CHAPTER 14

Navigating Late USSR Family Planning

Scattered Narratives from Demography and Medicine

Nataliya Shok and Nadezhda Beliakova

The history of Soviet family planning policy is a complex subject involving several important agents, including demographers, physicians, women, and the state. The perspective of each has its own scope that pertains to a particular focus in historical research—women's history, medical history, economic and sociopolitical histories. Navigating around these complexities requires interdisciplinary methodology.

This chapter focuses on the expert communities of Soviet demographers and doctors, drawing lessons not only from demographic discussions but also from debates in the medical community and in healthcare policy. This includes the introduction and analysis of the trends in Soviet family planning policy and practice mirrored in the historiography. It was called "sanitary and demographic statistics," "social-hygienic aspects of reproduction of the family size regulation," medical demography and family planning in the late 1980s. This complex approach based on the idea of socialized medicine and the model of centralized state-funded and guaranteed health care allowed Soviets to use the medical data in planning and implementing policies in healthcare, demographic and family planning. The chapter authors offer a novel approach to study them together with this combination of concerns about the Soviet population, reproductive policies, and demographics because the history of Soviet social medicine is deeply underdeveloped.

The existence of interconnectedness between Soviet demography and social medicine (social hygiene based on medical statistics, which was known as the discipline "healthcare management") methodologies also aided in the investigation of the role of female agency and leadership of women gynecologists in discussions on family planning with the focus of women's reproductive health and reproductive behavior. This chapter deals with and unites analytically the previously undescribed interdisciplinary historiography and partially classified high-level discussions in the Ministry of Health of the USSR.

History of Medicine, Demographics, and Soviet Family Planning

Over the course of Soviet history, healthcare professionals were in a difficult position, balancing between professional duties and ethics, while being state employees responsible for the implementation of state healthcare policies and providing medical services to the population within the limited state budget capacities. The medical history of the USSR is fragmented. On the one hand, historians talk about public medical discourse reflected in the media in an all-Union journal *Zdorov'e* (Health).[1] On the other hand, the internal agenda of the healthcare system in the USSR is underdeveloped in the intellectual and political histories. The Soviet tradition of the history of medicine was created and is still maintained by physicians. This fact underpins the limited focus of available sources and the complexities of their narratives regarding the social implication of medicine and healthcare policies. The social history of medicine is only just becoming a part of a broader policy debate in historical research on the Soviet Union[2] and socialist Eastern Europe.[3] The scope of this debate often touches on abortion, but does not address the broader, rather heterogeneous professional medical narrative on demographics and family planning Soviet policies, which requires deeper understanding of the specifics of medical historiography, knowledge of medical terminology and of the formal and informal structures of medical community, as well as an understanding of the methodology of the history of medicine.

Our focus on expert knowledge helped us collect the scant and simultaneously closely guarded evidence from archival documents of the Ministry of Health of the USSR from the State Archive of the Russian Federation: documentation from the Medical Collegium of the USSR

Ministry of Health[4] and the Scientific Medical Council of the USSR Ministry of Health[5] as well as transcripts of meetings of the ministers of health of the Soviet Union republics, including those marked "for official use only (DSP)." This allowed us to track the dynamics of the highest-level professional discussions in the Soviet medical community. This previously unknown healthcare data shows the medical side of population and family planning practices and policies in the USSR. The analysis gives voice to the medical community and places the social history of medicine, and female doctors, into the context of broader historical narratives on reproduction and demographic policies.

The Soviet medical community saw the following professional duties as a part of state demographic policy: clinical medicine issues (gynecological diseases and related reproductive health issues, anesthesia in obstetrics and pediatrics, etc.), social medicine and medical statistics (social hygiene and medical demography) within the scope of preventive socialist medicine (abortion data, maternal and child mortality, etc.) and public health issues (healthcare infrastructure, health economics, medical education and professional training, the pharmaceutical industry), and medical scientific and technological capacities. Underemphasizing the medical side of demographics may lead to an incorrect and misleading conclusion on the history of Soviet family planning.

While demographers focused on household economics and social policies related to childcare and female labor conditions, the logic of the USSR medical system balanced ensuring the health of the population (and special groups: children and women) with subordinating the structural and economic development of that system to state planning. The catastrophic underfunding and regional inequalities of population and health policies can only be historically investigated through relevant expert discussions of demographers and doctors about the complexities, inconsistency, and volatility of Soviet family planning policies across regions and periods.

The high degree of agency of women's reproductive choices and behavior in different regions of the USSR, including the popularity of certain medical methods in obstetrics and gynecology, were emphasized by both demographers and medical expert communities. This is indicated and evinced primarily by the large number of female doctors who worked in the field of obstetrics and gynecology in the USSR. Soviet family planning's medical history allows the authors to identify key female figures in

medicine whose unique interdisciplinary expertise combined clinical obstetrics and gynecology with preventative (social) medicine. This expertise was based on analyzing medical demographic data and health statistics, and a clear understanding of healthcare's and physicians' roles in state family planning policies. Focusing on the expert position of female doctors allows us to see the formation of the discourse of women's health in conjunction with family planning and to note both female doctors' agency in knowledge on women's health for family planning and the systemic problems of the Soviet healthcare system they identify.

Female Doctors' Agency in Developing the Discourse of Soviet Family Size Regulation

> *Currently, women in the USSR regulate the number of children in the family, so it is necessary to strive to ensure that they carry out this regulation with the help of contraceptives, and not by abortion, which harms the health of a woman, especially a first-time pregnant one, even if it is performed in a hospital by a doctor.*[6]

This remarkable statement recognizing a woman's reproductive rights and how they manifested in the practice of family size regulations, while at the same time stating the harm of abortion to a woman's health, appeared in 1969 when doctor Elizaveta Alikhanovna Sadvokasova published her monograph *Socio-hygienic Aspects of Family Size Regulation*.[7]

Meanwhile, as a doctor with experience in military medicine gained during World War II, E. A. Sadvokasova had been dealing with the theory and methodology of sanitary and statistical research as well as the problem of abortion and its impact on the reproduction of the population for several decades. Having held for many years the position of Head of the Department of Medical Statistics at the Institute of Social Hygiene and Healthcare Organization named after N. A. Semashko in Moscow, and then working as a teacher in advanced training courses for doctors from different Soviet regions, Sadvokasova had unique access to medical information, as well as opportunities to broadcast her opinions in the medical community.

Based on medical statistics collected by medical departments and summarized in the records of the Institute of Social Hygiene and Healthcare Organization, Sadvokasova analyzed the impact of abortion on the

reproduction of the Soviet population.[8] This study was later defended as her doctoral dissertation, entitled "Abortion as a Social and Hygienic Problem" (1965). The first section of the book consisted of a historical analysis of abortion problems abroad (in both capitalist and socialist countries), and the second section concentrated on the problems of abortion in the USSR. To determine the motivation of women who choose to receive abortions in the RSFSR after 1958, she sent out a survey through doctors and nurses of regional medical facilities who came to Moscow for advanced training courses and received more than twenty-five thousand responses. Sadvokasova considered the evolution of the use of abortions (and their legislative regulation) over a long historical period, regionally and globally. Therefore, the materials of the XII session of the UN Commission on Population (1963) were important for her as comparative material, and she recorded the general patterns of population movement in the developed countries (both capitalist and socialist), as well as the trend toward a decrease in the birth rate in all socialist countries.

The book recorded a consensus of doctors on the dangers of abortion for a woman's health and noted inconsistent differences in the data for the mortality of women, especially in the case of incomplete (criminal) abortion, through the Central Statistical Office of the USSR and within the Ministry of Health of the USSR. Sadvokasova claimed:

> the new generation of doctors of gynecological clinics turned out to be completely unfamiliar with the work of educating women to have the right attitude toward abortion as a far from harmless operation. Doctors did not train women in the use of contraceptives, which, moreover, were not available in sufficient quantity, and their quality left much to be desired.[9]

This situation, in her opinion, had developed as a result of the state policy of legislative prohibition of abortions since 1936, when the development, mass production, and public information about contraception stopped, and the role of informing women about contraceptive methods in medical consultations was excluded from the duties of doctors. Thus, family planning became one of the shortcomings of the system of medical education and training in obstetrics and gynecology, which points to the lack of a systemic family planning strategy at the state level that combined components of the health system, medical education, and financial policy.

Sadvokasova found that only at the all-Union meeting of the active medical workers (23 October 1956) did the report of the Minister of Health of the USSR "On Measures to Further Improve Medical Care for the Population" emphasize the need to explain the harmfulness of abortion for a woman's health, to promote contraception, and to study the reasons why women were able to receive an abortion in facilities other than a medical institution. Sadvokasova also found that:

> At the XI session of the General Meeting of the USSR Academy of Medical Sciences on 15–20 April 1957, the leadership of healthcare has presented a serious bill to Soviet scientists, who over the past twenty years have done almost nothing in the field of finding the least intrusive methods of preventing pregnancy.[10]

This consideration of the medical professional discourse around women's reproductive health allows us to identify the scientific and technological aspect of the problem of Soviet population policy and family planning, which has not previously been highlighted in historiography. Sadvokasova noted the opening of research centers and laboratories beginning in the late 1950s. For example, in 1958 in Georgia (Tbilisi) The Scientific Research Institute of Physiology and Pathology of Women was opened. A special laboratory for the research and testing of new contraceptives was created at the Ukrainian Academy of Medical Sciences. In Kyiv the first special office on the use of contraceptives was opened in 1958.[11] During the first Congress of Obstetricians and Gynecologists of the RSFSR (1960), measures were discussed to reduce abortions, expand the use of contraceptives, and improve public health education; the congress paid attention to local experiments with promoting contraception over abortion in individual consultations. However, Sadvokasova recognized the categorical shortage of developments in the field of contraception, both the production of effective contraceptives and their popularization.

Sadvokasova's monograph is an example conceptualization of the problem of abortion in family planning discourse in social medicine. She argued that "abortion is one of the widespread ways a woman consciously regulates the number of children."[12] She stressed that according to her survey, the main motive for obtaining abortions was "the mother's unwillingness to remain pregnant," which was common among both rural

and urban groups, while "the father's unwillingness to have a child" featured in a negligible percentage of responses. The author noted "the complete independence of the Soviet woman in the family, in connection with which she considers her own desire to have a child very much and takes much less into account the desire of the father."[13] The need to work on an equal footing with a man while bearing the responsibilities of raising children and running a household (the double burden) led women to limit the number of children they had. In urban conditions in the USSR, women usually decided to have only one child, and in rural areas, two.

For the state to participate adequately in family planning, Sadvokasova proposed the following measures: streamlining the social and labor activities of mothers, creating preferential conditions for them; streamlining the living conditions of the family (first of all, solving the housing issue); and introducing material incentives for childbearing starting with the second child. Thus, it was not a question of restricting women's reproductive rights, but of ensuring the social rights of a working mother. She argued:

> to increase the birth rate, it is necessary to create conditions under which parents would like to have not one, but two–three children, i.e., as many as necessary for the normal reproduction of the population. In the case of unwillingness to have a child, women and men should have the necessary knowledge and means to prevent pregnancy. If an unwanted pregnancy has nevertheless occurred, the woman should retain the right to resort to an artificial abortion . . . obstetricians-gynecologists, health care organizers and others, on whom it may depend, should strive to provide Soviet women with the opportunity to protect themselves from unwanted pregnancy. It is necessary to take measures to prevent artificial abortion by creating and expanding the production, sale and use of effective and convenient contraceptives.[14]

Thus, we clearly see that in the medical environment, in the context of sanitary and hygienic discourse, by the end of the 1960s, a woman's right to family planning and birth control, including the right to abortion, was firmly established. However, following the logic of women's reproductive healthcare, it was necessary to organize the production of and access to effective contraceptives that would be approved by the medical community.

While paying great attention to abortion practices in family planning around the world, Sadvokasova focused on the social, economic, and regional specifics of the reasons for abortions chosen by women as a way of regulating family size, and never once paid attention to the ethnic component of fertility. Her research field was focused on the RSFSR, and within the RSFSR, she drew attention to the urban-rural ratio on a regional dimension.[15] In addition, she clearly identified a key problem in Soviet medicine: the exclusion of educational programs on forms of contraception for physicians and for the public after 1936 and isolated attempts by physicians beginning in the second half of the 1950s, not only in Moscow but also at the level of the republics, to seek comprehensive approaches to family regulations that were safe for women's health.

Demographic Policy: Approach to Family Planning by Recognizing Republic's Inequalities

Sadvokasova's work was based on medical statistics, but it existed in the rather isolated world of doctors, which was confidential by departmental regulations. However, it was not only in the medical community that there was interest in what was happening to the reproductive behavior of the population. Centralized planning of economic development in the Soviet Union presupposed knowledge and forecasting of the population's participation in production, age structure of the population, population growth trends, migration, and other factors, etc. Without forecasting population trends, the planned economy of the USSR could not develop. The tendency of population aging, the stable decline in birth rate, and the high mortality rates of able-bodied populations forced representatives of the planned economy to take a closer look at the processes occurring within the population. Meanwhile, in the Soviet Union, which was developing its infrastructure of comprehensive development according to plans drawn up from the union center, the problems of population reproduction in different regions with uneven demographic development were becoming the object of demographers'attention. In 1967, the Soviet demographer Dmitrij Valentey (1922–1994) published *Theory and Politics of Population*, in which he pointed out:

> Changes in reproduction parameters are assessed by many scientists as unfavorable in several regions of the country. . . . Among them, issues related to the birth rate are of particular importance. The birth rate in our country is steadily falling. In a certain part of the Soviet Union, even the simple renewal of a generation is not ensured. . . . It is necessary to introduce differentiated demographic legislation, since what is appropriate in Ukraine, or the Baltic states is completely inappropriate in central Asia or Azerbaijan. . . . How can we change the parameters of population reproduction in areas where they are unfavorable? How can you increase the birth rate there? We have to think about it today.[16]

Thus, Soviet demographers approached family planning through the socioeconomic optics of reproduction of the population under socialism. Even then, the term "demographic policy" was perceived by certain circles of Soviet experts as a policy of birth control imposed by international organizations in developing countries[17] and elicited a wary response. Gradually, demographers developed an understanding of demographic policy as a set of measures aimed at regulating reproduction.[18] At the declarative level, socialist countries aimed to implement social and economic measures to improve health, reduce mortality, increase life expectancy, and raise the material and cultural level of the population.

In 1970, Valentina Bodrova comprehensively considered the demographic policy of Czechoslovakia, the German Democratic Republic, Hungary, and Bulgaria[19] as part of socioeconomic policy and associated it with the importance of labor resources.[20] However, there have been other attempts to describe existing practices of family regulation. The Kyiv demographic school characterized demographic policy as a system of measures directly aimed at shaping the conscious demographic behavior of its members that was desirable for society.[21] Primarily, the researchers recognized that people themselves set standards regarding the necessary number of children and their gender. The number of children is normalized in the context of a certain quality of life. The demographer Anatoly Antonov introduced the concept of "social norm of children."[22]

A fundamental problem, according to demographers, across the Soviet Union since the late 1960s had been the widening gap between regions and socialist republics with low and high birth rates. The population in the European part of the country decreased, while the share of the peoples of central Asia and Transcaucasia increased. Demographers responded to this

new trend with the new vision of the state policy: "the demographic policy in our country should have one specific goal—the creation of a fundamentally unified type of population reproduction for the country, the reduction of regional variations in life expectancy, and the leveling of ethnic differences in the intensity of migration."[23]

The population growth in the central Asian republics made this part of the USSR stand out as a special demographic region with a high birth rate. Uzbekistan, Kyrgyzstan, Tajikistan, and Turkmenistan occupied about 6 percent of the territory of the Soviet Union, and about 11 percent of the population lived there.[24] The fear that the existing "large differences in birth rates among different nations and nationalities" would not disappear by themselves suggested to some authors the need to orient demographic policy toward erasing large differences in birth rates. They recommended that in regions with a low birth rate, large families be spoken of as necessary for society and mainly the positive aspects of having many children were noted, and that in republics with a high birth rate, more and more statements be made against having many children. Large families would be declared to be the main cause of high infant mortality, low employment of women, and, as a result, their real social inequality. Large families were to be seen as a brake on the social and economic development of republics with a labor surplus. In the republics with high population growth rates, the problems of family planning were actively discussed. In this context, family planning policy was often seen to include purposeful activities to reduce the frequent birth rate. This policy emphasized the need for a "flexible demographic policy, a gradual transition from a large family to a medium-sized family," and included critique of "thoughtless and provocative attacks on the traditionally high large number of children."[25]

Some of the demographers' proposals received practical implementation at the regional level. Thus, Dmitrij Valentey (the deputy chair of the Moscow Council Commission on Human Resources) participated in the development and implementation, at the Moscow level, of a resolution "On the state and measures to improve the demographic situation and stimulate natural population growth in the city of Moscow."[26] It was the first regional program to improve the demographic situation in the RSFSR. A year later, a similar program was adopted by the Bashkir ASSR (1978). In order to provide scientific support for the development of measures that met the needs of families, employees of the Center for the Study of Population

Problems of the Faculty of Economics of Moscow State University conducted a unique survey of two-child families in 1978 (the head of the study was Anatoly Antonov, who is repeatedly quoted in our chapter).[27]

At the level of theoretical research, the task was to learn how to interpret the patterns and causes of the populations' reproductive behavior and then discern what policies could influence it. In regions with a high birth rate, research into the history of reproductive behavior began, and interestingly, a trend in philosophy developed regarding the concept of tradition[28] and its influence on family reproductive behavior. The importance of local traditions and the influence of social authority in the extended family have both been cited as factors inhibiting modernization of family planning and women's agency in choosing reproductive behavior. Trends in the uneven distribution (неравномерное распределение) of population worried Soviet experts in connection with the socioeconomic development of a complex conglomerate of Soviet republics formed on a territorial basis and the search for balance between the interests of the union center and regional republican elites, increasing their independence from the union center in the management of the regions during Brezhnev's policy of "rooting" out the elites (коренизации элит).

Thus, in 1988 the Institute of Sociology of the USSR Academy of Sciences held a Family Planning and National Traditions Conference. The report by Anatoly Antonov, published as a preprint entitled "Features of the Evolution of Demographic Processes, Socio-normative Regulation of Reproductive Behavior and Family Planning," made public at the all-Union level a discussion on problems of "overpopulation" and the attitude to large families. As a Union-wide program, Antonov put forward a single goal for the Union—the creation of an average family (three to four children) as the norm for the entire USSR, "at the same time, achieving this goal in regions with low and high fertility requires taking into account regional, national, and socio-cultural, including religious, characteristics."[29] Apparently, the logic of seeking a union-wide balance was causing tension in the regions as perestroika progressed and the interests of the Union as a whole became increasingly imbalanced with regional elites. The attention to regional peculiarities was recorded by the Family Planning and National Traditions Conference (with a focus on trends in the Caucasus and Asian SSRs) in November 1988, held in Tbilisi, where researchers explored the introduction of family planning in the republics discourse and documented

the presence of social groups in the republics of central Asia that opposed "family planning" (which in this context implied a conscious choice of reproductive behavior by the woman to regulate the number of children and increase the interval between births).

Soviet demographers focused on significant population growth in specific republics of central Asia and the Caucasus and proposed as one of the interpretive models of the specificity of social relations, suggesting "tradition" as an important component of family planning. The medical statistics regarding a set of indicators concerning the complex issues of reproductive practices of women's and children's health were inaccessible to demographers (as were many other indicators of population movement, including mortality, which were classified at the highest level). Meanwhile, the head of the unique laboratory of medical demography[30] that existed at the G.N. Gabrichev Moscow Research Institute of Epidemiology and Microbiology, Mikhail Bednii (1932–1990), highlighted: "despite the fact that demographers and social hygienists give preference to social factors in the formation of a certain level of health, very often changes in the dynamics of such indicators as mortality or life expectancy are attributed to the successes or shortcomings of medicine."[31]

Family Planning and the Soviet Ministry of Health: Logic of Medicine and Health Economics

Soviet family planning and population policies were entangled with the World Health Organization (WHO) and the UN positions.[32] Apparently, the WHO brochures and guidelines,[33] available in the USSR, were not accepted as a guide to direct action, but rather triggered the need to produce a socialist vision of the international public health agenda reflecting Soviet peculiarities.

For example, in her memoirs, Dr. Elena Novikova[34] pointed out that in neonatology, women's reproductive health remained secondary to the care for children's health. This mirrors the internal materials of the Ministry of Health that show the professional debates on distribution of financial and political priorities among departments, as well as the various difficulties experienced by the ministries of health in the Soviet republics regarding fertility and children's and women's health and morbidity. The materials of the meeting of the Medical Collegium of the Ministry of Health[35] indicated

that “the population of the USSR in 1977 was 260 million, of which 62 percent were in urban settlements.” The trends in declining fertility were especially noticeable in republics with traditionally high fertility. In regions with low fertility, low infant mortality was also observed. According to the 1977 data, infant mortality remained high. Thus, 29.6 deaths per 1,000 births were recorded in seven Soviet Socialist Republics: the Ukrainian SSR, the Kazakh SSR, the Turkmen, Georgian, Moldavian, Kyrgyz, and Tajik republics. There was an increase in infant mortality of 2–16.7 percent compared to 1976. These statistics did not reflect neonatal mortality. The documents stated that in the Tajik, Uzbek, Turkmen, and some autonomous republics of the RSFSR, “the irresponsible attitude of healthcare institutions to the established procedure for registering newborns and infants born and deceased has not been eliminated.”[36] Of course, the quality of statistical data provided from the most problematic USSR republics can only reflect certain dynamics, and further research requires data from regional and local archives.

Issues of women’s reproductive health were recorded separately. They often appeared in conjunction with the financing of obstetrics and gynecology. For example, in 1977, during the meeting[37] of the Ministers of Health of the Union Republics the chair and then-minister of the USSR Ministry of Health, Boris Petrovsky, displayed the bureaucratic logic of the Soviet health economics and infrastructure for gynecology:

> We spend 200 thousand rubles every day on just the meal. . . . We will improve maternity services. I traveled to many republics to see maternity hospitals. In Moscow, Ivanovo, Narva they are good. What can I say about the new project?[38] It is better than the old ones, but these maternity hospitals’ projects do not consider several features of the modern era. And we need to pay close attention to the available maternity hospitals, since in some we have an excess of operating rooms; in one republic there are twenty-four operating rooms per thousand-bed hospital. What for? And maternity hospitals lack the proper conditions for women in labor. There are no aseptic and antiseptic facilities. The Ministry of Health of the USSR should take direct responsibility for this matter.[39]

The last remark about the chronic underfunding of obstetrics and maternity care is confirmed in earlier materials from 1975[40] about the causes of

female mortality. In the interests of this chapter, we will give excerpts from the data of the All-Union Research Institute of Obstetrics and Gynecology.[41]

The archival file also presents unique materials related to the medical research of birth histories. The Research Institute of Obstetrics and Gynecology conducted a study[42] of about 2,500 birth histories of women who died from complications of pregnancy, childbirth, and the postpartum period. Based on this analysis, doctors formed a general picture of the statistics on the causes of these women's mortality. They identified six main causes of female mortality: bleeding;[43] complications of pregnancy at up to twenty-eight weeks; sepsis (the most common, 85 percent of women); artificial termination of pregnancy outside of medical institutions (criminal abortions); ectopic pregnancy; and rupture of the uterus. The total number of women in the USSR who died from complications of pregnancy, childbirth, and the postpartum period was: 1960—6,017 women; 1965—4,516 women; 1970—3,750 women; and 1975—3,415 women.

Republican differences were identified; accordingly, however, medical data was country-wide and showed no cultural or ethnic factor in statistics—all statistics were collected according to either disease or the reason of death without any ethnic details. However, certain interesting numbers have come to light about the fact that Soviet health care's main problems were underfunding and lack of proportional/equal development of health care. The supply of personnel and the volume of medical services were not linked to the demographics of a particular territory. This led to irrational use of funds and comparable trends among different republics, for example, the Baltic and Central Asian ones (see figures 14.1 and 14.2).

We can observe the same numbers and similar dynamics in abortion rates within a decade among very different republics—Lithuanian and Armenian SSRs, and between Tadjik, Turkmenian, and Estonian SSRs. That shows that there were much greater correlations between the republics of the "North" and the "South" in terms of the number of abortions and their dynamics.

However, this similarity does not only apply to absolute numbers—the indicators on the number of abortions per one thousand women of fertile age again show the proximity of women's reproductive practices in the Uzbek, Lithuanian, and Tajik republics.

Interestingly, the lowest level of abortion was in Azerbaijan SSR, even comparing to European republics and other Caucasian and central Asian republics. Another fascinating feature is the similar tendencies over the decade among fertile women between Uzbek SSR, Lithuanian SSR, and Tadj SSR. Rates of abortion in Estonian SSR were much higher—107.1 in 1975.

These facts necessitate serious consideration of incorporating medical demographic data into the history of Eastern European and Soviet Union population and family policy history. Stable trends reflected in medical statistics suggest a fresh look at reproductive practices in socialist republics, highlighting the active influence of modernization on family planning in both southern and northern republics of the Soviet Union. They also demonstrate complex correlations between regions and the frequency of the practice of abortion as a means of family planning. It leaves open the question of how abortion practices and tradition, as a distinctive feature of family regulation in the central Asian republics, were correlated in these statistics. The focus of physicians in discussing family planning was on female and infant mortality, which in the late USSR showed an unpleasant tendency of increase.

Table 14.1. Abortion dynamic in USSR republics. Table created by Nataliya Shok and Nadezhda Beliakova.

	1975	1980	1985
Lith SSR	45,582	45,189	42,026
TajSSR	39,396	40,135	40,656
ArmenianSSR	45,483	32,604	33,896
TurkmSSR	34,124	33,762	31,139
EstonSSR	39,641	36,157	34,844

Table 14.2. Number of abortions per one thousand women in fertile age. Table created by Nataliya Shok and Nadezhda Beliakova.

	1975	1980	1985
USSR	105.7	102.3	98.4
Uzbek SSR	51.9	43.8	46.9
Azer SSR	43.1	39	30.8
Lith SSR	53	50.9	46.3
Tadjik SSR	53.4	45.3	39.5

Soviet healthcare professionals saw the following factors as the basis for reducing female mortality:[44] increasing the general sanitary culture of women; improving maternity care in the country; improving obstetric and gynecological science; finding new effective medicines to use in obstetric practice (combating bleeding, toxicosis, labor anomalies, etc.), as well as finding effective contraceptives. The latter would contribute not only to reducing the number of abortions but also to reducing gynecological morbidity, and thereby complications of pregnancy and childbirth. Thus, if we compare the clinical dimension of medical issues and supplement it with Sadvokasova's analysis of the healthcare system, we can see the full picture of the problems of Soviet population policy, including family planning. Solving these medical problems in both clinical and preventive medicine was hampered by the stable social practices and attitudes of women regarding birth control, as well as the weak pharmacological and medical-technological provision of this type of medical care in the USSR. These debates continued during the 1980s within the frame of family planning.

Family Planning in Soviet Medicine and Healthcare: A 1987 Case Study

In the late Soviet Union, the term "family planning" appeared at a meeting of the Presidium of the Scientific Medical Council of the Ministry of Health of the USSR on 26 March 1987.[45] Generally, such meetings often touched on problems of all-Union significance such as emerging technologies or new drug development. This meeting focused on scientific and healthcare

programs related to family planning with a special focus on its social dimensions. According to the deputy chair of the Ministry of Health, N. A. Shluger, the program was supervised at the highest level of the All-Union Central Council of Trade Unions of the USSR[46] and the republic's councils. The discussion was attended by the heads of two programs developed in different scientific institutions of the USSR Academy of Medical Sciences and Ministry of Health. Two speakers were executive healthcare professionals with extensive experience of working with WHO. Remarkably, they saw Soviet domestic family planning priorities differently.

The discussion is interesting because of three facts. First, it represents existing tension among Soviet physicians. The term "family planning" itself began to be used more frequently in Soviet public health during 1980s while the negative connotation of it grew. Cold War politics forced population growth as an issue to be considered within the realm of foreign policy and diplomacy, both of which were fueled with ideological rivalry. Since the 1960s the United States had linked foreign policy with family planning and population control with the intention to change the demographic structure of foreign countries and the magnitude of the initiative.[47]

Irina Manuylova,[48] one of the regular contributors to the journal *Zdorov'e*, a gynecologist-endocrinologist, voiced the question:[49] "How do you feel about the fact that in sixty countries there is a tendency to unification between the family planning policies and maternal and child health protection services? We are afraid of this term. We are being asked to replace family planning with birth control." Unfortunately, in the document it is not clear who asked for a terminological replacement. Evidently, the WHO definition of family planning as "the birth of a child at a convenient time for the family" was not universally accepted among doctors as a public good. According to Manuylova, the term "family planning" concealed the term "birth control."

Second, it highlighted the existing controversies in the medical community that are rarely visible to the public—the competition between different branches of medicine dealing with the same issue. In the case of the 1987 debate, it was gynecology and pediatrics. The latter was represented by the preventive medicine institution, and the former by the clinical and the scientific.

Manuylova sharply characterized the state of women's reproductive healthcare: "We are ranked first in the world for abortions. We have 5 percent coverage of intrauterine contraception. Most tumors are due to reproductive behavior. We could not purchase contraceptives for a year and a half. We ruined hormonal contraception."[50] A year later, the all-Union society Znanie published Manuylova's *Family Planning and Women's Health*, which focused on women's reproductive health and options for safe contraception. The book did not present the harsh criticism voiced within the medical community against the Soviet bureaucracy about its scattered, uncoordinated contraceptive programs; nevertheless, the ascent of professional medical debates on the specifics of women's health seems remarkable.

Third, this case again shows strong female leadership strategies among women physicians in the USSR, which during perestroika became more publicly vocal. Dr. Manuylova, and likewise her earlier female colleagues, argued that effective population policies must deal with essentials—women's reproductive health and related medical services. Her colleague, and opponent, was Vladimir Ovcharov, an expert on sanitary statistics from the All-Union Research Institute of Social Hygiene and Public Health named after N. A. Semashko of the Ministry of Health of the USSR.[51] At the 1987 meeting of the Presidium of the Scientific Medical Council, Ovcharov appealed to the social part of the concept of family planning and drew participants' attention to child mortality. He noted: "Of course, contraception, everything related to prematurity, the pathology of childbirth is irreplaceable. But we are losing children who have survived for a month or one year of life." He considered child mortality as a kind of social consequence of the inefficiency of family planning programs.

Manuylova, as a gynecologist, pointed out the incompleteness of Ovcharov's approach, noting that it did not pay attention to women's reproductive health, abortion prevention campaigns, availability of high-quality contraception, or treatment of gynecological diseases. Manuylova highlighted the need to combine women's reproductive health, contraception, and prevention of infant mortality at an early age into a single family planning program with the funding necessary for serious comprehensive research.[52] She emphasized the need for scientific and technical support of the program. She noted that the state invested a lot of money in children, in the care of premature babies (babies weighing five

hundred grams or less were considered premature), while the greatest mortality was observed in the perinatal period, which depends on women's reproductive health before the pregnancy.[53] Manuylova believed that the primary task was the prevention of abortions. The popularity of abortion in the late Soviet period as the socially approved method of birth control stood in contrast with the medical advances in contraceptives and was caused by limited awareness of contraception, underfunded health care, and the unavailability of safe contraceptives.

This case again shows strong female leadership strategies among women physicians in the USSR. However, in a new circumstance of perestroika their narrative has slightly changed, turning to a bigger publicity. In conclusion, Manuylova highlighted the need to consider the unique Soviet healthcare reality: "We need to create our own family planning service; we need to oblige the family service to engage with contraception," and continued: "When will there be a normal provision of contraceptives? We are the only country that does not produce them."[54] Evidently, there was no coherent and robust vision among high-level executives in the Ministry of Health of the USSR on how to prioritize this work. To some extent, we can even talk about the competition of medical programs on family planning and the structures responsible for them. This fragmentation showed important directions of disagreement: (1) how state family planning policy should be framed; (2) how public health budgets would be allocated; and (3) among physicians with different clinical backgrounds, the debated question was whether Soviet family planning should prioritize female reproductive health and contraception (reduction of maternal mortality), or newborn and child health (reduction of infant mortality). Thirteen years after the UN World Population Conference in 1974, the family planning agenda in Soviet medical professional debates appeared controversial around the priorities of "reduction of fetal, infant and early childhood mortality" and "related maternal morbidity and mortality,"[55] and regarding the term "family planning" itself.

Medical Measures and Family Planning Policy in the Late USSR

The late Soviet period was characterized by increased glasnost and the policy of new thinking. Those factors underpinned new tendencies in communication on public health, too. The increased publicity in the case of

the healthcare reforms in abortion services aimed to reduce female mortality and gynecological trauma among Soviet women, while the problem with contraception remained. However, the drivers of these public health measures were undermined by internal discussions in the Medical Collegium of the Ministry of Health of the USSR. In 1987 another report titled "The Report of Serious Shortcomings in the Organization of Medical Care for Women with Artificial Termination of Pregnancy and Improvement of Work to Combat Abortions in the Country"[56] (with a note "for internal use only") provided a retrospective overview of the medical component of women's reproductive health across the Soviet republics. It negatively assessed the general state of maternity care due to lack of funding, poor medical services, and underdeveloped infrastructure. Most gynecological units, especially those where abortions were performed, were in dilapidated, cramped, poorly heated rooms that had not been repaired for years. Observers recorded overcrowding in the wards (cities: Nikolaev, Kostroma, Shymkent, Timertau, Saransk, Moscow, etc.). The low availability of gynecological beds caused queues for abortion-related hospitalization (Shymkent, Kalinin, Moscow, Kursk region, certain districts of the Moldavian SSR).[57]

Another important issue was anesthesia during abortions:[58] "In most hospitals, the operation of artificial termination of pregnancy is performed without effective anesthesia, and often no anesthesia at all. According to the inspections, modern methods of anesthesia (mask with appropriate premedication, intravenous) are used in 5–20 percent of cases."[59] The problem existed due to the absence of anesthesiologists in abortion units and low budgets for the purchase of medicines in gynecological hospitals: "65 kopecks per bed while the cost of one ampoule of calypsol is one ruble 92 kopecks."[60]

The data also highlights the irresponsible attitude of doctors: "In recent years, the number of complaints from the population about the rude, abusive attitude of health workers to women admitted to the hospital in connection with abortion has increased, and there are frequent cases of extortion for anesthesia of abortion surgery."[61]

Separately, the unsatisfactory level of contraception was noted: "obstetricians and gynecologists have not achieved a radical change in the psychology of women in relation to family planning issues regarding the use of contraceptives."[62] In all the republics of Central Asia and a number

of republics of Transcaucasia, there were many women whose intervals between childbirth were less than two years, which significantly increases obstetric pathology, maternal and child mortality. Outdated and ineffective methods of contraception continued to be widely used by the population, while intrauterine (IUD) and hormonal contraceptives were not being sufficiently introduced. Separately, the work to prevent abortions among "organized contingents of women workers of industrial enterprises and the agricultural industry"[63] was noted as unsatisfactory. And monitoring of women using intrauterine devices and hormonal contraceptives was poorly conducted because doing so required additional paperwork for doctors who would have to do separate paperwork for both kinds of monitoring. Despite the recommendations of the Ministry of Health, doctors did not prescribe hormonal contraceptives frequently enough; applications for these drugs were significantly lower than the needs of the population.

Based on this variety of shortcomings in medical care for women, instructions were formulated for the chief obstetricians and gynecologists of the ministries of health of the Soviet republics and heads of medical institutions:[64] (1) to establish strict control over the use of IUDs and to expand their use after abortions; (2) to assist the groups of women at high risk of unplanned pregnancy on family planning; (3) to analyze quarterly the deaths of women after abortion, and based on the results, to take concrete measures to improve the quality of medical care for women with complications after abortions; (4) to carry out on-site inspections of the organization and quality of work on family planning. In order to ensure 100 percent effective anesthesia during abortion operations, it was instructed "to establish additional positions of anesthesiologists-resuscitators in hospitals performing artificial abortion . . . To strengthen control over the completeness and quality of analgesia during artificial abortion, to enforce strict penalties against doctors who allow the performance of this operation without anesthesia."[65] The Minister of Health, Evgeniy Chazov, issued an order for all the ministries of health across the USSR. The document stated the obligation to introduce "into practice by the end of 1987 the vacuum aspiration method"[66] for the artificial termination of early pregnancy publicly known as "mini abortion." Also, physicians had to take measures "*to maximize the coverage of women after this operation with contraceptives*."[67]

The limits of the medical statistics are well known.[68] However, medical data is essential for the history of Soviet population and family planning policy developments because it was methodologically connected to demographics such as sanitary and demographic statistics, and later, as medical demographics. Soviet demographic debates and later family planning were intrinsically linked with medicine within the larger concept of state-funded centralized socialist health care.

In 1989, by the decision of the Central Committee of the CPSU, the Family and Health Association was established. The health-related part of family planning—information on contraceptives—became part of its activities. The medical dimension of family planning policy became evident in the late Soviet period. But in the early 1990s the USSR collapsed, which undermined the further transition of the state strategy related to demography and reproductive health policy.

Conclusion

This study demonstrates the absence of any universal Soviet family planning program. The term "family planning" (in the sense of its Western understanding) appears on the public agenda only in the final years of the Soviet Union, starting from perestroika. An interdisciplinary analysis of the history of demography and social medicine statistics from the perspective of Soviet population policy made it possible to expand the scope of research on Soviet family planning. It includes new dimensions—health economics, clinical medicine and public health debates, and regional studies with a focus on the social and cultural diversity of Soviet women's reproductive behavior and attitudes.

Medical archives and records of expert debates among demographers and doctors helped us see the new level of women's agency in reproductive policies and the diverse topics that were seen as a part of policy on population, demography, and reproduction. The combination of medical archival materials and historiographical analysis of demographers' discussions helped us broaden understanding of Soviet family policy beyond the limits of abortion. The family planning discourse shifted from the figure of a woman choosing abortion as the only means of birth control to healthcare structures and their capacities to provide women with medical services according to their reproductive choices.

The chapter shows the gradual formation of the family planning discourse. Its components consisted of multiple areas of state policy—demographic (economic/population) policy and healthcare policy. The latter had considered two levels—clinical medicine (obstetrics and gynecology, pediatrics) and public health policy (prevention, social hygiene, and epidemiology of women's and children's diseases). The whole family planning discourse was formed around medical subjects—abortion, maternity care, and contraception. These topics took up the greatest amount of the attention of doctors, demographers and sociologists, and of course the women themselves. At the same time, a full-fledged opportunity to study the issue of family planning in the USSR arose due to the inclusion of medical professional discussions on the level of the Ministry of Health of the USSR.

Soviet doctors approached family planning in terms of the need to reduce infant and female mortality. Since the mid-1970s, attempts to solve these issues were systematically visible in the Soviet Ministry of Health. Catastrophic underfunding of the maternity care system and the lack of reproductive health programs made it even more difficult to provide adequate reproductive health care. However, harsh criticism by doctors of the state of obstetrics and gynecology remained internal and did not reach the level of public discussions. Public opinion made doctors responsible for a catastrophic situation in maternity health care. Our research makes it possible to understand the logic and perception of the doctors themselves. We noted that the medical community was very closed, indeed very vulnerable, in its role as intermediary between state policy and the everyday life practices of citizens related to reproduction and mortality. It was the doctors who pointed out the direct connection between abortion, women's health problems, and female mortality.

In the late Soviet Union the discourse on family planning appeared on the public agenda under the influence of international structures and their views on reproductive health. By the end of the 1980s the discourse on family planning had become medicalized. During the 1990s a medical understanding of family planning was enshrined in a Russian Federal Law.[69] This may have been associated with the rapid development of assisted reproductive technologies, but also with the human genome project. By 1998, the targeted federal family planning program in the Russian Federation ended, and the Family Planning and Reproduction Center in the

structure of the Ministry of Health was liquidated. The discourse on family planning has disappeared from demographic programs developed in the context of Putin's new demographic policy.

Dr. Nataliya Shok is a Public Policy Fellow at the Wilson Center and Adjunct Associate Professor at Georgetown University School of Medicine in Washington, DC, USA. She holds degrees in philosophy (MA), political science (PhD), and history of medicine (Dr. Sci.). She is working on the interaction between foreign policy and health, science diplomacy and bio-security in the context of the pandemic preparedness, response, and beyond. Her research focuses on the international collaboration in science and health over the years—from Cold War cooperation in eradicating polio and smallpox to the more recent competitive nature of the COVID-19 response.

Dr. Nadezhda Beliakova, PhD in history, is a Research Fellow in East European Studies at the University of Bielefeld, Germany. Her research focuses on the entangled history of religion in the 20th century, religion and gender during the Cold War, and the intersection of religion and women's health under socialism. Drawing on extensive interdisciplinary expertise, her work integrates archival research and oral history, particularly in the republics of the former Soviet Union. Her published studies explore women's religiosity during socialism and the rise of anti-gender movements in Eastern Europe.

Notes

1. Hilevych and Sato, "Popular Medical Discourses on Birth Control," 99–122.
2. Rivkin-Fish, "Legacies," 1731–35; Nakachi, *Replacing the Dead*.
3. Lišková, "History of Medicine in Eastern Europe," 181–94.
4. The Medical Collegium consisted of the Chair (the Minister) and deputies ex officio, as well as other senior officials of the Ministry. The members of the Collegium and Deputy Ministers were approved by the USSR Council of Ministers. The decisions of the Collegium were, as a rule, enshrined by orders of the Minister. In cases of disagreement between the Minister and the Collegium, the Minister decided how to act, but had to report the disagreement to the USSR Council of Ministers.

5. The Scientific Medical Council was a management body within the USSR Ministry of Health (and within the ministries of health of Union republics), providing scientific and methodological guidance for the USSR (or respective republic's) medical research institutions. The Scientific Medical Council interacted with the Presidium of the USSR Academy of Medical Sciences, which was responsible for the general management of medical science in the country, with the departments of the USSR Ministry of Health and Union republics.
6. Sadvokasova, *Social'no-gigienicheskie aspekty regulirovanija razmerov sem'i*. Over ten thousand copies were published.
7. Elizaveta (Zeynep) Sadvakasova (1903–1971), doctor of medical sciences (1966) and professor (1967). In 1927 she graduated from the medical faculty of the first Moscow State University. She had worked for a long time in various roles within the Ministry of Health. She was born in the family of the famous Kazakh politician Alikhan Bukeykhanov (1866–1937), one of the founders of Kazakh statehood. He was married to a Russian, the daughter of the repressed Narodolovtsy Elena Sevostyanova. Their daughter Elizaveta received her medical education after the revolution, first at Tomsk University, then at Moscow Medical University. Her first husband, Smagul Sadovkasov (1900–1933), was the Commissar of Education of the Kazakh SSR, and their only son died during World War II. During World War II she was a military doctor, Major of Medical Service, and was awarded with orders and medals. From 1945 to 1948 she was the scientific secretary of the All-Union Scientific Research Institute for Social Hygiene and Organization of Public Health, and from 1959 to 1969 she was head of this institute's department of sanitary statistics. Sadvokasova's last place of work was the Central Institute for Advanced Training of Physicians. Her second husband, Max Natanovich Kleiman (1891–1996), was the deputy director of the Institute of Maternity and Infancy and the deputy head of the Department of the Ministry of Health.
8. http://www.demoscope.ru/weekly/2003/0123/nauka02.php.
9. Sadvokasova, *Social'no-gigienicheskie aspekty regulirovanija razmerov sem'i*, 125.
10. Ibid.
11. Telnova, "Nash opit preduprejdeniya beremennosti."
12. Sadvokasova, *Social'no-gigienicheskie aspekty regulirovanija razmerov sem'i*, 125.

13. Ibid., 162.
14. Ibid., 182.
15. In the RSFSR, she preferred the North, the Far East, the Urals, the North Caucasus, the Volga region, Eastern and Western Siberia, Moscow, the Center and the North-West, without specifically focusing on the republics and autonomous entities.
16. Valentei, *Teoriya i politika narodonaseleniya*, 163–64.
17. Burnashev, "Aktualnie"; Guzevatii, "Demograficheskaya politika v razvivayuschihsya stranah."
18. Elizarov, "Teoriya i praktika demograficheskoi politiki v SSSR," 73. For reference: Namestnikova, "Sovetskaya visshaya shkola i nauka o narodonaselenii," 79–84.
19. Bodrova, "Demograficheskie processi i demograficheskaya politika v socialisticheskih stranah Evropi."
20. Larmin, *Metodologicheskie problemy izuchenija narodonaselenija*.
21. Piskunov and Steshenko, "O demograficheskoi politike socialisticheskogo obschestva."
22. Antonov, *Sociologiya rojdaemosti*.
23. Kvasha, *Demograficheskaya politika v SSSR*, 117.
24. Vasil'eva et al., *Dinamika naselenija SSSR*; Darskij and Andreev, "Vosproizvodstvo naselenija otdel'nyh nacional'nostej v SSSR," 3–10.
25. See more: Elizarov, "Teoriya i praktika demograficheskoi politiki v SSSR," 81.
26. Resolution of the Bureau of the Moscow City Committee of the CPSU and the Executive Committee of the Mossovet. 1977.
27. Elizarov, "Teoriya i praktika demograficheskoi politiki v SSSR," 78.
28. Plahov, *Tradicii i obshhestvo*.
29. Antonov, "Osobennosti jevoljucii demograficheskih processov, social'no-normativnoj reguljacii reproduktivnogo povedenija i planirovanija sem'i," 17.
30. In the Soviet Union, medical demography, which has its roots in the Russian Empire, was continued by individual researchers. See for example: Novosel´skiĭ, *Voprosy demograficheskoĭ i sanitarnoĭ statistiki*.
31. Bednyĭ, *Mediko-demograficheskoe izuchenie narodonaseleniia͡*, 3–12.
32. WHO. Tech. Rep. 1971. No. 476. https://pdf.usaid.gov/pdf_docs/PNAAH494.pdf.

33. The following were translated into Russian: The WHO report “Health and Family Planning” (1970), described family planning as a priority for health care; the WHO Health Personnel Department recommendations “Aspects of Family Planning in the Training of Nurses and Midwives” (1975); the report of the WHO Committee of Experts “Family Planning: Evaluation of the Activities of Health Services” (1977); “Intrauterine Devices and Their Role in Family Planning.”
34. Elena Vyacheslavovna Novikova (nee. Angevich; 30 November 1923—11 January 2021, Moscow) was a Soviet and Russian pediatrician, a specialist in neonatology, and one of the founders of the Soviet and Russian school of neonatologists. Novikova was a Doctor of Medical Sciences (1967), professor, and Honored Scientist of the RSFSR. In 1972, she was the Deputy Minister of Health for the Health of Women and Children. Before that she served as the head of the Department for Newborns and Premature Babies of the Research Institute of Pediatrics of the USSR Academy of Medical Sciences.
35. State Archives of the Russian Federation (GARF), fond 8009, opis 50, delo 6953, list 65.
36. GARF, fond 8009, opis 50, delo 6953, list 67. 16.11.1977.
37. The meeting was held as part of the implementation of the Resolution of the Council of Ministers of the USSR “O merah po dalneishemu uluchsheniyu zdravoohraneniya i medicinskoi nauki v strane” dated 5 July 1968, no. 517.
38. The whole meeting was about the new design of maternity hospitals.
39. GARF, fond 8009, opis 50, delo 6268, list 59.
40. GARF, fond 8009, opis 50, delo 5464. «Заключения по материалам ЦСУ СССР «Предпосылки смертности населения в демографическом прогнозе к 1985 и 2000 годам»
41. GARF, fond 8009, opis 50, delo 5464, list 58.
42. GARF, fond 8009, opis 50, delo 5464, list 61.
43. The greatest number of deaths from bleeding occurs at the ages of thirty to thirty-nine (57 percent of all maternal mortality from blood loss); under thirty—25 percent; forty and over—18 percent.
44. GARF, fond 8009, opis 50, delo 5464, list 64.
45. GARF, fond 8009, opis 51, delo 3129, list 40–45.
46. The All-Union Central Council of Professional Unions was the central organ of trade unions in the USSR that was responsible for the management of all trade

union organizations in the Soviet Union from 1918 to 1990. It had de facto ministerial status.

47. Sharpless J. World population growth, family planning, and American foreign policy. J Policy Hist. 1995;7(1):72–102. https://doi.org:10.1017/s0898030600004152.

48. Irina Aleksandrovna Manuylova (born 1923) is a Soviet gynecologist-endocrinologist and educator, doctor of Medical Sciences (1966), and professor (1966). She was a corresponding member of the USSR Academy of Medical Sciences (1982). Manuylova was the chair of the commission on obstetric and gynecological endocrinology at the Presidium of the USSR Academy of Medical Sciences and deputy chair of the committee on steroids of the commission of the Presidium of the USSR Academy of Sciences on the scientific foundations of medicine, a WHO expert on maternal and child health, editor of the Obstetrics and Gynecology section of the *Great Medical Encyclopedia*, and member of the editorial board of the journal *Soviet Medicine*. Manuylova was an honorary member of the Hungarian Society of Obstetricians and Gynecologists. Since 1990 she has been a member of the Bureau of the Clinical Department of the Russian Academy of Medical Sciences and a member of the Interdepartmental Scientific Council on Obstetrics and Gynecology of the Ministry of Health of the Russian Federation.

49. GARF, fond 8009, opis 51, delo 3129, list 40.

50. GARF, fond 8009, opis 51, delo 3129, list 41.

51. Vladimir Kuprianovich Ovcharov (1925–2005) was a Soviet and Russian scientist, Doctor of Medical Sciences, and a professor; he was a corresponding member of the Russian Academy of Medical Sciences (1995). From 1955 until the end of his life, Ovcharov worked at the All-Union Research Institute of Social Hygiene and Health Organization named after N. A. Semashko of the USSR Ministry of Health (now the National Research Institute of Public Health named after N. A. Semashko), with the exception of 1970–1975, when he worked at the WHO headquarters in Geneva. In 1978 he became deputy director for scientific work at the research institute; in 1982, he became its director, and from 1988–2005, again he became deputy director for scientific work.

52. GARF, fond 8009, opis 51, delo 3129, list 42.

53. The perinatal period is the period from 23 weeks of pregnancy (antenatal), including the period of labor (intranatal) and ending 168 hours (7 days) after

birth (postnatal).

54. GARF, fond 8009, opis 51, delo 3129, list 42.

55. https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/E_CONF.60_19_Plan.pdf. Pp. 15–16.

56. GARF, fond 8009, opis 51, delo 2781, list 136–146.

57. GARF, fond 8009, opis 51, delo 2781, list 144.

58. In Soviet gynecology the problem of pain relief has been a significant one for many years. A method of psychoprophylaxis for pain was even developed and gained international recognition. See more: Michaels, *Lamaze*.

59. GARF, fond 8009, opis 51, delo 2781, list 145.

60. GARF, fond 8009, opis 51, delo 2781, list 145.

61. GARF, fond 8009, opis 51, delo 2781, list 145.

62. GARF, fond 8009, opis 51, delo 2781, list 142.

63. GARF, fond 8009, opis 51, delo 2781, list 143.

64. GARF, fond 8009, opis 51, delo 2781, list 160.

65. GARF, fond 8009, opis 51, delo 2781, list 159.

66. Jukovskii, "Mini-abort," 13. This article was printed in the family planning section and explains the meaning of a new medical procedure. A "mini abortion" is an abortion at an earlier stage (not later than the twentieth day after menstrual delay). Technically, it avoids "dilation of the cervix with metal bougies" and involves "using a flexible plastic cannula instead of a metal curette" and avoids general anesthesia. Importantly, it is not a traumatic and painful curettage, but a vacuum aspiration, which is carried out within a minute and a half to two minutes. If the outcome is favorable, the woman can return to normal activities within two hours, after a short (thirty to sixty minutes) rest. The rate of complications is five to six times lower than after conventional abortion. The author of the article emphasized that abortion cannot be completely harmless and safe: for three weeks after a mini abortion, sexual relations and alcohol are prohibited so as not to provoke inflammation in the uterus.

67. GARF, fond 8009, opis 51, delo 2781, list 159.

68. The Soviet case was discussed during the meeting of the Medical Collegium of the USSR Ministry of Health in September 1987 titled "On Measures to Streamline Statistical Reporting and Eliminate Illegal Reporting in the System

of the USSR Ministry of Health." The case materials contain statistical data from different years and the results of the audit. In total, 633 institutions were checked, and illegal reporting was revealed in 452 (71 percent) of 937 forms containing about five hundred thousand indicators. Approximate costs for the preparation of these reports amounted to twenty thousand rubles. The authors of the report state that providing cumbersome explanatory notes, reviews, and certificates containing a large number of statistical indicators remains the practice in the republics' ministries of health. The largest volume of illegal reporting was revealed in the Azerbaijan USSR: fifty-two forms for forty-nine thousand indicators; in the RSFSR, ninety-four forms for sixty-three thousand indicators; and in the Ukrainian SSR, three hundred five forms for ninety thousand indicators. GARF, fond 8009, opis 51, delo 2777, list 100.

69. Fundamentals of the legislation of the Russian Federation on the protection of the health of citizens. 22 March 1993 N 5487–1.

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