory authorities brought forth positive changes (*Barata et al.* 2020; *Declan et al.* 2020; *Rocca-Ihenacho, Alonso* 2020; *Yuill et al.* 2020).

During the first year of the pandemic some women in Russia risked home births, with assistance of a midwife and a doula (remaining within the "family sector" of health care):

Inf.: Well, we've just had the quarantine. I had, I can't remember exactly now, really, I had two or three births in March. Let us say March, yeah. And none in April. I had two home births in May. And none in July <...>
T.K.: Two home births. What does it mean? Did they have to give birth at their own home?
Inf.: They did not have to. They wanted to have a home birth. A visiting midwife and me were there. A home birth with a visiting midwife.
T.K.: So these women decided to not risk it on principle. What was their motivation? It was May, wasn't it?
Inf.: It was May. Some wanted to have a home birth from the very start. And the others were thinking over it, they had doubts. And they'd had their first childbirth at a maternity ward. And so, because the epidemiological situation did not look very good, they did not want to be isolated from the baby and so on. So, they risked a home birth (The informant is a doula from Saint Petersburg, an economist and a mother of one; August 17, 2020).

The midwife-led continuity model is officially recognized in Portugal, Ireland, England, Canada and in some of the states of the U.S.A. Therefore, pre-COVID, midwife-led continuity care was provided to "low-risk women" along with individual assistance from private maternity/"community centers" (sometimes even during home births). But these services were not very popular because the costs of them are not covered by the state. Yet with the pandemic the situation changed: some of these centers and midwives found themselves overwhelmed with the demand from new customers afraid of hospitals and of the risks of contracting COVID-19 in childbirth (*Barata et al.* 2020), while others were shut down by the regulatory authorities (*Declan et al.* 2020; *Rocca-Ihenacho, Alonso* 2020; *Yuill et al.* 2020). On the contrary, in New Zealand and the Netherlands, unlike the majority of Western countries, small pop-up birth centers received support from the state to limit the risks of cross colonization of medics and patients and to alleviate the burden the pandemic had put on hospital staff (*Rocca-Ihenacho, Alonso* 2020; *Yuill et al.* 2020).

38 doulas from the Russian Association of Professional Doulas (uniting Russian-speaking professionals worldwide) organized a free-of-charge online space to help the pregnant women and mothers of Russia. On top of that, while being out of institutionalized work, Russian and North American doulas took up free-of-charge online birth and motherhood support (*Castaneda, Searcy* 2020; *Rivera* 2020).

T.K..: Look, do I get it right that you haven't been practicing during the whole lockdown and while the 8th was closed as well, because it was "red-zoned", as far as I remember, right? And it only opened in August or in September or something. Right?
Inf.: I had online births; I've discovered that thing for myself. You know, there was that joke: "Well, everything's gone online – people are hooking up online, having sex online... Now we only have to start giving birth online." Well, it's not a joke for me anymore. I have accompanied births online several times during this pandemic already. I wasn't traveling there in person, yeah.
T.K.: So, you've discovered the online in the Summer, right? Or was it in the Spring already?
Inf.: It was Spring. Yes, in the Spring, right when it started, I already had some contracts that I could not attend in person. So, I accompanied them online. Of course, there are peculiarities. It is obviously not the same. But a women could use and appreciate this type of support as well.
T.K..: But what about tactility?
Inf.: Yes, sure. No tactility here, of course. But I've said before and I'll say it again, the vibe was rather more important to women. You know, some calm, supportive wave, when someone's talking to the woman, with some, we were meditating, relaxing. She had very stressful childbirth in Malta. When she was giving birth, she went into early labor. I was accompanying the girls, one of them gave birth in America. I mean, I'd never find myself in such a situation, where people are in other countries than me and all that. But it turned out it's okay, I mean, this can be a valuable experience of support as well. Maybe it has a future too, as an option, why not? (The informant is a doula from Moscow, a psychologist and a mother of three; June 21, 2021).

All in all, during the period when partner-accompanied births were put on hold in smaller Russian towns, the women shifted to prenatal and postnatal support online and offline as well – within the quasi-traditional sector of health care.

T.K.: What did the doulas of your town do for a living since the COVID pandemic started?
Inf.: Nothing. They worked their other jobs: as nutritionists, breast-feeding counsellors, swaddlers. I worked as a swaddler and a breast-feeding counsellor too, I also held prenatal meetings with women (The informant is a doula from Russia's Far East, a translator and a mother of three; July 17, 2021).

Since the pandemic started, the Ministry of Health of Russian Federation has issued four versions of Methodical guidelines on "Organization of providing medical aid to pregnant women, women in labor, puerperants and infants in case of the new COVID-19 coronavirus infection" (issued on April 24, 2020, May 28, 2020, February 25, 2021, and July 05, 2021, respectively). These guidelines are addressed to hospital staff – they are required to perform additional testing of pregnant women and to correctly route and separate the "COVID-negative" patients and those with "COVID status unknown". One of the versions of guidelines prescribes COVID-positive patients to wear face masks during labor and mandatory ("forced", as doulas put it) separation of mothers from children in case the coronavirus infection is suspected[34]. The latter is what causes the most tension with the mothers and perinatal professionals who hold up the concept of the "golden hour" and

[34] § 6 (on rooming-in of mothers and newborn children) и § 8.2. (on providing medical aid to newborn children) of Methodical guidelines of July 05, 2021 "Organization of providing medical aid to pregnant women, women in labor, puerperants and infants in the setting of the new coronavirus infection COVID-19".

imprinting (especially when medical professionals resort to adjudicative mechanisms of protection over the newborn's life and welfare when disputes arise with the parents).

> There is a vast amount of evidence that staying in contact with the mother and breast-feeding is beneficial for the child in case of a diagnosed coronavirus infection, nevertheless even mere suspicion of the coronavirus infection is enough to separate the mother from the child in Russian maternity wards. Sadly, this practice can lead to cessation of breast-feeding, interruption of parent-child bonding, health and emotional risks both for the mother and the newborn. The WHO recommends maintaining the contact with the child and breast-feeding (Maria Molodtsova – a doula and a lawyer).[35]

In real practice in Russia, the requirements for the tests undergone by women in labor, their individual assistants and partners (after they were readmitted to Moscow healthcare facilities on August 14, 2020) are very volatile – both regarding the tests for COVID themselves, their frequency and the period of their validity. The requirement imposed by Federal Law No. 323 concerning mandatory infectious disease clearance for the father of the child is met on the basis of a set of samples taken, which, in turn, can vary from town to town and from hospital to hospital.

> – Could you please elaborate on partner-accompanied births?
> – I can repeat yet again, partner-accompanied births, either under the OMI or under the VMI, it does not matter, they are allowed. Who is the partner in this birth? It's the husband or a close relative. I'm saying that again, a close relative is a mother or a sister. But of course, I find myself at a loss when I'm told: "I want my brother to be there when I'm giving birth." You know, to be frank with you, we don't really embrace that. We feel a little weird when you require it. So, it's a mother or a sister. Or your husband, your boyfriend, whoever he is to you, your partner, whomever you choose – that's up to you. Whoever is the closest to you during childbirth, you're welcome to bring that person. But he must undergo a medical assessment. What exactly does that assessment include? <...> Okay, so starting with the tests: RW/syphilis, HIV/AIDS, hepatitis, fluorography, and if you've undergone CT in the last 6 months, please bring that as well. A test for measles antibodies – if you have no negative antibodies then you haven't had measles and you're not vaccinated, so you'll need to get vaccinated against measles. And the key test we're having here nowadays is the PCR swab for COVID. It's valid for a week. So, if you've had COVID, if you've got the antibodies, it does not necessarily mean that you're not contagious, only the PCR swab can show that. That's why I don't know which information you're getting exactly. So, only the PCR swab – a negative PCR swab good for a week. And then you're very welcome, we'll be happy to see you in our maternity ward. You don't have to sign the card. You just arrive here with your partner. The partner must change into cotton clothes (An obstetrician-gynecologist, deputy chief physician; "Open House Day" in a Moscow obstetric hospital, March 11, 2021).

According to the latest version of the federal guidelines from July 05, 2021, "partner-accompanied births must be prohibited in case of possible/confirmed COVID-19 infection to ensure contagion risk reduction", and if the woman in labor is COVID-negative, partner-accompanied birth is possible in case the partner "provides a PCR test confirming COVID-negative status, taken not earlier than 48 hours before the estimated date of birth" (point 5.4.). It is also recommended to "keep the balance between social distancing measures and the necessity of social and emotional support".

As has already been mentioned above, there were limitations on or terminations whatsoever of partner-accompanied births, doula-provided support and the functioning of midwifery maternity centers in the Western countries (namely, in Portugal, in the U.S., in Canada, Ireland, Italy and England) during the first months of the pandemic. These restrictions were imposed either by governments or by local authorities and/or hospitals

[35] https://new-degree.ru/articles/separation

themselves. But as time went, the women and perinatal professionals were reclaiming their right for support during childbirth provided either by an individual midwife in a midwifery center (like in Ireland) or by their partner (provided they proved COVID-negative), as recommended by the WHO guidelines issued in September[36]. The regulatory authorities take the opinion of the WHO into account as well and make some concession to women, either allowing one person to accompany a woman during childbirth (a husband or a doula), like in Canada or in some states of the U.S. (*Castaneda, Searcy* 2020; *Rivera* 2020; *Rocca-Ihenacho, Alonso* 2020), or allowing support during a single stage of the birthing process (during childbirth or immediately after childbirth), like in Portugal (*Barata et al.* 2020). At the same time, it has been noted that both Western hospitals and Russian maternity wards tend to implement a stricter internal policy regardless of the COVID status of the participants in a childbirth: excessive medicalization of childbirth to speed up the process; limitations on accompaniment to keep the medics safer; separation of the mother from the newborn to ensure the safety of the latter (*Barata et al.* 2020; *Castaneda, Searcy* 2020; *Declan et al.* 2020; *Quagliariello, Grotti* 2020; *Rivera* 2020; *Rocca-Ihenacho, Alonso* 2020; *Yuill et al.* 2020).

* * *

In the Spring/Summer 2020, epidemic-control rules and regulations issued by the Rospotrebnadzor and emergency regulations imposed by Moscow authorities put everyday communing and workload of the citizens on hold. Nevertheless, some of the measures introduced back then and the sanctions for non-compliance with them (fines) are still valid, ensuring the medicalization of everyday life for an indefinite period of time (*Kuksa* 2020a, 2020b, 2021).

The decisions made by the Rospotrebnadzor in the beginning of the pandemic demonstrate adherence to the post-Soviet logic of unlimited sanitary and epidemiological rulemaking and control that led to the nondistinction by the sanitary authority between sanitary legal modes during an actual emergency. The blurring of the line between the total ("quarantine") and partial ("preventative") epidemic-control modes, the legal foundations for their respective introductions, altogether with the excessiveness of both the regulatory and non-binding documents drafted by the federal service and the ambiguity of the wording used for limitations on everyday life and activities of both natural and legal persons led either to voluntary or formal compliance with these restrictions both in medical and popular practice, and thus the regulations proved not so effective and productive.

Emergency rulings by the key regulatory authorities and introduction of new requirements and modes have repealed some of the norms listed by Federal Law No. 323, those ensuring patient choice and family support, in all but name, while, at the same time, limiting the rights of non-infected/asymptomatic patients within the basic program of obligatory medical insurance in the name of the new priorities.

Moscow obstetric hospitals received controversial directives concerning implementation of both "preventative" and "quarantine" measures from the local Rospotrebnadzor and MHD, and, as a result, interpreted the ban on hospital ward visitations extensively, temporarily putting partner-accompanied births and other family-oriented practices (like open maternity wards and children's intensive care) on hold.

The rulings of the local Rospotrebnadzor offices and MHD were not sufficiently public, unambiguous and legally justified as required by the law. Therefore, a wide circle of concerned parties (first and foremost, the patients, their family members, legal representatives and visitors) were unable to familiarize themselves with the content of the

[36] See guidelines of September 02, 2020, on the WHO website: https://www.who.int/ru/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/coronavirus-disease-covid-19-pregnancy-and-childbirth

documents that, since the start of the pandemic, limited their rights guaranteed by Federal Law No. 323.

Since the very first days of the pandemic, the freedom of choice of an obstetric care facility – the principle ensuring actual competition between maternity wards and doctors – was restricted in larger Russian cities due to repurposing of maternity wards into "red zones" as well as because of changes in routing and hospitalization of women who proved COVID-positive or whose COVID status was "unknown". The guidelines issued by the key regulatory authorities required healthcare facilities to act upon a presumption that pregnant women, women in labor, mothers, infants and others taking care of them had COVID-19, "until proven otherwise". Since the regulatory situation is off standard due to the multitude of potential infection sources, both sides of the legal relations – the subjects providing and receiving medical aid respectively – turn into objects of medicalization, budgeting from the Ministry of Health and sanitary and epidemiological control from the Rospotrebnadzor.

On the premises of state-owned obstetric facilities, the family support practices such as partner-accompanied births, parents' stay in children's intensive care and doula-provided support are temporarily put on hold. Instead of the rooming-in and the direct skin-on-skin contact between the mother and the newborn, as recommended by the WHO to support breast-feeding (especially during the first "golden hour"), maternity patients are forced to observe social distancing and even self-isolation from their newborn children. Pregnant women, women in labor and their loved ones, who, pre-COVID, used to hold legally guaranteed statuses of patients, partners, legal representatives or visitors respectively, became "coronavirus threat sources" while on the premises of healthcare facilities, first and foremost for the doctors and for their own babies – despite returning to their family homes after their hospital discharge.

Stripping the subjects involved in childbirth of their usual pre-COVID agency does not though remove the support they receive from the "family" and (quasi)"traditional" sectors of health care (*Kleinman* 1978) beyond state-funded facilities. Perinatal asisstants and practices of continuing life itself help overcome the conspiracy and eschatological discourses of both lay people and the academic establishment along with the fears of ascetism and of "canceling thy neighbor", of return to "bare life", of supreme domain of the biopower and loss of peuperal and funeral rituals (*Bakhmatova* 2020; *Kirziuk* 2021; *Manichkin* 2021; *Agamben* 1998). Temporary terminations of partner- and doula-accompanied birth, limitations on the rooming-in and other non-medical and family forms of care in state-funded obstetrics transfer these interactions into the spaces invisible to and unregulated by the state, that are organized by experienced mothers of many children for the purpose of accompaniment during home births, online support in maternity hospitals, (un)paid prenatal and postnatal counseling and rehabilitation.

References

Agamben, D. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Redwood City: Stanford University Press, 1998.

Bakhmatova, M.N. 2020. Khronika koronavirusa v Italii: "mazuny" dvadtsat' pervogo veka [The Chronicle of Coronavirus in Italy: The Anointers of the 21st Century]. *Meditsinskaia antropologiia i bioetika* 1 (19): 28–48. http://doi.org/10.33876/2224-9680/2020-1-19/02

Barata, C., D.M. Neves, and M. Santos. 2020. COVID-19 Containment Measures, Perinatal Experiences, and the Fight for Childbirth Rights in Portugal. *Medical Anthropology Quarterly Rapid Response Blog Series*. 11.08.2020. https://medanthroquarterly.org/rapid-response/2020/08/covid-19-containment-measures-perinatal-experiences-and-the-fight-for

Barkun, M. 2015. Conspiracy Theories as Stigmatized Knowledge. *Diogenes* 62 (3–4): 114–120. https://doi.org/10.1177/0392192116669288

Castaneda, A.N., and J.J. Searcy. 2020. COVID-19 and the Birth of the Virtual Doula. *Medical Anthropology Quarterly Rapid Response Blog Series*. 19.06.2020. https://medanthroquarterly.org/rapid-response/2020/06/covid-19-and-the-birth-of-the-virtual-doula

Declan, D., J. Webster, J. Murphy-Lawless, and P. Hughes. 2020. COVID-19: Challenging Ireland to Move from Mastership to Midwifeship. *Medical Anthropology Quarterly Rapid Response Blog Series*. 11.08.2020. https://medanthroquarterly.org/rapid-response/2020/08/covid-19-challenging-ireland-to-move-from-mastership-to-midwifeship

Eisenberg, L. 1977. Disease and Illness: Distinctions between Professional and Popular Ideas of Sickness. *Culture, Medicine, and Psychiatry* 1 (1): 9–23.

Good, B.J. 1994. *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.

Good, M.D., P. Brodwin, B.J. Good, and A. Kleinman. 1994. *Pain as Human Experience: An Anthropological Perspective*. Berkeley: University of California Press.

Good, B.J., M. Fischer, S. Willen, and M. Good. 2010. *A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities*. New Jersey: Wiley-Blackwell.

Kharitonova, V.I. 2020. Pandemiia COVID-19: idei patsientoorientirovannosti vracha i motivatsii patsienta (po materialam internet-istochnikov) [The COVID-19 Pandemic: Some Thoughts on Patient-Oriented Healthcare and Patient Motivation (According to Online Sources)]. *Sibirskie istoricheskie issledovaniia* 4: 217–239.

Kirziuk, A.A. 2021. "U menia net strakha": kovid-dissidenty v poiskakh agentnosti i pravdy ["I Have No Fear": COVID Deniers in Search of Agency and Truth]. *Monitoring obshchestvennogo mneniia: ekonomicheskie i sotsial'nye peremeny* 2: 484–509. https://doi.org/10.14515/monitoring.2021.2.1776

Kleinman, A. 1978. Concepts and a Model for the Comparison of Medical Systems as Cultural Systems. *Social Science and Medicine* 12 (1): 85–93.

Kleinman, A. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kleinman, A. 1992. Everything That Really Matters: Social Suffering, Subjectivity, and the Remaking of Human Experience in a Disordering World. *Harvard Theological Review* 90 (3): 315–316.

Kleinman, A. 1994. Pain and Resistance: The Delegitimation and Relegitimation ol Local Worlds. In *Pain as Human Experience: An Anthropological Perspective*, edited by M.D. Good, P. Brodwin, B.J. Good, and A. Kleinman, 169–197. Berkeley: University of California Press.

Kleinman, A. 2019. *The Soul of Care: The Moral Education of a Husband and a Doctor*. New York: Viking.

Kuksa, T.L. 2020. Biopoliticheskie resheniia i pravozashchitnyi aktivizm v period rasprostraneniia COVID-2019 v Rossii: ogranicheniia sub'ektnosti i novye granitsy vzaimozavisimosti [Biopolitical Decisions and Human Rights Activism during the Spread of COVID-19 in Russia: Subjectivity Limitations and New Limits of Interdependency]. *Meditsinskaia antropologiia i bioetika* 1 (19): 67–99. http://doi.org/10.33876/2224-9680/2020-1-19/04

Kuksa, T.L. 2020. Chrezvychainoe gosudarstvennoe regulirovanie rasprostraneniia COVID-19 v Rossii: biurokraticheskaia logika priniatiia reshenii i medikalizatsiia povsednevnosti v nachale pandemii [Emergency State Regulation to Prevent the Spread of COVID-19 in Russia: Bureaucratic Logic of Decision-Making and Medicalization of Everyday Life at the Beginning of the Pandemic]. *Zhurnal sotsiologii i sotsial'noi antropologii* 23 (4): 183–203. https://doi.org/10.31119/jssa.2020.23.4.7

Kuksa, T.L. 2021. Doul'skoe soprovozhdenie rodov: genezis, diskursy i praktiki emotsional'noi i fizicheskoi nemeditsinskoi zaboty [Doula Support during Childbirth: Genesis, Discourses, and Practices of Emotional and Physical Non-Medical Care]. *Monitoring obshchestvennogo mneniia: ekonomicheskie i sotsial'nye peremeny* 3 (163): 226–249. https://doi.org/10.14515/monitoring.2021.3.1902

Kuksa, T.L., and S.V. Shnyrova. 2021. Vzgliad douly na prizvanie i professiiu: prebyvat' s zhenshhinoi v tochke boli [A Doula's Perspective on Her Vocation and Profession: Being with the Woman at the Point of Pain]. *Medicinskaia antropologiia i bioetika* 1 (21). https://doi.org/10.33876/2224-9680/2021-1-21/16

Manichkin, N.A. 2021. Biopoliticheskie aspekty pandemii COVID-19: obshchestvennaia diskussiia o svobode i transformatsiiakh sotsial'noi zhizni [Biopolitical Aspects of the COVID-19 Pandemic: Public Discussion about Freedom and Transformation of Social Life]. *Sibirskie istoricheskie issledovaniia* 2: 141–161.

Melley, T. 2000. *Empire of Conspiracy: The Culture of Paranoia in Postwar America*. Ithaca: Cornell University Press. https://doi.org/10.7591/9781501713019

Melley, T. 2008. Brainwashed! Conspiracy Theory and Ideology in the Postwar United States. *New German Critique* 35 (1): 145–164. https://doi.org/10.1215/0094033X-2007-023

Mikhel, D.V. 2017. Bolezn', biomeditsina i stradanie v fokuse meditsinskoi antropologii: analiz idei Artura Kleinmana [Sickness, Biomedicine and Suffering in the Focus of Medical Anthropology: An Analysis of Arthur Kleinman's Ideas]. *Tsivilizatsiia – obshchestvo – chelovek* 4–5: 49–60.

Quagliariello, C., and V. Grotti. 2020. Birthing Alone: Pregnancy and Maternity Care in the Shadow of COVID-19 in Italy. *Medical Anthropology Quarterly Rapid Response Blog Series*. 19.07.2020. https://medanthroquarterly.org/rapid-response/2020/06/birthing-alone-pregnancy-and-maternity-care-in-the-shadow-of

Rivera, M. 2020. New York's Virtual Black Birth Workers: A Birth Justice Response to COVID-19. *Medical Anthropology Quarterly Rapid Response Blog Series*. 11.08.2020. https://medanthroquarterly.org/rapid-response/2020/08/new-yorks-virtual-black-birth-workers-a-birth-justice-response

Rocca-Ihenacho, L, and C. Alonso. 2020. Where do Women Birth during a Pandemic? Changing Perspectives on Safe Motherhood during the COVID-19 Pandemic. *Journal of Global Health Science* 2 (1). https://doi.org/10.35500/jghs.2020.2.e4

Varley, E., and A.E. Strong. 2020. COVID-19 and SRH/MNH: A Curated Online Collection for Medical Anthropology Quarterly. *Medical Anthropology Quarterly Rapid Response Blog Series*. 12.08.2020.https://medanthroquarterly.org/rapid-response/2020/08/covid-19-and-srh-mnh-a-curated-online-collection-for

Yuill, C., C. McCourt, and L. Rocca-Ihenacho. 2020. "Pop-up" Birth Centers? Considering COVID-19 Responses and Place of Birth in England. *Medical Anthropology Quarterly Rapid Response Blog Series*. 19.06.2020. https://medanthroquarterly.org/rapid-response/2020/06/pop-up-birth-centers-considering-covid-19-responses-and-place