GENDER AND WORK IN SOVIET RUSSIA : THE MEDICAL PROFESSION

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ABSTRACT

Despite proclamations of equality, the Soviet workplace was characterised by patterns of gender segregation. Across the economy, women were concentrated into the least prestigious and lowest paid occupations and within occupational groupings, positions of authority tended to be reserved for men. This thesis focuses on the medical profession in order to outline the nature of gender inequality in work in Soviet Russia. The medical profession was a predominantly female occupation, and yet was characterised by a gender hierarchy by specialisation and qualifications. This thesis provides a detailed account of this hierarchy and argues that a description of such patterns is only a partial picture. It is also important to provide an explanation.

Based on the analysis of Soviet press and academic sources and research among female doctors in Russia, this thesis develops the argument that gender inequality in Soviet Russia should be understood in relation to the state's strategy for social reproduction and the contradictions that women's labour posed for this. Women were regarded as essential for both production and biological reproduction, yet their participation in both was often contradictory for the system as a whole. It was also often contradictory for the women themselves and their reactions to state policy were simultaneously shaped by and acted to shape such policy. In this way, by providing an analysis of gender inequality in work in Soviet Russia it is possible then to develop a clearer understanding of the nature and extent of the changes taking place in the current period of transition.

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INTRODUCTION: GENDER AND WORK IN SOVIET RUSSIA

Although gender equality was enshrined in the Soviet constitution this did not correspond to the actual nature of gender divisions in Soviet society. Though women in Soviet Russia were an integral part of the workforce and so in theory have achieved a level of independence and self identity that Western feminists have fought for, in practice this liberated image did not represent the harsh reality of Soviet women's lives and masked the sexual division of labour within the workplace.

In 1928, at the onset of the process of industrialisation and the establishment of the Soviet system, 24% of the workforce was female (Lapidus 1978: 165). The first five year plan in 1928, initially envisaged, only a slight increase in the number of women employed but by 1930 it was apparent that women were a vital source of labour to fill the ever increasing labour shortage. This was highlighted by a Central Committee manifesto in 1930 which stated that in order to "ensure the fulfilment of the production programme of the third year of the five year period" it was essential to "draw more juvenile workers as well as wives of workers and other toilers into production"(Lapidus 1978: 98).

However by the 1950s, it was estimated that around 16 million women of working age were not participating in production, making

up 90% of the total non working population. The reasons given for the reluctance of women to enter production centred on the inadequacy of child care facilities and the lack of suitable job opportunities for women resulting from the emphasis on investment in heavy industry. There were also financial reasons why women did not enter production. For some families women earned more on their private plots than in production, while for others the payment for services such as child care would have absorbed all the woman's wages making paid employment futile. Therefore, the solution to the labour shortage that women presented was not without problems under conditions of inadequate services and low wages. Nevertheless, between 1959 and 1970 the number of women employed rose by 21% primarily as a result of the development of the service sector and the concentration of women's employment within this area. By 1970 women constituted 51% of the workforce in Soviet Russia. (Lapidus 1978 : 173, 165).

At first glance, the high rates of female labour force participation may have seemed impressive, in comparison with lower rates in the west, but when the overall participation rate is broken down, patterns of vertical and horizontal segregation similar to those experienced by women in the West become apparent. Horizontal segregation refers to processes whereby men and women are commonly working in different occupations. Vertical segregation refers to processes whereby men are most commonly working in higher grade occupations and women in lower grades.

In Russia, there was evidence of the horizontal segregation of women in the labour force. Within both industry and the service sector, many

of the jobs women were employed in became feminised, that is were overwhelmingly female and it was taken for granted that only women would enter such fields. For example 99% of typists were women. In other occupations the extent of the segregation was less intense, but women were nevertheless the majority workforce. Table 1 gives an outline of the patterns of horizontal segregation in various branches of the economy.

Table 1 : Proportion of Women by Branch of the Economy %

	1980	1990	1993
Total	52	52	51
Industry (production personnel)	49	48	46
Construction	29	27	25
Transport	25	25	26
Communications	71	71	70
Trade and public catering	80	80	77
Informational calculating services	71	82	75
Communal housing and consumer services	54	52	46
Health, physical education and social services	85	83	84
Education	78	79	80
Culture and art	70	71	73
Science and scientific services	52	53	53
Credit finances and insurance	87	90	91
Government apparatus	69	67	68
Others	53	47	41
Source : Morvant (1995)			

Moreover, the extent of horizontal segregation increased as women's participation in the economy increased. In 1959, 33% of women were employed in occupations in which women formed 70% or more of the labour force. By 1970, this had risen to 55% (Lapidus 1978: 173). It

was clear therefore that the growth in women's labour force participation was accompanied by a widening of the sex-typing of occupations.

In addition to patterns of horizontal segregation, it is also clear that the sexual division of labour in Soviet Russia was characterised by vertical segregation. Women were more likely to be employed in work classed as low skilled than men. In industry, the highest grade for a common male trade of fitter was 6 but for female trades it was 4. (Mezentseva 1994:114). In machine building and metal working 70% of women were in grades 1-3 and only 1.3% in the top grade (Boldyreva 1988:142). In light industry, for example the textile industry, while women constituted the majority of key production workers, it was the men who worked as auxiliaries in the higher skilled category job of machine repair. 45% of women were in the bottom two skill grades compared to only 5% of men. In heavy industry the reverse was the case, as women tended to work as auxiliaries, but in unskilled manual occupations. For example in meat processing 37.5% of women were on the bottom two skill grades compared to only 3.7% of men (McAuley 1981: 80). In managerial positions, women were drastically under-represented. In 1973, only 9% of enterprise directors were women (McAuley 1981: 88). The pattern was apparent throughout industry - the higher up the skill grade or hierarchy, the fewer women there were.

In the service sector the patterns were similar despite women's higher levels of education. While women account for 60% of those with higher education they only account for 6% of those in senior positions.(Soviet Weekly 6/9/90). In the USSR, in 1978 for every 1000

people employed in the national economy, 890 men and 888 women had higher or secondary education. These figures are impressive but only present one side of the story. Though women's education levels on entering the workforce were equivalent to men's, they remain within less prestigious and less well paid jobs. For example, 79% of primary teachers and 83% of primary school directors were women, only 29% of secondary school directors were female. In science, 50% of junior research associates, 24% of senior associates, 10% of associate professors and 10% of academicians were women (Lapidus 1978: 189). In medicine, as will be discussed in more detail in the chapters to follow, the majority of primary care physicians were women, whereas they were under-represented in higher levels of care, amongst managerial positions and amongst research posts.

Indeed, women's average pay at the same educational level as men was lower.(Rimashevskaya 1991:85; 92) So, it is not simply to the level of education that we must look, but also to the type of education. After leaving school, girls and boys tended to go to different types of colleges with most of the professional technical colleges , which are orientated towards providing skilled workers for the priority areas of industry, being male dominated.(Rimashevskaya 1991:87) As Rimashevskaya points out, "this suggests that women, while on the whole have roughly the same educational level as men, nonetheless are somewhat more poorly prepared from a skills and occupational standpoint: the relative lack of a specialised occupational education puts them in a relatively lower job position from the very beginning of their work activity"(Rimashevskaya 1988: 61).

These patterns of occupational segregation also resulted in women receiving lower pay than men. Overall women were paid on average one third less than men (McAuley 1981: 21). For example, male machine building workers in 1970 earned on average 149.1 rubles per month compared to 108.1 for women (McAuley 1981: 25). There were also differences between sectors. Engineers starting work in the construction industry would earn 100 rubles per month, but only 80 if they chose to work in the food and light industries (Chapman 1978: 230). While in health care the average wage in 1975 was 102.3 rubles per month in construction it was 176.8 (Lapidus 1978: 192). In relation to vertical segregation therefore two processes were apparent. Women and men were recruited differentialy into vertically ordered categories in the same occupation, for example in teaching. Secondly, women's careers were less dynamic than men's.

In agriculture, the patterns of vertical and horizontal segregation were replicated. As in industry, women were concentrated in unskilled manual work while the sphere of mechanised work was a male privilege. The persistence of the sexual division of labour in agriculture was also apparent within managerial positions. In 1980 only 1.9% of chairpersons on collective farms were women.[1]

It is not sufficient to simply describe these processes however. It is the purpose of this thesis also to seek an explanation for them. There are several forms of explanation for the patterns of occupational segregation in the capitalist mode of production which serve as a starting point. Firstly, supply side explanations which tend to focus on the qualities of female labour. The most prevalent of these is the

[1] For a detailed examination of women agricultural workers see Bridger 1987.

human capital approach. Human capital refers to the abilities that people bring to an employer including training, qualifications and experience. It assumes that people are paid according to their value based on their human capital. Women's work in the home makes it harder for them to acquire the same level of human capital as men. Myrdal and Klein point to difficulties for women in combining the roles of mother and worker (Myrdal and Klein 1956). This is a functionalist approach assuming a perfect labour market and rational consensual decision making in the family, as to the best way to divide responsibilities between men and women, inevitably men being involved in the labour market and women in the home.

From a different perspective, Hakim argues that female work patterns "should be regarded as a reflection of women's own preferences and choices" (Hakim 1991). In particular, while some women are career orientated, others are homemakers and rather than seeing all women as subjected to structural constraints, women's choices should be seen as freely made, that is, they should be regarded as 'self made women'.

However there are critics of such accounts. Empirically there is little evidence that workers' characters accounted for more than one fifth of the earning gap between men and women (Mincer and Polachek 1974). But on a more theoretical level, these assumptions about the labour market and about the nature of women's decisions are also flawed. Women's choices are shaped by the structures of gender inequality within which they live and are not necessarily the result of a consensual arrangement. Moreover the idea of skill upon which human capital rests has been questioned. Skill must be understood as socially constructed, that is, the skill rating attributed to any job can be

understood as not simply a matter of technology, but also of social relations and power struggles between different groups (Cockburn 1983; Game and Pringle 1983).

Secondly there are demand side explanations. In contrast to the supply side explanations these tend to argue that the explanation for occupational segregation lies not in the character of women's labour but in the nature of the demand for labour. The idea of the dual labour market was first proposed by Barron and Norris in 1976. They argued that the labour market was split into primary and secondary sectors (Barron and Norris 1976). Primary sector jobs are characterised by greater stability, higher pay and better chances for promotion than secondary sector jobs. Others argued that the dualist characterisation is too simplistic and that the labour market is better described as segmented. (Wilkinson 1981). Amongst these approaches there is a division between those who argue that segmentation is based on skill (Doeringer and Piore 1971) and those who see it as based on a power struggle between groups (Rubery 1978).

Feminist analyses are critical of this approach for failing adequately to account for gender inequality in the workplace. For example the Cambridge group tend to assume that women's worse position within the workforce relates solely to their position in the family (Craig et al. 1982). Walby argues however, that the position of women in the family may influence women's decisions but does not explain the patterns of gender inequality in the workplace (Walby 1986). It is argued that the exclusion of women from certain occupations is often the result of a power struggle involving male workers (Cockburn 1983) or professionals (Witz 1992).

This is by no means a comprehensive list, but gives an indication of the main debates in relation to occupational segregation under capitalism. While the details of the analyses would differ when applied to a different social system, that is to Soviet Russia, the broad questions addressed remain the same. How significant are social roles, particularly associated with the family, in the explanation? To what extent can gender divisions in the workplace be explained in relation to women and men's individual decisions or to structural factors?

Moreover what emerges from this brief description is that, as Crompton notes, none of the explanations are sufficient on their own. Rather, they represent factors in the explanation of occupational segregation and can be understood as "particular instances of more general theories which seek to explain the location of individuals in the positional structure" (Crompton and Sanderson 1990: 27). What is required is what Rubery and Fagan call a more 'holistic' approach to the analysis of occupational segregation(Rubery and Fagan 1995). It is also notable that Rubery argues that this would also provide a better basis for cross-cultural comparisons. "We need to understand the way in which the system of industrial, labour market and family organisation interrelate and the role of the society's political and social values in maintaining these relationships before we could expect to make sense of the differences between countries in the position of women (Rubery 1988).

This thesis aims to provide a holistic approach which will contribute to an understanding of gender inequality in Soviet Russia and specifically of patterns of occupational segregation. In order to do so, it is essential to establish a theoretical framework. In Chapter One it will

be shown that the existing literature on gender inequality in Soviet Russia fails fully to offer a theoretical understanding of the gendered nature of the Soviet social system.

In Chapter Two a new approach will be discussed. It will be argued that gender inequality in Soviet Russia can best be understood in relation to social reproduction. Social reproduction refers to the strategy of the state or central elite to reproduce the relations of production that maintain its position. Women in Russia hold a particularly significant position in relation to this process. Firstly in terms of biological reproduction, women were regulated as the reproducers of the nation and of the labour force. At the same time however, they were also direct producers within the labour force in both quantitative terms and in relation to their place in the labour hierarchy. These two aspects of womens' lives were often contradictory for the central elite and resulted in attempts to control women's labour force participation and biological reproduction primarily through protective legislation. The choices women made with respect to their family and work were therefore shaped to some degree by state policy. In turn as will be discussed, women's choices acted to shape future policies.

Chapters 3-5 focus specifically on women in the medical profession. The reasons for choosing female physicians as a case study are threefold. Firstly, since the 1930s the proportion of female doctors has remained constant at around 65-70%. It is clear therefore that this was a predominantly female profession and as such will serve to give an insight into the experiences of women working within a feminised occupational group. In particular, attention can be paid to questions

concerning the forms of horizontal and vertical segregation within medicine, the explanations for them and the attitudes of women to such patterns.

Secondly, very little research has been carried out in this area. Research into the health care system and the health labour force tends only to give passing comment to the fact that the majority of doctors in the Soviet Union were women. Little attempt is made to investigate the experiences of female doctors or the patterns of occupational segregation characteristic of the health care system, or to place these in the context of a wider understanding of gender inequality in Russia. Moreover, research into occupational segregation in Russia has tended either to present a very general empirical overview or to focus more on industrial workers than those within the service sector.[2] While the service sector was underdeveloped, it was nevertheless an important site for female employment, not least so in health care. A study of this occupational group will serve to highlight some of the issues facing women in the service sector, but will also highlight the issues facing 'professional' women.

This relates to the third reason for choosing female doctors as a case study. The medical profession in the west is a prestigious occupational group and it is in terms of forms of occupational closure, that is, the attempts by various interested parties including the state and the medical associations, that women's involvement in this profession has been studied in the west.[3] However, the situation within the

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[2] For example see Sacks 1976; McAuley 1981; Bowers 1996; Monousova 1996.
[3] For example see Witz 1992.

medical profession in Soviet Russia was very different. It is in fact questionable whether it could even be called a profession, given that the period immediately following the 1917 revolution saw the systematic deprofessionalisation of this group.

The study of female doctors therefore draws attention to the dangers of making assumptions about the patterns of gender inequality outwith the context within which they operate. While at first glance the predominance of women in the Russian medical profession may seem impressive, based on our perceptions of medicine as a high prestige occupation, when understood within the Soviet system, it becomes clear that the medical profession was low in both status and remuneration and that within it there operated a hierarchy with women situated at the lower end.

Finally, the health labour force and doctors in particular, are a useful case study to illuminate aspects of the theoretical framework which will be discussed in Chapter Two. There are two levels to this. Doctors, as state employees, are potentially important actors in the attempt by the central elite to regulate women's reproduction and labour and so to manage the contradiction between production and reproduction. But at another level many doctors are themselves women and as such are both subject to and react to state policies on the 'women question' and experience the forms and consequences of occupational segregation first hand.

In Chapter Three, the social transformation of the medical profession during the formative years of the Soviet system will be discussed. The change in the status, social character and role of the medical

profession will be examined in relation to the economic and control strategies of the central elite and policies towards women's labour force participation. It will be shown that the two processes occurred simultaneously which contribute to an understanding of the nature of the medical profession as low paid, low prestige and predominantly female - deprofessionalisation, feminisation.

In Chapter Four, the relationship between the medical profession and the state will be discussed. Female doctors were key employees for the state, as producers of a healthy workforce and so a healthy nation and as central to the regulation of reproduction. Yet, the medical labour force received low pay in relation to the economy as a whole and women within medicine received lower pay than their male counterparts. In addition to their low pay, women in medicine worked in very difficult and often dangerous conditions. This was contrary to the image of service sector work as more suitable to women and as less problematic for biological reproduction. It will be argued that the low pay and poor working conditions of Soviet doctors was not only contradictory for the women involved but also fostered low morale within the poorly equipped workforce. In turn this was problematic for the ability of doctors to perform their responsibilities and so was problematic for the system as a whole. The contradictory attitude of the state towards doctors in Russia, arising in part from priorities of the system and in part from the gendered nature of the health labour force, has been central to the collapse of the health care system, the ramifications of which are being witnessed today.

In Chapter Five, the choices made by women doctors will be examined in more detail. This chapter will examine the reasons given by women for choosing medicine as a career, the reasons for their choice of specialisation and the experiences they have in terms of career opportunities and prospects. In this way a fuller picture will emerge of the processes of horizontal and vertical segregation within medicine.

In the final two chapters, I will address the impact of the reforms that began with Perestroika in the mid 1980s on women's work in Russia and specifically on the work of the medical profession. In Chapter 6, changes in the nature of women's work during Perestroika 1986-91 will be examined with specific reference made to the work of female doctors. During this period, women were increasingly expected to be the flexible workforce and were encouraged to move out of industry and into service sector work, or to 'return to the home'. It was expected in this way that the demographic and social difficulties that were discussed openly under glasnost' could be resolved and that the economic priorities of the reforms, in relation to the size and distribution of the workforce, met. It is within this context that the reforms directed at the work of doctors should be understood. It will be argued that the critique of doctors' work which was central to the health care reforms, was on the one hand a reaction to the discrepancy between the expected role of health care in the reform process and the funding it was to receive. On the other hand, it must also be understood in relation to the concern over women's labour force participation. Women's work in medicine therefore highlights many of the contradictions posed by female paid labour during this period.

In Chapter 7, the impact of the post-communist reforms on women in medicine will be examined. In many respects, while the current economic and political reforms are radically changing the nature of Russian society, the policies towards women remain bound within the traditional Soviet policy agenda. Similarly the contradictory position of women in medicine within the Soviet system remains intact. Mounting social problems have raised the importance of quality health care provision, and so of the work of doctors, yet their own position is increasingly insecure. The period of transition is marked by a shift in responsibility away from the state to the individual which has implications for women in medicine, both as doctors and as women.

A note on method

The material for the case study was gathered in two periods from June to August 1995 and from May to July 1996 in Moscow and Voronezh. The interviews were carried out in Voronezh. Semi structured interviews were carried out with fifteen female doctors in Voronezh and one in Moscow and with the male head of the medical institute in Voronezh. Questionnaires were given to a further twenty four female doctors.[4] While given time and financial restraints it was impossible to achieve a representative sample, taking into account differneces in specialities, place of work, age and so on, attempts were made through snowballing to gain access to a wide range of doctors. The doctors in the study came from a range of specialities, were aged from twenty four to sevety four, and worked in both clinics and hospitals. The questions concentrated on providing information on

[4] See Appendix I for details of the doctors interviewed and Appendix II for the interview schedule.

the explanations women gave for their choice of profession and their career within that profession; the role and status of the medical profession; the impact that the reforms have had on their lives; and their attitudes towards the position of women in Russia.

A qualitative method was used in this study, in part because of the difficulty in gaining contact with a representative sample of doctors suitable for a quantitative approach. Moreover, it was felt that a qualitative approach could offer more of an insight from the insiders' perspective, that is, from the point of view of the female doctor in Russia. As Sherman and Webb argue, "qualitative research implies a direct concern with experience as it is 'lived' or 'felt' or 'undergone'....Qualitative research then, has the aim of understanding experience as nearly as possible as its participants feel it or live it" (Sherman and Webb 1988: 7).

While it may be the case, and of concern to quantitative analysts, that the sample of doctors interviewed may not be representative of the medical profession in Russia, a qualitative approach, through an in-depth examination of a smaller number of subjects can offer more insight than a more limited examination using larger numbers. Moreover, the concern for reliability and representativeness usually stems from questions over generalisability of the findings. In qualitative research, questions of generalisability are not necessarily of the same kind. Rather than being based on a concern over representative sampling and the statistical significance of the findings, qualitative research can be based on the idea of conceptual generalisability. Readers will be offered an insight into a particular

population which they can then add to their own knowledge of similar groups.

This is particularly true in relation to the use of a case study group. The in depth examination of a particular occupational group is particularly applicable as the research method for the purposes of this thesis. While there has been criticism of this method on the basis that the 'typicality' of the case and the generalisability of the findings can often be called into question. However, as Mitchell notes, case studies should be judged in terms of the "validity of the analysis rather than the representativeness of the events" (Mitchell 1983). The case study method was chosen for this thesis firstly because an examination of occupational segregation within the medical profession is an "apt illustration" of wider patterns of occupational segregation in Soviet Russia. Secondly, the case study method, by offering a holistic approach, offer greater insight into causal explanations, that is the material derived from the case study can be used to infer theoretical principles (Crompton and Sanderson 1990: 21).

1

GENDER INEQUALITY IN SOVIET RUSSIA : A LITERATURE REVIEW

In this chapter, the ways in which gender inequality in Soviet Russia has been addressed by both Soviet and western analysts will be discussed. Amongst Soviet analysts, women's position was examined primarily in relation to paid labour. Levels of female labour force participation, the conditions within which women worked and the disadvantages they faced in terms of promotion were discussed in relation to two of the major concerns of Soviet sociology : first the Soviet orthodox view that the emancipation of women depended on their involvement in paid labour; and second the concern with demographic problems of populations' growth and reproduction of the labour force that characterised much of Soviet history. Work in these areas was relatively critical, particularly from the 1960s, but was nevertheless limited by political constraints.

Western sources were far more critical but were subject to different constraints, most notably the difficulty in accessing information and carrying out field work. There were also more subtle political constraints given the highly politicised nature of the subject matter in the context of the Cold War. It will be shown that while both Soviet and western analysts offer interesting and informative accounts of gender inequality in Soviet Russia, there are some factors which need to be addressed further, particularly in relation to the research on

women's paid labour and the general empirical direction of most of this analysis. There is also a particular absence of research into gender inequality within the health sector, both from analysts who focus on gender inequality and from those who examine the organisation of the Soviet health service.

Soviet Analyses : Solving the 'Women Question'.

Official Soviet writing on women drew heavily on Engels. He argued that both the abolition of private property and the public control of production were necessary preconditions for women's emancipation (Engels 1985). As a result of such changes, he thought, it would be possible both to reintroduce women into the sphere of social production and to socialise the tasks of child-care and domestic work, thus making their position in society equal to that of men.

After the introduction of state planning and the collectivisation of agriculture, it was argued that both of Engels' preconditions had been achieved in Soviet society. Therefore, it was argued, there was no longer any impediment to womens' full social equality with men. During the period of 'socialism' there would still be some inequalities, but these would gradually be overcome along with the eradication of other remaining social inequalities, as part of the gradual building of communism. Meanwhile, although full gender equality would take a long time to achieve, women would enjoy equal rights in law with men and, in principle, all positions and jobs would be open to them.

During the mid 1960s, the idea that the 'women question' had been solved was rejected and wider and more critical discussion began to

take place. There were two key factors which brought about this more critical approach and which led to widespread discussions concerning the need to create the conditions for women to combine optimally their functions as mothers and as workers - the declining birth rate and the widespread labour shortage. The discussions among Soviet academics covered three main areas.

Firstly, women's labour force participation. While the fact of women's participation in the labour force was rarely condemned per se, many saw the high participation rates as neither natural nor desirable. For example, Sonin explained the high levels of female employment in relation to the huge demand for labour during earlier decades. He argued that the transition to a more intensive strategy of development would reduce the need for women within the labour force. "The rise in female labour activity should be viewed in close connection with the rise in demand for manpower in the economy, which affects the involvement of women in the sphere of social labour and their distribution within that sphere". He did not advocate a withdrawal of women from the labour force but their redistribution into work more suited to the female form, in particular in the service industry. "Work in the service branches usually requires a personal approach, neatness and precision, and relatively little physical labour. This created indubitable advantages for female labour" (Sonin 1982 :26, 28).

The extent of female labour force participation was also linked by many academics to economic need. It was believed that if the right conditions were created, in which men's wages would support the

family, many women would no longer feel the need to work outside the home.

"The supply of female labour is more elastic than that of males. It depends to a greater degree on the extent to which a family's requirements are satisfied by the earnings of the head of the family and by income from public consumption funds. The lower the level at which these requirements are being satisfied, the more the family needs earnings from its women" (Guseinov and Korchagin 1971).

Nevertheless the high level of female labour force participation was condemned in terms of the negative consequences it had for the birth rate, and the impact on the family. With increasing alarm over the falling birth rate, from the 1960s, Soviet commentators began to place more emphasis on the need to encourage women to fulfil their social duty as mothers.

"While noting that mass involvement of women in social production is a progressive and legitimate development contributing to their economic and social independence, we must also bear in mind that women perform another social function : motherhood. This aspect of their life is no less important for the development of society than their participation in the production of material and cultural values" (Kiseleva 1982: 286).

There was great concern that the common practice for families to have only one child would lead to negative population growth. In line with this concern it was argued that single children faced greater difficulties and were less likely to develop the qualities required of Soviet citizens. It was argued that being the centre of attention, the child will become egocentric with the "mentality of a parasite" and underdeveloped characteristics such as "collectivism, independence and responsibility for a task". (Novikova, Yazykova, Yankova 1978: 68). The solution for this lay for many in the reduction of women employed and even in restrictions on abortions (Kiseleva 1982).

Women's labour force participation was also seen to have negative consequences for family stability resulting in high divorce rates and a higher average age for marriage. Comparisons with the Central Asian republics with lower rates of female labour force participation and lower divorce rates led many to conclude that divorce and female employment were directly related. In turn this again was a cause of concern in relation to the falling birth rate (Korolev 1978).

The main concerns therefore in relation to levels of female employment were voiced in terms of the impact on society, in particular on the birth rate. However, there was some discussion of the burden of women's 'dual role' as workers and as domestic labourers on women themselves. A series of time budget studies were carried out which highlighted that women did 2-3 times more housework than men. The means by which it was thought this gap could be reduced varied, from investing in the production of mechanised time saving devices eg. washing machines, to the socialisation of household chores and finally to the more even distribution of tasks between men and women. "There can be no doubt that more extensive involvement of men in work around the home will yield positive results. Facts disprove the notion that men are ill adapted to this kind of work : men in fact make the best cooks in the world"(Novikova and Kutyrev 1978). Nevertheless domestic work was generally seen as a female domain and attention was focussed on how to minimise the problems it caused for women rather than questioning how to bring about a more equal distribution of responsibilities between men and women in the household.

Secondly, there was considerable discussion amongst Soviet analysts in relation to the distribution of the female labour force. The explanations for these patterns often focused on inherent differences between men and women, for example, it was argued "the psycho-physiological make-up of women permits them to carry out certain kinds of work more successfully than men, as for example, work demanding attention, accuracy and precision" (Kotliar and Shlemin 1974). Moreover, women were believed, by some, to lack the mental capacities to occupy positions of authority (Literaturnaia Gazeta 22/9/77).

Others emphasised more social factors involved, in particular the requirement for continuing education in order to raise skill levels and so occupational mobility and the disadvantaged position women's family responsibilities placed them in, in this respect (Shishkin 1976). The various explanations for the occupational segregation of women though had a common concern - how to minimise the dangers that the hazardous conditions which characterise some occupations pose to women (Sheputilina 1982).

Thirdly attention was turned to the conditions under which women were employed and the extent to which the legislation designed to protect them was ineffectual. Firstly, the list of occupations that were deemed too hazardous to women's health and so from which women were barred was criticised for being outdated. It was pointed out that since its adoption in 1932, new occupations had emerged that needed to be considered and the character of old occupations had changed (Novikova and Kutyrev 1978). There was also discussion as to whether a 'women only' list of trades should be introduced. Most

agreed that this would have further segregated women and instead stricter guide-lines for managers should be made available. "What managers need are guide-lines for worker screening , selection and placement on a scientific basis, taking into account the specific features of the female organism"(Novikova and Kutyrev 1978).

Soviet commentators found the reasons for the failure to effect measures to remove the appalling working conditions to be two fold. Firstly, many women were keen to work in what were regarded as the worst jobs or on night shifts since this paid more than regular work. "A significant proportion of women are still not interested in restrictions on the use of their labour, since heavy and harmful job slots usually pay better. In the majority of them, annual holidays are longer, the retirement age is lower and nutritious foods are provided"(Shishkin 1976: 116). Secondly, it was argued that managers had a material interest in continuing the employment of women in unskilled manual work. For example, "a production line was developed for a brick works that made it possible to employ thirty women instead of 300. It was not put into operation however because it is more profitable to employ women workers of low skills who are socially less mobile than men and whose demands regarding labour conditions are lower"(Novikova and Kutyrev 1978).

Significantly in this respect, more importance was placed by commentators on the economics of the enterprise than on notions of discrimination or prejudice. Novikova and Kutyrev noted that,

"Mechanisation and automation, as prime requisites for getting women out of hard physical jobs, encounter some opposition. The mechanism of this opposition is, of course, not due to sex differences. The problem obviously lies in the general

replacement of manual labour by machines and the introduction of the achievements of scientific and technological progress into industry as a whole. Thus it is not a 'woman's' problem or, more exactly, not only a 'woman's' problem" (Novikova and Kutyrev 1978).

It can be seen therefore that a wideranging critical discussion began to emerge in the 1960s among Soviet academics. The articles and books refered to here are just a few of the many that sought to address, what was commonly regarded as the 'women question'. This literature provides a wealth of information, in particular the attention paid not only to patterns of female employment, but also to the ways in which this related to wider demographic policies and economic strategies.

However, the Soviet research is necessarily limited by the boundaries of acceptable criticism beyond which it was dangerous for academics to step in the public arena. In this respect all Soviet academics were heavily influenced by the Party line which, in this case, was concerned with creating the conditions to allow women to combine their roles as mothers, housewives and workers. This provided the general framework within which any issues relating to women were to be dealt. There was no question of there being real conflict or problematic relations between men and women and many issues were never investigated, for example domestic violence or relations between male and female workers. Similarly, no conflict was said to exist between different classes and as such the depth of the investigation into such issues as rationalisation of production and the way in which gender inequality was integrated into class conflict, was limited. Given the absence of such restrictions, it fell to western Sovietologists to provide a more rigorous analysis of the position of women in the Soviet Union.

Western Analyses of Gender Inequality in Soviet Russia

The Western research into gender inequality in Soviet Russia contributed significantly to the understanding of the experience of Russian women. In these accounts, the position of women was characterised primarily by the dual burden, i.e. women's responsibility for paid labour and domestic labour. Thus it was shown that women in Russia did not achieve the equality that was once claimed and may even have been in a worse position than their counterparts in the West. They not only had to work long hours in often very tiring physically demanding occupations but also had to work in the home to care for husbands, and children. This dual burden was presented as being oppressive for women for several reasons.

Firstly, women's responsibility in the domestic sphere was regarded as problematic because their work in this area was undervalued. Corrin refers to "a climate where domestic work and child care is looked down on as a secondary occupation, or not 'real' work". This undervaluing of any work outside paid employment in turn meant that "low priority was accorded to recognition of women's heavy domestic responsibilities and to the equalising of opportunities and responsibilities among all adults"(Corrin 1992).

Secondly, the dual burden was problematic for women by limiting their opportunities for advancement in paid labour. "The conflict between work and the family has had important consequences for the productivity, fertility and self realisation of women, especially in the more demanding occupations with higher levels of responsibility" (Heitlinger 1979: 79). As Corrin noted, "in social terms, the consequences include the dampening of women's creative input by

illness and tiredness precluding involvement in community or national affairs" (Corrin 1992:18). There was general agreement therefore that women's family responsibilities restricted their options for career advancement. "The double burden placed on women by the combination of full-time employment and heavy family responsibility serves to free men to pursue educational and occupational advancement while restricting the mobility of women" (Lapidus 1978:277).

Thirdly, the dual burden had psychological consequences for women. As Corrin pointed out, "women were regarded as primarily responsible for creating a good home environment in terms of childcare, family support and domestic work, regardless of their public duties in terms of paid employment. Failure to achieve certain family goals is seen as women's failure, women's guilt". So the pressures of the dual burden on women could result in the development of what Markus refers to as a 'bad conscience'. "In the case where she is trying to fulfil both functions, she may have a sense of bad conscience about not being a good mother (when she is at work) and not being a good worker (when she is at home, for example with an ill child)" (Corrin 1990).

So in broad terms, the dual burden was oppressive for women because their work in the domestic sphere was regarded as secondary to that of paid labour, but at the same time, it created the conditions within which women were unable to advance in the 'real' world. In addition the pressures on women to live up to the expectations of the 'superwoman' image were psychologically oppressive. There are

several factors which these accounts drew upon to explain the dual burden.

Firstly the nature of Soviet industrial policy was argued to be important to women's dual burden. Heitlinger argued that "an understanding of the history of women's liberation in the Soviet Union requires knowledge of the prevailing strategy for industrial development, which had contradictory implications for sex equality" (Heitlinger 1979:79). There were two ways in which industrial policy was seen to have contributed to the establishment of the dual burden for women. Firstly, in terms of the impact it had on the proposed socialisation of domestic services. Lapidus argued that any revolutionary intentions or deeds were rendered obsolete by conditions of war and the need to modernise a largely rural economy. In the face of such adversities, the enhancement of gender equality was pushed down the line of policy and investment priorities. As a result, the theoretical commitment to socialised child care and domestic services was not transformed into practical deeds.

The extent to which this was justified or excused depended, to a large extent on the political position of the researcher. Heitlinger was quite optimistic about the future, and argued that men and women's roles were growing more equal. " In the not too distant future one can envisage a situation in the USSR in which both parties will be more equally involved in domestic work" (Heitlinger 1979:96). Lapidus on the other hand was more sceptical arguing that there were no attempts to alter significantly the division of labour between men and women. "The central thrust of Soviet policy has been to superimpose new obligations of work and citizenship on more traditional

definitions of femininity and to reshape to some extent the boundaries between public and family responsibilities - in short to facilitate women's performance of both roles - rather than to redefine both male and female roles" (Lapidus 1978:344).

The second aspect of industrial strategy regarded as significant for an understanding of the dual burden was the labour intensive nature of development. This meant that all labour reserves were to be tapped to fill the ever increasing demand for labour. In 1929, 27% of the workforce were women but by 1945 this had risen to 55.3% (Peers 1985:118). So women workers were regarded as central element in the economic development of Russia. As Lapidus pointed out, women were the "instruments and shock absorbers of a particular pattern of political, economic and social modernisation" (Lapidus 1978: 96). Similarly Peers noted that while women had been engaged in paid labour prior to the industrialisation drive, the "drives to develop the economy, with increasingly unrealistic targets for industrial expansion, meant that women were needed to enter the workforce in their hordes and to participate in this great effort....women's employment outside the home took on a new magnitude"(Peers 1985: 125-6).

Secondly the dual burden was explained in relation to demographic issues. Peers noted that "the Soviet demographic crisis and the difficulties confronting the leadership in alleviating it are an eloquent expression of the contradictory nature of women's position in the Soviet Union". She pointed to the way in which women were vital to the Soviet leadership and to the economy, not only as workers but as childbearers, most notably in the context of the labour shortage.

"The impressive rate of economic development achieved since the onset of Soviet industrialisation have, in large measure, been made possible by the abundance of potential labour resources....But Soviet economic planners and administrators are today finding this vital commodity in increasingly short supply" (Peers 1985: 116). The shortage of labour was in part a result of the depletion of the labour pools traditionally drawn upon, that is, women and peasants. But it was also a result of the fall in the birth rate and it was to this that attention was turned.

Heitlinger looked to Marxist theory to provide an explanation for women's dual burden. She referred to the dual aspects of the reproduction of the labour force that matched women's dual burden - daily maintenance through domestic labour and generational reproduction. Domestic labour in the home and in public services was regarded as unproductive because it did not involve the "embodiment of labour in a material product". As a result, little investment was allocated to this sphere, domestic labour remained predominantly within the home and women's dual burden was established. She concluded that "this relationship between the social sphere of 'work' and the private sphere of 'home' is the ultimate cause of women's oppressive labour conditions" (Heitlinger 1979:25, 28).

Secondly, Heitlinger pointed to the importance of generational reproduction for the smooth running of the economy. The strategies for economic growth in state socialist societies were based on "quantitative rather than qualitative improvement in labour productivity," which "required a substantial increase in the

employment of women - the reserve army of labour. This in turn has led, among other outcomes, to the exhaustion of the labour supply and a rapid decline in fertility" (Heitlinger 1979: 29). As a result, as Heitlinger argued, "the production of children has a paradoxical effect on the position of women in state socialist countries" arising from "the contradiction between the private nature and collective consequences of biological reproduction". The family, as the centre for child rearing is a "closed unit" and yet it holds the key to the future in terms of the children it produces, so the state constantly interfered in it. Refering to Eastern Europe as a whole Heitlinger noted that "policy makers in these societies are therefore faced with the tasks of finding material, psychological and emotional incentives that will persuade individual families to produce more children" (Heitlinger 1979: 30,29).

The third factor given by the dual burden approaches to explain the patterns of gender inequality was the conceptualisation of the 'women question' in Marxist theory. Lapidus argued that, "it left unclear the precise relationship of sex to class", "nor did it explain what changes the family would undergo in the future". She argued that in Engels' work, "the connection between production and reproduction remained ambiguous...and the question of how changes in institutional structure would alter psychological and cultural patterns underlying male-female relations was never explicitly addressed" (Lapidus 1978: 43). Corrin noted the practical implications of these problems within the Marxist treatment of the 'women question', for the failure of Bolshevik policies. "The importance of their analyses is that with the socialisation of housework and childcare tasks, the economic benefits of women's participation in the public sphere were

overestimated or rather, the high costs (economic and psychological) of making available public utilities for meals, laundry and child care, were radically underestimated" (Corrin 1990).

The inadequacies or shortsightedness of Marxist theory was therefore seen as an important element in explaining why women suffered the dual burden. Crucial issues such as the role of the family were not adequately theorised and as a result, such issues were treated as of secondary importance. It was argued that Marxist theory not only shaped policy towards women but also accounted, in part, for its failure (Molyneux 1981).

This focus on the importance of Marxist theory for an understanding of the dual burden was part of the wider emphasis on the role of ideology and the perceptions of male and female roles. Buckley noted that Marxist ideas concerning the women question remained "at the core of Soviet ideology" (Buckley 1988:224). Yet she pointed out that Soviet ideology on women is both inconsistent and often completely divorced from reality. A good example of this is the justification given for abortion legislation. In 1936 the criminalisation of abortion was justified in terms of the stable conditions which socialism offered women and so removed the need for abortions. In 1955 the benefits of living in a socialist society were again cited as a justification for a policy change but this time in terms of the high cultural levels which allowed abortion to be legalised. McAndrew also made this point in an article on Soviet women's magazines. She argued that "in the Soviet case, women's magazines are part of a complex ideological structure confronting women with the image of themselves as the

Super Achiever, the New Soviet woman, which is at some distance from the reality of most women's lives" (McAndrew 1985: 112).

Corrin noted that not only are there distinct images of what is masculine and what is feminine, but that feminine attributes were presented as less important. "Traditional 'masculine' values remain prized and prioritised in terms of aggression, competitiveness and powerfulness, whilst so-called 'feminine' values - consideration, cooperation and patience - are consciously undervalued" (Corrin 1990). For Corrin such images were important since "attitudes have a big role to play in changing certain conditions for women," for instance, "the discrimination women suffer in terms of inequality in pay, promotion prospects,training opportunities and working conditions within paid employment is linked to the fact that they are viewed initially as 'homemakers' in the broadest sense" (Corrin 1992:17).

The final factor considered in explaining the dual burden was the patterns of political authority characteristic of the Soviet system. Lapidus argued that the totalitarian nature of political control "precluded the emergence of a genuine civic culture that would permit the political participation of men and women alike as citizens rather than subjects" (Lapidus 1979: 339). As Corrin pointed out, "it is hardly surprising that women's groups did not form or survive during this bleak period" and as a result women were unable to unite as a group or to fight against the oppressions that resulted from the dual burden (Corrin 1992:19).

There were a range of factors therefore offered as an explanation of the dual burden for women. The western analyses recognised the importance of economic development, of demographics and of ideology in contributing to the patterns of gender inequality in Soviet Russia. Nevertheless while such accounts offered an invaluable insight into the position of women in the Soviet Union and other Eastern European countries, there are some aspects of their analysis which need to be developed further.

1. Women's Paid Labour

Firstly there are few studies that look explicitly at women workers and occupational segregation in Soviet Russia.[1] Rather, contained within the idea that the dual burden was oppressive for women because it limited opportunities in paid labour, is the assumption that family responsibilities created a situation in which women had neither the time nor the energy to strive for promotion. Their domestic role precluded them from gaining the necessary skills to be able to succeed in the workforce and so to a large extent can explain the patterns of occupational segregation.

However, while it is not denied that women have responsibilities in the domestic sphere that men do not, this is not a sufficient explanation of why women were segregated and lower paid within the labour force. Walby posed this question in relation to accounts of women's position in employment in Britain and I think her criticisms are valid for the literature on Soviet women.

[1] For an account of the position of women workers in pre revolutionary Russia see Glickman 1984 and Engel 1994.

> "If our analysis is restricted to the current moment then it will look, superficially, as if the family structures a woman's employment decisions. However, while this may be critical for an understanding of immediate decision making, it does not provide an explanation of the structures which constrain a woman's 'choice'. It does not explain why women do not have the same access as men to better jobs. It is an explanation of these circumstances that I seek, not a description of how women negotiate them" (Walby 1990:57).

Those accounts that did focus specifically on women's work were often very empirical. McAuley tried to measure objectively the extent of different forms of occupational segregation - horizontal, vertical and administrative (McAuley 1981). He argued that all forms were present and became more extensive as the Soviet system developed. His account was primarily empirical though he did offer some explanations to account for gender inequality in paid labour. He noted that protective legislation was an important factor in understanding occupational segregation since it limits women's opportunities, particularly in relation to training. But he pointed out that women themselves chose to avoid certain types of work and as such, occupational segregation "reflects self selection by girls and women themselves" (McAuley 1981 : 207). Women's dual burden was also significant in this respect. McAuley argued that it put a physical strain on women and so limited their ability within the workplace. In addition, domestic responsibilities detracted from women's commitment to their work (McAuley 1981: 208). Moses noted similar patterns of and reasons for occupational segregation as McAuley, but also considered the role of direct and indirect discrimination. He noted that women workers, particularly in 'male' sectors were subjected to sexist attitudes or abuse and that the discussion of such matters in the press served to reinforce the idea of women as weaker and in need of protection (Moses 1978: 26-30).

Both Moses and McAuley concluded that women did not have equality within the workplace in Soviet Russia in relation to pay and opportunities. While agreeing that occupational segregation was characteristic of the Soviet system, Sacks took a more positive view and argued that "different does not necessarily mean unequal and measures of dissimilarity may conceal very significant changes in the structure of the labour force that have had positive consequences for women" (Sacks 1976: 166). In particular he argued that women made advances into what were regarded as male occupations such as medicine. McAuley also pointed to a difference between women's opportunities in non manual and manual work. He argued that "among white collar workers and in professional occupations...women have made more notable gains; although such occupations as nursing and secretarial work are exclusively female in the USSR...women have penetrated many male occupational preserves" (McAuley 1981: 207).

However the assumption that women had made gains by entering professions such as medicine highlights the limited nature of their understanding of the processes of occupational segregation. It will be shown in subsequent chapters that women's entrance into the medical profession was accompanied by its systematic deprofessionalisation and as such women in Soviet Russia did not succeed in entering a prestigious male dominated field, but were recruited to fill places in a low status and low paid occupation. Moreover, within the medical profession, there existed a gendered hierarchy with women predominating in the least well paid and least prestigious specialisations.

Within the literature on the Soviet health service there was also very little attention paid to the gendered nature of the medical labour force. Knaus presented an interesting account of women's entrance into the medical profession in pre-revolutionary Russia, but his account was narrative rather than seeking to explain the processes he described (Knaus 1981). In addressing the question of the feminisation of medicine, Ryan argued that the low pay allocated to the medical profession meant that women were more likely to be interested in that work than men. Moreover, the lower status of medical institutes meant that women were able to gain entry more easily to them than to other institutes of higher education. In relation to vertical segregation, he argued that women had fewer opportunities than men to advance in their careers (Ryan 1989: 37-48). Similarly, Navarro argued that medicine received low priority in the Soviet development strategy and in a society in which "men were assumed to be more productive", women entered the low priority sectors. He also noted that women's role in the family meant that they were believed to be, by nature, better at caring work (Navarro 1977:75-80).

However their analysis of the gender hierarchy within medicine was incidental rather than a fundamental aspect of their work. Their understanding of the process of occupational segregation, as with analysts examining women's paid labour, was limited by their failure to theorise on gender inequality in Soviet Russia. This led to an oversimplification of the problem, as a result of which these studies tell us little about the impact of state policy on women's choices and the expectations of the women entering medicine themselves; and the actual processes of occupational segregation within medicine. Studies of women's paid labour and of the health service are also

limited by their failure to address the attitudes of the women themselves. This was understandable given the difficulties of such research at that time, but nevertheless forced them to make assumptions about women's role in the process of occupational segregation.

The work of Filtzer goes some way towards countering the lack of theorising in the studies described above. For Filtzer, a central aspect of labour relations in the Soviet Union was the partial control by workers over the labour process, but he points out that women were to some extent an exception to this. Filtzer tries to explain the fact that women were ghettoised into two types of work and to incorporate this into his analysis. He noted that women were concentrated in light industry where due to the nature of technology used, women had less control over the pace of work and the use of their work time and in unskilled manual auxiliary work in heavy industry where they had greater control over the labour process.

Filtzer argued that women's work in light industry was a crucial element in determining the nature of Soviet production relations for several reasons. In terms of investment, light industry subsidises investment in heavy industry with profits being taken for the state budget rather than being used to improve the appalling conditions in industries such as textiles, or to invest in new technology. Thus the elite's control over the production of the surplus in light industry compensated for its lack of control in heavy industry and allowed concessions to be made to the male workforce. Women's auxiliary work in heavy industry was also crucial in this respect for by excluding women from skilled work, they were pressured into work

in light industry which, given the terrible working conditions, they would more than likely avoid if there was a better alternative. This segregation of women into unskilled work primarily occurred after WWII when women were displaced from the skilled trades they were involved in during the war and protective legislation was enacted to enforce this. As a result the concentration of women into high intensity work in light industry and unskilled auxiliary work in heavy industry was entrenched.

However, Filtzer also recognised that female labour was contradictory for the elite since their role in auxiliary work involved an enormous waste of resources and acted to perpetuate the backwardness of the Soviet economy. Yet at the same time it provided the elite with the means to partially compensate for their loss of control which is both reflected in and perpetuated by this backwardness.

Filtzer's account goes some way towards providing an understanding of gender inequality in relation to Soviet social relations. His analysis of the relationship between light and heavy industry is also useful in addressing the position of women within the service sector and so within medicine since like light industry, the service sector was peripheral in the economy. Nevertheless, while recognising the complexities and contradictions involved in female labour and the implications of this for the nature of Soviet production relations, Filtzer leaves many questions unanswered.

Within his limited class based framework, he is unable to address why it was women who were subjected to stricter controls and so served the purpose of allowing the elite some control over the

surplus. In addition, he ignores other contradictions inherent in female labour in a class society, that is the problematic relationship between production and reproduction which, as will be discussed in the next chapter, is crucial in understanding the policy of the ruling stratum towards women in work and the resulting gender relations.

Though Filtzer recognises the importance of deskilling in perpetuating gender inequality, he is vague about the processes by which certain occupations were defined as skilled and why these were predominantly occupied by men. It is not enough to note that women were displaced from certain skilled occupations, we must also examine the conflicts and struggles involved in this. Though it must be acknowledged that women were excluded from training to certain skilled occupations, and that their domestic responsibilities in some ways deny them the same access to training, this does not provide an adequate explanation. Skill must be understood not purely in terms of the objective technical requirements, but also as a social and subjective concept. "Far from being an objective economic fact, skill is often an ideological category imposed upon certain types of work by virtue of the sex and power of the workers who perform it"(Phillips and Taylor 1980). Thus the subjectivity of skill and the implications this has for gender inequality at work must be central to the analysis. This can only be done effectively however, within the context of a wider theory of gender inequality which Filtzer fails to offer, Though he gives a superficial examination of these issues, being primarily class based, his analysis of gender inequality lacks clarity and consideration and as a result suffers some conceptual confusions which detract from the empirical detail he provides.

While Filtzer stresses that the position of women in the home and at work mutually determine each other, he is unclear as to the relationship between the two. Primarily Filtzer defines their interrelation in terms of ideology and attitudes. Women's position in the home not only affects the attitudes of male workers and management so that discrimination at work is seen as natural, but also limits their opportunities for acquiring skills to advance their careers. In turn, their subordinate position in work reinforces male prejudice (Filtzer 1992: 178). Filtzer argues that, women's role in domestic labour was "determined by two main factors : the traditional sexual division of labour and the shortages of food, household appliances and communal services endemic to the Soviet economy"(Filtzer 1992: 199). The lack of domestic amenities explains the need for and the burden of domestic labour but it does not explain why it is women who shoulder this burden. Therefore the explanation must lie for Filtzer in the " traditional sexual division of labour", which he implies is rooted in ideology. Women's "role in the family" is crucial in "reproducing a patriarchal ideology"(Filtzer 1992: 205). Furthermore it "has been part of the official ideology and popular attitudes that women despite participating fully in social production should also bear the major responsibility for running the home" (Filtzer 1992: 196). He concludes with the rather vague statement that "the domestic position of women - and women in general- was economically, culturally and politically determined"(Filtzer 1992: 199).

Therefore Filtzer's analysis focuses on a patriarchal ideology which perpetuates male prejudice and results in women's subordination in the home and at work. His analysis is therefore dangerously close to

placing gender inequality in an ideologically based patriarchal system distinct from the mode of production. I think it is unlikely that this is what he intended but he makes no attempt to address the theoretical implications that arise from his work. Instead he assumes the validity of using concepts such as 'patriarchal ideology' as a means to account for gender inequality and in this way avoids the complexities involved. This is a reflection of the limited nature of his analysis which by concentrating completely on production, is unable to fully explain gender inequality.

2. The Significance of Biological Reproduction

Though the 'dual burden' theories did recognise the importance of women's contribution to biological reproduction, they do not fully explain the significance this had for women in the Soviet Union. Both Peers and Heitlinger linked generational reproduction with the smooth running of the economy through the continual provision of a labour force. However, they failed to look beyond the immediate need for labour to the importance of gender within Soviet production relations which contribute to the labour shortage and the wider implications of biological reproduction for national identity.

Similarly, the concept 'reproduction' was used as though it were unproblematic. Generally it was used to refer simply to childbearing as the key form of the reproduction of the labour force and the significance of the reproduction of the labour force was assumed rather than explained. This is not to say that reproduction is not a significant concept in understanding gender inequality in the Soviet Union, but it must be used carefully avoiding assumptions and confusions concerning its meaning and significance. In particular,

since the relevance of 'reproduction' for the operation of the economy is widely recognised, a full understanding of the social relations of production is essential to the study of gender inequality.

3. Beyond the dual burden

This criticism of the use of 'reproduction' is actually part of the wider and most significant problem with the 'dual burden' approach. The literature on gender inequality in Russia, though providing a considerable amount of information and putting on the map a previously neglected subject, failed to develop fully a theoretical framework within which the empirical information the research uncovered could be understood. Indeed it has been argued that the use of the concept 'dual burden' is in itself very limiting because it tends to focus on the time spent in paid work and in the home rather than the relations involved in perpetuating gender inequality (Haug 1991).

This lack of theorising is most apparent in the failure to develop an understanding of the Soviet mode of production. The Soviet system as a whole is described as state socialist, however this cannot simply be assumed, for the nature of the Soviet system is a matter of great debate which should not necessarily lie outside the scope of work on the position of women. Corrin refers to the societies of Eastern Europe as 'socialist' or 'state socialist', the inverted commas indicating there is something questionable about those labels, yet she "attempts no grand definitions of how such societies have been and are currently constituted" (Corrin 1990). However, it will be argued in the following chapter that gender relations cannot be isolated from other social relations, but rather must be understood as central elements within

the relations that characterise the Soviet system. By examining the gender relations the nature of the system as a whole becomes the subject of investigation.

The primarily empirical focus on the work mentioned can be explained in part by the political climate of the 1970s and 80s, when most of the western analysis of gender inequality in Soviet Russia took place, which provided a frame of reference within which accounts were written. Research into the Soviet Union during the Cold War was by its very nature comparative. In relation to gender, the question of whether the position of women in the Soviet Union was better or worse than in the capitalist west was addressed. As Hilary Pilkington has pointed out,

> "There has been no vacuum of information on the position of women in the Soviet Union. On the contrary, a significant amount of important and interesting work has already been done .... The problem for those studying the experience of Soviet women is using this large body of information in a way that will really aid understanding of just what this experience has been. In particular readers of the existing material on Soviet women should bear in mind that the aim of those writing has generally been to explore the 'politics of equality' by looking at the 'Soviet model'" (Pilkington 1992: 185).

There was a tendency therefore to compare levels of equality between socialism and capitalism and to neglect both the actual experiences of Soviet women, as opposed to the legislative forms of equality, and the relationship between gender, class and race relations (Pilkington 1992:187).

While the context is different, similar problems are faced today by western analysts of gender inequality in former communist states. A

problem emerges in terms of the applicability of Western feminist analysis to women in Eastern Europe. Nanette Funk poses the question of "whether Western feminism's issues, claims and goals can be anything other than 'relative', appropriate in the West but not in the East"(Funk 1993: 321). As an example of this she refers to the different attitudes to paid labour - regarded as a goal by feminists in the West but not in the East - and concludes that the different attitudes do not reflect intrinsic differences between East and West but rather differences in the 'historically specific social meanings' given to certain practices and institutions.

One key issue in relation to the applicability of western feminist concepts is the question of the 'family'. Funk argues that Eastern European women's conception of the family is very different to that of women in the West. Olga Lipovskaya argues that the family was the primary site of opposition to the state, within which it was possible to achieve greater freedom. The family was " bound by strong ties of caring and sharing, where one learns the precious skills of compassion and understanding (which it can be argued, go beyond the usual expectations and demands of the western nuclear family" (Lipovskaya 1994).

It is vital therefore to recognise the historical specificity of the concepts of feminist analysis, whether it is the family, reproduction or the sexual division of labour. By failing to do so there is a danger of becoming what Nora Jung refers to as a 'Western supremacist'. This refers to "feminist scholars who perceive knowledge produced in the

West to be superior to that produced by non-Westerners"(Jung 1994: 208).[2]

One of the main problems for western feminists is that while recognising that western feminist concepts have to be used with caution in varied historically specific contexts, their analyses are based on the assumption that the very contexts which they are so keen to be aware of are to a large extent outwith their frameworks. Chris Corrin points out, as we have seen, that women cannot be regarded as one category since "societies differ in so many ways in terms of cultural, traditional, religious, ethnic and class complexities". Yet she states that "in terms of 'state socialism and so-called socialist societies, I attempt no grand definitions of how such societies have been and are currently constituted" (Corrin 1990). It is therefore difficult to understand fully what the differences she refers to are and how significant they are for the way that society functions in general and in relation to gender inequality in particular.

It is clear therefore that it is essential to recognise the experiential differences between Eastern European women and Western feminists. However, this recognition although offering some safeguard against 'western supremacism' does not offer a full understanding of the structures which shape these experiences. The fact that the nature of the societies referred to is often not questioned but is rather assumed has severe implications for the application of Western feminist analysis since it involves the implicit assumption that concepts such

[2] The same criticism was made by Maria Lazreg (1988) in her account of women in Algeria. She notes that the concepts and perspectives used by Western feminists to study Middle Eastern women reflect the "dynamics of global politics. The political attitudes of 'centre' states are mirrored in feminist attitudes towards women from 'peripheral' states".

as the sexual division of labour or the family can be understood in isolation from the mode of production within which they exist and so gives them an almost universal, ahistorical status. The theoretical framework described in the next chapter sets out to develop a deeper understanding of gender inequality in Soviet Russia which avoids these problems.

2

BEYOND THE DUAL BURDEN: THEORISING GENDER INEQUALITY IN SOVIET RUSSIA

In this chapter I will outline the basis for a theoretical understanding of gender inequality in Soviet Russia. The review of the literature examining women in Russia identified the need for a more rigorous theoretical underpinning. Yet this is a matter fraught with difficulties. As a western woman, my understanding of gender relations is necessarily grounded in the concepts of feminism developed in the west. The concepts employed in feminist theory are the subject of intense debate as to their validity and efficacy in furthering our understanding, but there is also the question of whether these concepts can be applied to the understanding of gender inequality in a system very different from the capitalist or patriarchal capitalist system within which they were developed.

It would be impossible here to attempt a comprehensive review of western feminist theory and its applicability to the study of Soviet Russia. In the first section , I will focus on the concept 'patriarchy', primarily because of its importance within feminism, but also because it is increasingly used in western feminist analyses of women in Russia (Corrin 1990; Waters 1993; Attwood 1996;). In the second section, analyses that examine the relations between production and reproduction will be addressed and the applicability of this type of

approach questioned. It will be shown that while this approach has been problematic and subject to justified criticism, it nevertheless merits further attention. In particular, problems associated with economic reductionism and functionalism will be addressed.

Finally, I will go on to outline a new approach to understanding gender inequality in Soviet Russia. This framework avoids the marginalisation of gender to the realms of theoretical insignificance since gender relations are an integral component in the analysis of social relations in Soviet Russia. At the same time, it avoids the separation of gender relations from other social relations, emphasising instead the need for a unitary and integrated analysis of gender inequality.

Feminism and Postmodernism

Before going on to examine the concepts of 'patriarchy' and 'reproduction', it is worth noting the trend in recent years, in western feminist theory towards a 'turn to culture' through the adoption of the post modernist mantle (Roseneil 1995). The post modernist movement in feminism has questioned the efficacy or validity of using such concepts as 'patriarchy' or 'reproduction' in creating theoretical meta-narratives. Barrett notes that there has been a shift in attention from the concern with 'things' to the concern with 'words', that is, from an analysis of the structures that shaped women's oppression to the discursive construction of identities and experience (Barrett 1992: 201-19). This debate is particularly important in the context of theorising gender inequality in Russia because it calls into question and demands the problematisation of feminist concepts such as 'patriarchy', 'reproduction' and 'woman'. In particular post

modernism cautions against essentialism and the generalisation of feminist concepts outwith their historical and cultural context (Nicholson 1992).

However, there is a concern that the interest of feminist post modernism in deconstruction poses the danger of fragmenting our understanding of social relations and social context to such an extent that it would become impossible to speak about inequality and so to have any kind of feminist movement (Walby 1992: 31-52). Fraser and Nicholson call for a combination of post modernist incredulity towards meta-narratives with the social-critical power of feminism. They argue that theories and concepts such as reproduction and patriarchy need not be abandoned altogether, but must be "framed by a historical narrative and rendered temporally and culturally specific" (Fraser and Nicholson 1992: 34). Yet it has been noted that the concern to avoid essentialism and universalism, that is, to be historically and culturally specific, lay at the heart of much feminist work prior to the post modernist/feminist merger (Roseneil 1995).

In relation to theorising gender inequality in Soviet Russia, it is essential to understand the social context within which women live. This means that concepts like 'patriarchy' or 'reproduction' cannot be assumed to have universal significance or meaning. However, it does not mean that any attempt to develop a theoretical framework for understanding the structures that shape gender inequality should be abandoned in favour of a concern with 'words'. It is recognised that the use of categories such as 'men' and 'women' can be problematic if differences within the categories are ignored (Pilkington 1992), and if the social construction of the categories is neglected, that is, the

category 'women' is taken to be an absolute in need of no further examination (Connell 1987: 61). It is important not to assume similarities between women and their difference from men, on the basis of biology given the ability of people to act and transform the structures which influence them and in fact change the meanings attached to categories used.

What is required is an analysis which uses as its frame of reference, the historical and cultural context of Soviet Russia and which avoids the essentialist assumptions concerning the experiences of women. Before going on to outline in detail the basis for such an analysis, I will briefly discuss the ways in which 'patriarchy' and 'reproduction' have been applied in feminist theory in order to assess how applicable they may be for an analysis of gender inequality in Soviet Russia.

Patriarchy and Dual Systems Theory

The concept 'patriarchy' has been the subject of much debate within feminist theory. Patriarchy has been employed in different ways to provide an explanation of gender inequality that on the one hand avoids the submersion of gender in class conflict debates while at the same time recognises that the subordination of women occurs within a specific mode of production and so any explanation must bear this in mind and avoid the dangers of essentialism and universalism. In the attempt to do this, 'patriarchy' has been attributed a level of analytic independence from the mode of production, thus creating a dual systems perspective. There is insufficient space in this context to provide a detailed or comprehensive analysis of the application of 'patriarchy' in feminist theory. Rather, the focus will be on the

implications of the dual systems approach for the analysis of gender inequality in Soviet Russia.

In her seminal article 'The Unhappy Marriage of Marxism and Feminism' Heidi Hartmann established the basis for the dual systems approach. She defined patriarchy as "a set of social relations between men which have a material base" (Hartmann 1981: 15). She noted that "the crucial elements of patriarchy as we currently experience them are : heterosexual marriage (and consequent homophobia), female childrearing and housework, women's economic dependence on men (enforced by arrangements in the labour market), the state and numerous institutions based on social relations among men" (Hartmann 1981: 18-19). The patriarchal elements of the social structure were, for Hartmann, theoretically distinct from other elements, in particular those relating to economic production. So although patriarchal relations were seen to operate within the sphere of economic production, they were analytically distinct and changes in the latter do not necessarily lead to changes within the sex-gender system.

Hartmann's account is useful in that she recognised that gender inequality is not solely rooted in the domestic sphere. However, her conceptualisation of patriarchy is somewhat vague and confused. This results from her attempt to account for the importance of gender inequality in areas other than the home in terms of patriarchal relations within existing social structures, but she fails to provide an adequate understanding of the articulation between different elements of the social structure and so is left with a rather loose definition of patriarchy that could refer to almost anything.

Consequently, her understanding of the relationship between patriarchy and capitalism is problematic for with no definite basis for patriarchy as a system, her separation of patriarchy from the mode of production becomes hard to sustain. If a dual systems approach is to be used, it must be shown that patriarchy or the sex/gender system has an independent basis rather than taking this as an a priori based on the fact that women have been oppressed under different modes of production.

Sylvia Walby attempts to do just this, and while I do not think she succeeds, her account is perhaps the most sophisticated attempt. She defines patriarchy as "a system of interrelated social structures through which men exploit women" (Walby 1986: 51). In this way she, like Hartmann stresses the importance of understanding patriarchal relations in all spheres of society, not just in the family. Walby sets out the structures in which patriarchy operates - paid work, the household, the state, male violence and sexuality (Walby 1990).

Walby also tried to make the concept of 'patriarchy' more dynamic, by stating that there are different forms of patriarchy - public and private - in which different structures have dominance. Private patriarchy is based on household production as the main site of women's oppression while public patriarchy is based principally in the public sites. In private patriarchy the expropriation of women's labour takes place in the home by individual patriarchs, while in public patriarchy collective appropriation takes place. In private patriarchy the main patriarchal strategy is exclusionary while in public patriarchy it is segregationist and subordinating (Walby 1990: 23-4).

At first glance, Walby's approach may seem to offer a suitable framework for the study of gender inequality in Soviet Russia. The focus on the the structures of patriarchy operating outwith the domestic sphere, in particular in the state and in paid employment have a degree of resonance, given the high level of state intervention in the lives of Russian women and their widespread participation in the workforce. Moreover the notion of different forms of patriarchy seems to lend itself to cross cultural analysis by grounding the concept 'patriarchy' in the historical and cultural specificity that it was previously lacking.

However there are problems with Walby's account and with 'patriarchy' which cast doubt on these claims. Most importantly, it is not clear what is the basis of the patriarchal system and its separation from the mode of production in the different forms. In private patriarchy the basis of her argument is that men exploit women in the household, yet she centres this claim on what she regards as typical situations rather than on a systematic analysis of the defining features of this patriarchal mode of production. So for her, women are 'typically' given less than men and 'typically' work longer hours within the patriarchal mode of production but this typicality implies that this need not necessarily be the case. If the woman does receive as much or more than her husband or if she worked shorter hours is she then still exploited? According to Walby's account she would not be. In addition if, as is increasingly the case, the wife works and the husband is unemployed and dependent of her income is he then exploited by her? Walby's framework for the patriarchal mode of production only applies to a certain form of household and does not accommodate the experience of women who live outwith it. She

provides the framework for an analysis of relations between market and non market workers rather than between men and women (Crompton and Sanderson 1990: 16).

Her analysis of public patriarchy may seem to address some of these difficulties, but in this case it is even more unclear how it is possible to understand patriarchy as an independent system. In public patriarchy the dominant structure of women's oppression is in employment and the state, the arenas in which the mode of production most obviously operates, making the distinction between it and the patriarchal mode of production even more confused. She states that public patriarchy involves the collective appropriation of women's labour in paid employment yet the basis for the patriarchal mode of production is the exploitation of women's surplus labour by men in the household (Walby 1986: 52-4). If in public patriarchy this changes and the basis for women's oppression is the appropriation of their surplus labour within paid employment then the use of the concept 'patriarchy' as an independent mode of production becomes groundless. This is not to say however, that gender inequality can simply be understood in relation to class conflict analyses, but rather, that other concepts may provide a more incisive analysis of the position of women in society. Moreover, Walby's systemic approach tends to ignore the importance of individuals in creating and recreating the institutions or structures that shape their actions and decisions (Granovetter 1985).

Even when changes in the form of women's oppression are recognised, as with Walby for example, there is still the question of the basis on which patriarchy can be said to have an independent

existence as a system. Very often this problem is ignored completely, and when it is addressed, attention is either paid to relations within the domestic mode of production and as a result, relations between it and the capitalist system are ignored, or attention is paid to the interrelationship between the two systems while the functioning of and the relations within the patriarchal system itself remain somewhat vague. Therefore patriarchy should not be given the status of a system. Indeed it offers little in terms of its use as an analytical tool. Rather, it is a descriptive mechanism detailing certain aspects of women's experience. "The concept of patriarchy names relations, events, suffering, powerlessness, repression which happens in many forms in our experience" (Smith 1983) .

The reason for the analytical separation between patriarchy and the mode of production is based on a dissatisfaction with class conflict analyses which while providing a coherent and accepted account of the economic mode of production, fail to explain women's specific place within it. The solution lay in adding an explanation of gender hierarchies within the framework of patriarchy without challenging any of the ideas they were dissatisfied with. Thus in a similar fashion to the traditional marxist accounts which have tried to offer some explanation of gender inequality, dual system theories have transplanted patriarchy onto an otherwise unaltered explanation.

So while Walby is right to emphasise the significance of gender relations in paid work for the wider position of women in society, her analysis is incomplete for she neglects the impact of gender on production relations, the ways in which gender relations influence the nature of the system and so the operation of the mode of

production as a whole. A solution to the neglect of gender relations by class conflict analyses cannot be found without seriously challenging the basis of that theory (Beechy 1979; Vogel 1995). Gender relations must be regarded as central, fundamental elements of any theory concerned with the social relations characteristic of a particular society. Thus it is necessary to develop a framework within which the social relations of a society are regarded as one system with gender relations as an essential element.

Reproduction and Production

The concept of reproduction, has been used by feminists in addressing this problem. 'Reproduction' was introduced into feminist analyses to counter the emphasis on production in marxism and the consequent failure to theorise gender adequately.[1] It was proposed that women's oppression could be explained in terms of relations of reproduction existing within the family, while class oppression was explained in terms of relations of production outwith the family. This was often posed in terms of Althusser's conceptualisation of the

[1] See for example the work of R. McDonough and R. Harrison 'Patriarchy and Relations of Production' in Kuhn and Wolpe (eds), Feminism and Materialism 1978 ; V Beechy 'On Patriarchy' in Feminist review no 3 1979; M. McIntosh, 'The Sexual Division of Labour and the Subordination of Women' in K Young et al.. (eds) Of Marriage and the Market : Women's Subordination in International Perspective 1981; Pat and Hugh Armstrong 'Beyond Sexless Class and Classless Sex', Studies in Political Economy no 10 1983 and 'More on Marxism and Feminism' in Studies of Political Economy no 15 1984;J Humphries and J Rubery 'The reconstitution of the supply side of the labour market: the relative autonomy of social reproduction' Cambridge Journal of Economics, 1984 331-46; J Brenner and M Ramas, 'Rethinking Women's Oppression' New Left Review 144 1984; L Vogel, Women Questions : Essays for a Materialist Feminism Pluto 1995.

'relative autonomy' of aspects of the superstructure from the economic base. In this way it was believed that the economism of marxism could be avoided and the oppression of women neatly slotted into an otherwise unaltered theory.

Economism is perhaps seen as the greatest obstacle for class conflict analyses, in particular Marxist analyses in providing an understanding of gender inequality, since it is argued that too much is left unexplained by the exaggerated role given to the economic sphere. In response to this, much feminist theory either adopted Althusser's approach focussing on ideology as 'relatively autonomous' from the economic level, or stressed the importance of reproduction as something distinct from the economic sphere of production. Implicit in this latter approach, is the assumption that reproduction is synonymous with the family and production is synonymous with the workplace.

However, such analyses are limited by the assumption that women's biological role in human reproduction leads automatically to the development of relations of reproduction, embodied in inequality in the family (McIntosh 1981). There is little attempt made to establish how and why the biological fact of women's reproductive capacities develops into unequal relations of reproduction. Secondly there is the assumption that reproduction refers only to the domestic sphere (Humphries and Rubery 1984). This is a reflection of the conceptual separation between reproduction and production. This is in part the result of a desire to avoid criticisms of economism and in part the result of a focus on institutions rather than social relations.

However, there is much in this that is problematic and that needs rethinking. Firstly, economism need not necessarily be seen as the result of an over-emphasis on the economic. Rather, it is a valid criticism of what we understand by the 'economic'. Thus rather than giving 'relative autonomy' to different levels or separating completely the economic from the non-economic the conceptualisation of the economic structure itself should be re-defined. Corrigan and Sayer argue that the base/superstructure debates have missed the point (Corrigan and Sayer 1978). They note that Marx does not classify in the abstract, any particular social relations as production relations. On the contrary he notes that it is only through empirical observation that this can be ascertained. Beyond this, all that can be said for definite is that production relations consist of any social relations which are indispensable to a given mode of production. Since the economic structure is made up of the totality of production relations it follows that social relations cannot be excluded from 'the economy' in terms of some innate, ahistorical property they have but rather on the basis of their necessity for the continuance of the mode of production. Thus, what is traditionally regarded as part of the superstructure and so determined by the economic base may in fact be part of the base itself.

Such a conceptualisation refutes the assumption that reproduction and production must be separated in order to avoid an economistic explanation of gender inequality, by positing the possibility that reproduction itself may be part of the economic structure. This point is also made by Seecombe who argues that "in most Marxist literature, the field of production is reduced to the production of material goods, the forces of production to the instruments of labour and social

relations of production to those relations found at the site of goods production. In this framework, the production of the species and its labour power does not appear" (Seecombe 1988). Similarly Adkins and Lury argue that the material and the economic are too often conflated and recommend that a wider understanding of the 'material' to include non-economic processes such as motherhood and sexuality be adopted (Adkins and Lury 1992).

The second aspect of the separation between production and reproduction in much feminist work is related to this and involves the association of production and reproduction with the workplace and the family respectively, with the roots of women's oppression perceived to lie in the latter (McIntosh 1981). Not only does this deny the importance of gender relations in paid work in shaping the structures within which domestic relations are formed and reformed but it also ignores the significance of gender relations in shaping production relations. In this respect, what is understood as reproduction cannot be confined to a particular sphere or institution, but can only be understood in terms of the relations involved.

But it is not only the conceptualisation of the relationship between production and reproduction that is problematic. Inherent in this is the meaning attributed to the concept 'reproduction'. It is necessary to question what is meant by reproduction and to what extent gender inequality can be explained by specific aspects of the term. Edholm et al. made a significant contribution to this problem, noting that reproduction refers to three different processes - social reproduction, human reproduction and reproduction of the labour force (which in turn can be divided into the maintenance of the labour force and the

allocation of agents to positions within the labour process) (Edholm et al. 1977). They clearly highlight the different dimensions to reproduction and the need to distinguish between them which was lacking in much of the work on reproduction.

Finally, as Connell (1987) points out, the problem with accounts based around the idea of social reproduction is often that they are static accounts in which the social system is simply reproduced. Rather, he argues, there is a process of constant construction and reconstruction of the structures and relations that form a social system. "Social structure must be seen as constantly constituted rather than constantly reproduced. And that makes sense only if theory acknowledges the constant possibility that structure will be constituted in a different way. Groups that hold power do try to reproduce the structure that gives them privilege. But it is always an open question whether and how they will succeed. Social reproduction therefore is an object of strategy....It cannot be made a postulate or presupposition of theory" (Connell 1987: 44).

Towards a New Approach : Theorising Gender Inequality in Soviet Russia

From the discussion above several key points emerge which form the basis of the development of a theoretical approach to understanding gender inequality in Soviet Russia. There are several other themes which run throughout the fundamental proposal of the thesis that gender relations are central to an understanding of the Soviet social system and to the division of labour within paid employment. Firstly, it it argued that gender is a social process. Gender is not a static concept, but rather must be understood as a social process which is

constantly constructing and reconstructing relations with particular structures. Moss argues that "gender is that set of concrete processes through which individuals gain experience of and attach meanings to the uneven distribution of power between men and women. These concrete processes include daily interactions in the home, workplace and sites where individuals do not engage in labour...Also gender is simultaneously an on-going mediation of an individual's experience of these relations" (Moss 1994).

Secondly, in relation to this, it is argued that the labour force must be understood as a social construction. It was noted above that the attribution of skill ratings to particular jobs results in part from the gender of those employed. Gender attributes are ascribed to jobs in relation to the type of work being carried out and those employed to do it. Such a construction is all the more significant when it also forms the basis of a labour hierarchy, as was the case in Soviet Russia.

Thirdly, it is essential to establish the relationship between structure and agency in understanding gender inequality. Giddens presents an approach that allows for an acceptance of the importance of structures in shaping people's actions, but at the same time does not regard the individual as a 'structural dope' with no role to play. Giddens argues that "structure [is] the medium and outcome of the conduct it recursively organises; the structural properties of social systems do not exist outside action but are chronically implicated in its production and reproduction (Giddens 1984: 374). He refers therefore to the 'duality of structure' in arguing that while peoples' actions always presuppose some kind of structure, their actions recreate the structures.

However it must also be noted that structuration is not a neutral or ungendered process. For example Adkins argues that the ability of women workers to be active subjects in the labour market is limited by the position that they occupy. She notes that "the different relation that men and women have to action means that whilst women are an integral part of the occupational structure, the structure itself can be determined by the action of male workers in a way that it simply cannot be by female workers" (Adkins and Lury 1992).

The fourth theme of the thesis concerns the role of the state. It is important to recognise the influential role played by the state in shaping women's lives through the regulation of labour force participation, biological reproduction and sexuality and the distribution of social benefits. In this respect, the state plays a constituitive role in forming and reforming social patterns, but also plays a part in the creation and recreation of social categories. The relationship of structure to action is particularly relevant in this respect, particularly in view of the nature of the Soviet political system. It will be shown that while state policies shaped the nature of the social system and so women's place within it, the agendas of women and men within the workplace and of managers, were often contrary to the state's policy measures. While state policy therefore, shaped women's lives in Russia, it did not necessarily dictate the exact form that these would take.

Fifthly it is argued that while social reproduction analyses are often flawed, this does not mean that the concept need be abandoned altogether. Its appeal lies in the attempt to see the system of social relations in any particular society operating as a whole rather than as

separate systems in order to explain different forms of inequality, as with the dual systems approach. Nevertheless, the problems associated with this approach must be addressed. Firstly, it is essential therefore to avoid making assumptions concerning the meaning of 'reproduction' and its implications for gender inequality. As Edholm et al. noted, the first step is to address the different meanings of reproduction. They refer to social reproduction as being of a different theoretical order to that of human reproduction and the reproduction of the labour force. They note that "any theory of social reproduction has to reveal what the basic structures of a given mode of production are, and then to demonstrate the necessity for their continued existence in order to ensure the continued existence of the mode of production itself" (Edholm et al. 1977: 105). I would add to this that since production is a social process, social reproduction actually refers to the reproduction of the relations of production.

However, this in itself is too simplistic a definition. Social reproduction must be understood as a strategy on the part of the central elite in Soviet Russia to reproduce the system to best suit their needs. It will be shown that gender was central to this strategy both quantitatively in relation to the biological reproduction of the population and of the labour force, but also qualitatively in relation to the forms of control over the workforce. From this perspective social reproduction can be understood as an open-ended and a dynamic process in which people play active parts. This approach will illustrate the role played by various actors whether it be the central elite, managers, female or male workers, in shaping and reshaping the structures in which they live and the strategy of social reproduction.

Moreover, in referring to social reproduction as the reproduction of the relations of production it may seem that this approach is functionalist. However, one of the central features of this analysis is the significance given to gender relations in understanding the inherently contradictory nature of Soviet society. Not only were the strategies employed by the state in relation to women often contradictory, but the reactions of the women and of economic managers served to exacerbate and create new contradictions. While gender was central to the process of social reproduction, it was by no means functional for it.

It will be argued here that in Soviet Russia social reproduction related to two key concerns - biological reproduction and the reproduction of forms of control. It will be shown that both these elements were central to the operation of the Soviet system and that gender relations were in turn central to them.

1. The State and Biological Reproduction

It is vital to point out that we cannot simply assume the significance of the fact that women and men have different roles in biological reproduction. Rather, this must be a step in building the foundations for the theoretical framework. While men and women have differing roles in the process of biological reproduction, the implications of this for the position of women and for social relations in general is a very contentious area. Indeed, there is a tendency to link, without question, biological reproduction and the 'family', thus transposing the meaning of concepts specific to our society onto all societies past and present. This has led others to question the relevance of biology at all for the position of women (Barrett 1980; Connell 1987; Delphy

1993). While not denying that differences in biology exist it is argued that it is the cultural influences which create gender distinctions that must be examined.

Moreover, some argue that biological differences are not simply based on the male/female dichotomy (Connell 1987: 78). There are many more biological similarities than differences between men and women, and there are many cases where a simple distinction cannot be made. The relationship between gender and biology must therefore never be assumed, as Connell argues,

"the social is radically unnatural...But this unnaturalness does not mean disconnection, a radical separation from nature. On the contrary, the unnaturalness of society is sustained by a particular kind of connection with nature - a connection through practice. In the practice of labour, the natural world is appropriated by human beings and transformed both physically and in terms of meaning. In the practices of sexuality and power as well as certain kinds of labour (for example nursing), the human body itself is an object of practice....Practice issues from the human and social side of the transaction; it *deals with* natural qualities of its objects including the biological characteristic of bodies. It gives them a social determination. The connection between social and natural structures is one of practical relevance not of causation" (Connell 1987: 78).

This response must be seen as part of the desire by feminists to avoid the dangers of placing biology at the forefront of a theory of gender inequality. In particular if women's position is seen to rest purely in their biology then we could infer from this that gender inequality is natural and there is little room for change. However, this should not mean that the relevance of the biological reproductive difference

between men and women should be dismissed. While the significance of this cannot be assumed it must be investigated (Brenner and Rammas 1984).

There were two ways in which biological reproduction was important in the Soviet system. Firstly it was important in terms of the state's concern over the reproduction of the nation and secondly in terms of concern over the reproduction of the labour force. It will be shown that gender was a central factor in both.

1.1 Reproduction of the Nation

While there is considerable debate as to the nature of the 'nation', questions of nationhood figured prominently in the history of the USSR, in part because it was in essence an amalgamation of nations, but also because as a single entity, as a single nation, it symbolised a whole new economic form.[2] From its earliest days the isolation of the USSR from the capitalist world established the need to strengthen its nationhood both ideologically and materially. With the onset of the Cold War, this situation was further reinforced. In order to be a world force in the face of opposition from the capitalist west, the USSR not only had to demonstrate its economic prowess, but also had to maintain a military structure of sufficient capacity to defend its position. This was done initially through the development of the country's industrial and military base and later through the space programme. While much of the 'race' with capitalism was a charade, for the USSR never came near to matching its economic power, it nevertheless served a political purpose in legitimating the positions

[2] On the question of the 'nation' see B. Anderson, Imagined Communities, Verso 1983.

of the Soviet central elite. The constant comparisons in terms of economic and military might were intended to demonstrate that the Soviet system, or the Soviet nation, was superior to those in the west, which in turn would reflect well upon the leadership.

Women were regarded as a central component in ensuring that the nation was reproduced. It was the task of Soviet women to ensure that the population was maintained at such a level that the nation could itself be maintained both through internal development and protection from external intervention. In the Soviet Union, the presentation of women's role in this can best be described as the 'people as power discourse'(Yurval Davis 1996). In this respect,the future of the nation is seen to depend on its continuous growth based primarily on the reproductive powers of women who are called upon to have more children. The roots of the discourse varied throughout the course of the Soviet system. While in the 1930s the need to build a strong economy meant women were expected to reproduce more workers, in the post war era, the tensions of the Cold War exacerbated this need for more labourers, but also saw a general population decline arising from the WWII losses. By the late 1970s, the demographic impact of the war on the population of child bearing age was negligible, yet it remained a key feature in demographic discussions. War losses came to symbolise the nation and women's role in its reproduction.

The demographic difficulties that arose also highlighted that the 'people as power discourse' was not only variable over time, but also that the power of the people had to have the right ethnic balance. While it is valid to say that there was a concern for the reproduction

of the Soviet nation as a whole, there was also considerable concern that some elements within it seemed to be reproducing much quicker than others. The birth rate in the Central Asian republics far exceeded that within the Slavic republics. Not only were the former regarded to a large extent as racially inferior but they were also the least developed industrially and so the least able to contribute to the development of the Soviet economic system.

By virtue of their role in biological reproduction Soviet Russian women were held responsible for maintaining the birth rate at such a level that the army and the labour force could function. But concern also lay with the 'appearance of nationhood' as a legitimating force. Concerns for mothers and for the birthrate while in part were genuine concerns that the population be reproduced at the necessary rate, also served as political currency, giving a concrete focus to the idea of the nation.

1.2 Reproduction of the Labour Force

As was mentioned above, the reproduction of the labour force was an important aspect of the reproduction of the nation itself. Since the basis for the USSR was its status as a new economic system, building the economy was from its onset regarded as the most important aspect of development. It is in this respect that women's role in biological reproduction was most significant throughout the Soviet era. It is also in relation to this that the contradictions that women presented to the central elite, can be best understood.

On the one hand childbearing was essential to the continuance of the system for without it there would be no generational replacement and

in turn the reproduction of the labour force and so of the conditions for production itself would become far more complex, having to rely wholly on outside sources of labour. On the other hand, women were regarded as essential contributors to the creation of a surplus through their direct involvement in production, particularly in conditions of the severe labour shortage which was a central feature of the system.[3] However, their capacity to do so was limited, at the least in terms of time taken out immediately before and after the birth.

So women's role in childbearing was placed in contradiction to their role as direct producers and the immediate production of the surplus and thus its appropriation by the central elite. In this sense, women's labour therefore posed a contradiction for the central elite concerned with the overall immediate and long term continuance of the system and their place within it. While women's labour was required within the workplace, to build the economy, they were also needed to reproduce the next generation.

The central planners employed a dual strategy to resolve this contradiction women's labour posed for biological reproduction, which had severe implications for the position of women. On the one hand, measures had to be taken to minimise the risk to childbearing that women's participation in production would have. Physical bodies do not exist independently of their social surroundings, in particular, the economic system can affect the number of pregnancies women have, fertility rates, and the rates of infant mortality. On the other

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[3] In any social formation cooperative human labour produces more than is necessary for the simple reproduction of human life. This is what is known as the surplus.

hand, in the context of a growing demand for labour, measures had to be taken to ensure the participation of women in the labour force. With this in mind, attempts were made firstly, to control biological reproduction directly through abortion legislation and contraceptive availability and more indirectly through increasingly conservative family legislation. Secondly, attempts were made to control women's paid labour, on the one hand by encouraging their participation, while at the same time ensuring that it was limited, most notably through the use of protective legislation. These two aspects although separated here for the sake of clarity, are closely interrelated, for example maternity leave serves both to encourage women into the workforce while at the same time, minimising the risks to pregnant women and new borns.

Control over biological reproduction

During the Soviet period, the policy towards biological reproduction had five key features. Firstly, it was characterised by a continual concern over the birthrate. This was particularly acute from the 1930s onwards as a result of the industrialisation strategy and war losses. Secondly, in line with this, motherhood was not regarded as an individual concern but a social duty. Thirdly, women had very limited options for birth control, with abortion remaining throughout the Soviet era, the main method. Fourthly, there was continual debate over the role played by the family in biological reproduction. Fifthly, sexuality in Soviet Russia was subjected to strict social control.

i) <u>The birth rate</u>

Throughout the Soviet period there were concerns expressed in relation to the low birth rate. In the 1920s there were concerns that the legalisation of abortion had had a detrimental affect on the birth rate. As the number of abortions rose, particularly in the late 1920s, the birth rate fell. Between 1927 and 1935 it fell from 45 births per 1000 people to 30.1 (Goldman 1993: 290). In the 1930s the concern over the birth rate was highlighted by Strumilin who concluded that in the prevailing conditions the birthrate was likely to fall by a further 10% very quickly (Goldman 1993: 292). These concerns culminated in the 1936 Law on Abortion. Its aim was presented as "the strengthening of the family, the safeguarding of the health of millions of women, and the rearing of a numerically strong and healthy generation" (Goldman 1993: 260).

By 1944 concerns were increasing over the falling birthrate, particularly as a result of the war. This culminated in the 1944 Family Act which set out further the aims of the 1936 abortion law in which the reproduction of a new generation was regarded as vital for the continuation of the economy and of the country as a whole. Maternity leave was increased to eleven weeks, awards were given to women who had many children with top prize of 'Heroine mother' given to those with ten or more children and couples who were childless were taxed. The war losses had an on-going impact on the concern for women's role in reproduction throughout the Brezhnev years as demographers raised the alarm over the falling birth rate. In 1960, the net population increase was 18 per 1000 and by 1976 this had fallen to 8 per 1000. It was predicted to fall to 5.8 by the year 2000 (Hegelson 1982). However there were other significant factors which contributed

to the post war demographic changes, including urbanisation and the resulting changes in living conditions and increased access to education. While there is no doubt that the war losses were significant and did create a gender imbalance for some years, the impact of the war on reproduction also became a key feature of the discursive construction of the Soviet nation and of women's role in its reproduction.

ii) Motherhood as a social duty

The second aspect of the state's control over women's biological reproduction was the continual emphasis on motherhood as a social duty. Under the Commissariat of Health the Department for the Protection of Motherhood and Children (OMM) was set up in 1918. Its guiding principles reflect this belief in the social obligation that women had to produce :

"1. Childbearing is the social function of the woman and the duty of the government is to enable her to fulfil this function.
2. It is the duty of the government to educate the mother citizen.
3. The child must be physically protected; breast-feeding is therefore a social duty of women" (Heitlinger 1979: 108).

With the establishment of this organisation, the Bolsheviks established the relationship between the state and women in terms of biological reproduction. The state's concern with the extent to which women were carrying out their social duty was a feature of policy making up to and including the Gorbachev period when the notorious call to allow women to "return to their purely womanly mission" was made (Gorbachev 1987: 117).

The emphasis on women's role as mothers crossed class boundaries. This can be seen from the encouragement given to organisations such as the Wives of Engineers in Heavy Industry. At their conference in 1936 they proclaimed their aim to "introduce into life Comrade Stalin's slogan about the care of men". Just as Stakhanovites were praised as model workers to be exemplified, these women were seen to embody the true values of womanhood, above all in dedication as carers. "Whenever the leading men in production and agriculture do their work, their wives must fight for culture and for a happy life, they must take an active part in the common struggle for increasing production. Our place is wherever there is need of care for human beings"(Schlesinger 1949: 237; 249).

However, the demographic imbalance between the Asian and European regions of the Soviet Union led by the 1960s to the adoption of policies designed to correct this and so to differentiated policies towards women of different ethnic background. The focus shifted to encouraging families to have up to three children therefore implicitly encouraging European women to have more and Asian women to have fewer children.

iii) Birth Control

Women in Soviet Russia had very few options for birth control. Contraceptives were virtually unavailable. In 1988, it was estimated that only 18% were using a contraceptive (Du Plessix Gray 1991: 19). In the absence of any modern forms of contraception, women resorted to traditional and far from reliable forms of birth control such as coitus interruptus and various barrier methods such as using four small

balls to block the cervix (Goldman 1993: 259). But the most commonly used method of birth control was abortion.

Abortions were legalised in 1920. It was recognised that an increasing number of women were opting for backstreet abortions and rather than punish the women, it was more just to legalise it . It was nevertheless, referred to as 'this evil' (Goldman 1993: 255). Abortion was tolerated in line with the belief that the harsh economic conditions made it a practical necessity for women, but it was never advocated in terms of women's right to choose. So while on the one hand it was recognised that abortion was necessary due to the material conditions characteristic at that time, on the other hand it was hoped that that situation would not last long and women would again embrace the joys of motherhood. " We hope that in the future, with the increase in the material wealth of our Union, in the standard of living and in the cultural level of the working people, that women will lose their fear of maternity. Pregnancy will become a joy and not a sorrow and abortion as a mass phenomenon will no longer have a role in our Union". Yet while this situation lay in the future, it was felt that in tandem with the new legislation there should take place "agitation against abortion among the masses of working women"(Goldman 1993: 256).

Throughout the latter half of the 1920s and into the 30s, concern grew over the number of abortions and in particular the ratio of abortions to live births. Between 1924 and 1926 the abortion/live birth ratio increased from 40:100 to 107:100 (Goldman 1993: 261). In 1936 abortion was banned. In the new legislation, the social conditions in the USSR were compared to capitalist countries which "deprive women...of the

impulse of childbearing. Their will to motherhood is paralysed". The USSR on the contrary was said to provide "all the conditions for giving birth to and bringing up a healthy generation"(Schlesinger 1949: 265).

Whereas in 1920, it was recognised that abortions would take place whether or not they were legal, in 1936 in line with the repressive nature of all legislation, criminalisation was regarded as an effective means of control. But as Goldman says, "the 1936 law confused women's methods of limiting marital fertility (legal abortion) with their motivations. The state believed that by depriving women of the method of limiting fertility, it would also eliminate their motivation for doing so" (Schlesinger 1949: 293). This was however a false assumption. In 1939 in Moscow, the incidence of abortion was higher than in 1926 when it was legal. Many women resorted to the network of illegal abortionists that had been maintained even during the period of legalisation.

The post Stalin period saw a retreat from the repressive nature of policy enacted during that time, but the attitude towards abortion and maternity did not significantly alter. Although abortion was legalised in 1955 this was primarily a populist measure and one which sought to avoid the serious health problems that were resulting from abortions performed illegally and without the necessary care or expertise. As in 1920, within the new law the glory of motherhood was continually stressed. The decree introducing the new law explicitly pointed to the "measures taken by the Soviet state to encourage motherhood and protect children" as creating the conditions within which abortion could be allowed but that "the

prevention of abortion can be ensured by extending further the state measures for the encouragement of motherhood and measures of an educational and explanatory nature" (Current Digest of the Soviet Press Vol. 7, no.48: 25). So, although abortion was allowed it was by no means advocated.

It may seem contradictory that while the state wanted to raise the birth rate, given the acute demographic problems in this period, abortion was in fact legalised. In part this was an economic problem relating to the neglect of the service sphere and its inability to produce the required contraceptive replacement for abortions. However one of the main disincentives to encouraging contraception as an alternative to abortion was the doctors themselves given that abortion was a source of revenue for them.

Birth control was also controlled by the state through the regulation of knowledge. Not only was sex education absent from schools, but the information passed on by doctors, particularly to newly weds, validated the traditional and unreliable methods of birth control and spoke in only negative terms about modern forms of contraception(Joy 1995).

The situation remained the same for the remainder of the Soviet era, with women continuing to have abortions in very high numbers, with continual pronouncements about the harm that this was doing to women and to the birth rate, yet with no effort to improve the availability of alternative forms of birth control.

iv) Family Policy

Debates over the role played by the family in biological reproduction were a continual feature, from the arguments for the withering away of the family and the free union of couples in the immediate post revolution period to the stress on family stability as essential for a strong society and for reproducing new generations. While in the post revolution period, there were some such as Kollontai who advocated the abandonment of the family unit, this was never fully accepted nor translated into policy. The 1944 law finalised the shift that had been taking place since the late 1920s from the idea of the family gradually 'withering away' as a social institution, to the family as the key centre for childbearing and child rearing.

From the late 1920s plans were enacted to reduce both the numbers of children entering state care, for example parents who abandoned children were to be prosecuted, but also to reduce the numbers already in state care. Between 1927 and 1929 68 000 children were removed from state homes and sent either to peasant familles or factories to work or back to their parents. One reason for this shift was that the family was regarded as an "inexpensive alternative to state care" (Goldman 1993: 308). This trend from the 1920s was continued in the 1944 law. The traditional family was regarded as the best arena in which to ensure reproduction and the law therefore set out measures for its protection. Couples living together but not married were not recognised in law and the cost of divorce was increased. It was hoped that by strengthening the binds of marriage, as a result the family unit would also be strengthened and the demographic imbalances of the war would be resolved (Buckley 1988: 134).

In the post WWII period, attention again shifted to the family and the rising divorce rates. In 1960, there were 12 marriages and 1 divorce per 1000 population, and by 1988 this had risen to 3.3 divorces and only 9.4 marriages per 1000. Moreover, one quarter of marriages ended after less than five years (Pilkington 1992: 208). The demographic problems were linked to the instability within marriages which it was believed discouraged women from having children.

The focusing of attention on the 'family', biological reproduction and women's role within it served to enforce women's domestic responsibilities. Within the dual burden literature there is the assumption that family responsibilities created a situation in which women had neither the time nor the energy to strive for promotion within the workplace. However, while it is not denied that women have responsibilities in the domestic sphere that men do not, this is not a sufficient explanation of why women are segregated and lower paid within paid labour since it does not explain why women do not have the same access as men to better jobs. As will be discussed shortly, the rhetoric of motherhood and the family as central to women's lives was reinforced by concrete protective measures which were significant in understanding occupational segregation.

In relation to paid labour the family unit was also central to the accumulation process. In the period of the first five year plan, it was noted that many women were drawn into the workforce. It would appear that this would have benefited women by giving them a certain degree of independence from men and so challenged relations within the home. However, during this period, real wages were halved and the inclusion of women in paid labour did not bring

about an increase in families real incomes. On the contrary, in 1932, real income's per capita were only 51% of the 1928 level. This meant in effect that employers got two for the price of one and women, whose wages were far lower than men's, were still dependent on the family unit for their survival. "Wage policy did not encourage the 'withering away' of the family, but rather relied on the family unit as an effective means of labour exploitation" (Goldman 1993: 316-7).

Women's entry into the workforce therefore did little to change traditional family relations. Women not only remained financially dependent, but also perceived their role in paid labour to be secondary to the core, male workers. So while in terms of immediate decisions, women's family responsibilities may have limited their options for career advancement, political involvement, or may have resulted in them choosing to give up work or work part time if it was financially viable, such decisions can only be understood in relation to the wider policies concerning reproduction and the particular role that women played in this.

v) Sexuality

Sexuality in Soviet Russia was subjected to severe social control. While in the early post-revolutionary period, discussions focused on free love and the liberation of sexuality, by the late 1920s, sexuality came firmly under the rubric of state control. Sexuality was constrained in terms of : legislation limiting the forms that were permitted, the deviation from which was regarded as anti-Soviet activity; the state discourse on sexuality, which linked sexuality to state duties and certainly did not present sex as anything to be enjoyed, particularly by women; and finally it was constrained in

terms of the control of knowledge with virtually no sex education available to young people. This control over sexuality was central to political authoritarianism and the denial of individualism, but also to the control over biological reproduction, since by preventing discussion of and indeed outlawing any form of sexual activity that could not produce children, that is, homosexuality, sex was presented as related purely to reproduction. The emphasis on biological production and the family, established rigid boundaries for the expression of individual sexuality. Indeed, "it presented disciplined, heterosexual sex within marriage as the only true model of Communist sexuality" (Shreeves 1992).

Therefore, attempts to regulate biological reproduction were directed solely towards women and concentrated on controlling their reproductivity either directly through birth control or indirectly through propaganda campaigns and family legislation. However, there was a second aspect to the state's strategy towards women - the attempt to regulate women's labour force participation, in particular the focus on the 'protection' of women as potential mothers and so as a privileged group of workers.

Control over women's paid labour

Protective legislation in Soviet Russia took two basic forms- as measures to encourage women into the workforce, and into particular sectors of the economy, and as measures to safeguard women as potential mothers. Various measures were introduced to encourage women to enter production. The Council of Peoples Commissars drew up a list of occupations and trades to be reserved

predominantly for women thus hoping to encourage women into these newly designated forms of 'women's work'.

However, while women were in general encouraged to participate in the workforce, limits were set to this participation. Though the 1918 Labour Code established legal equality for women at work it also maintained the protective legislation enacted in the 1890s (Dewar 1956; Griffin 1968). Women were banned from night work and overtime and from any jobs detrimental to their health. A list of jobs was drawn up from which women were excluded. This was in line with the idea that procreation was a social function for women and their special duties in this matter required protective legislation.

This legal 'protection' of female workers fluctuated according to the need for women in the labour force, that is, in the times of greatest demand it was relaxed and when demand fell it was re-introduced.[4] In this way, women were regarded as a flexible workforce and protective legislation was often directed towards that end. During the NEP, the equal right of women to employment was tossed aside in the face of a decline in the demand for labour. Night work and overtime bans were put into place and women were the targets of redundancies. In the first five year plan period, the ban on night work was lifted and appeals were made in *Pravda* to repeal the ban in underground work. In 1940 further job restrictions for women were lifted when occupations previously banned for women were opened eg mining, work on river transport and cargo ships etc.

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[4] For example, during NEP job restrictions in terms of overtime, and underground work were enforced but abandoned in 1940 when the need for female labour was most acute.

Protective legislation often meant that women were excluded from many skilled jobs, in particular when legislation sought to 'protect' women from the dangers of mechanisation. So in the post war period, as new mechanised jobs were created they were consistently denied to women who instead became further entrenched in the heavy manual auxiliary work that was not subject to mechanisation and from which it was not necessary to protect women. This was reinforced by the restriction of access to training programmes to allow women to qualify at least formally for skilled work. Until 1967, women were barred from courses at vocational training colleges for certain skilled trades, for example tool setters on automatic machines and electrical fitters. Even after this ban was lifted, intake at the colleges was still biased against women since it was based on the requirements of the factory directors who more often than not requested male trainees. The segregation of women into particular sectors and occupations was firmly entrenched in the decades following Stalin's death. During this period the contradictions between women's contribution to production and their role in reproduction were particularly transparent.

Protective legislation not only offered little protection to women in terms of their health at work but it also had severe negative consequences for women. During NEP this 'protection' made women an expensive option for factory managers and indeed was to a large extent accountable for the high levels of unemployment among women at that time. This 'protection' signified women, in both material and ideological terms, as weaker and as a secondary group of workers. By forcing employers to provide childcare facilities, paid maternity leave, time off for sick children, time off for breast feeding,

and by restricting the ways in which women could be used within the workforce, for example the overtime bans, the state was not creating a group of privileged workers as they claimed, but instead ensured that in the eyes of the managers and other workers, women workers were problematic. Also, being in need of constant protection as mothers, they could never be seen as 'real' workers who were fully committed to their work. Protective legislation therefore reinforced and was part of the gender discourse concernng women's labour. In turn this acted to shape women's decisions in relation to employment and as such the stereotypes of women as second class workers were often self fulfilling. For example, as will be discussed in chapter 5, women often gave as their reason for entering medicine, the belief that women are by nature suited to this type of work.

In Soviet Russia, women's role or potential role in biological reproduction was a functional aspect of the state's concern for the reproduction of the labour force and of the reproduction of the nation. The contradiction between the dynamics of production and the requirements of biological reproduction took the form of a contradiction for the central planners since their primary aim was to raise the amount of surplus produced. As a result, they were faced with the contradiction between the immediate need to appropriate the surplus and the long term need for a new generation, for the reproduction of the nation. Women were simultaneously potential producers and reproducers and were therefore contradictory for the overall aim of the central planners. In Soviet Russia this contradiction was particularly acute since given the labour shortage, women were a key element in the labour force and their participation in paid work was vital for the operation of the system. Yet at the same

time it was essential for the long term reproduction of the system and therefore for the central elite, that women's role in generational replacement be ensured. Women were subjected to controls both as reproducers and as producers, as the central elite sought to minimise the effects of the contradiction.

Nevertheless, it is important to recognise that women were not simply passive objects of the centre's strategy to control their reproduction and labour force participation. It was as individuals in response to the conditions to which they were subjected women acted to limit their family size and as individuals that they responded to the difficult conditions within which they worked. In turn, these responses acted to shape central policies. Regardless of central policy or dangers to their health, women clearly did not see the restrictions on their work as for their benefit or the benefit of their children. Rather they were simply limiting women's opportunities to earn more money. One female lift operator in the mining industry argued that "if women want to work in harmful and heavy labour it is their right" (Trud 21/7/88). Not only did this kind of work provide greater monthly earnings but also a higher pension ten years earlier than for work in better conditions. Soviet women felt they had a right to these entitlements and were willing to pay almost anything for them. As one female miner said, "offer me good wages and I'll crawl into a nuclear reactor let alone go underground" (Laputina 1990). It is clear from this that women reacted to their segregation in low paid jobs, by seeking additional earnings through involvement in dangerous work. In turn, this created a more real need for protective legislation to be implemented.

While Russian women could not act collectively or have a collective voice, they did react to the conditions within which they lived and worked, often in ways which were contra to the directions of central policy. Similarly managers of workplaces were not simply state puppets, but acted to preserve their positions in ways which were not necessarily functional for the economy as a whole. This will be discussed below as the second aspect of social reproduction is examined - the reproduction of the form of control.

2. Gender Relations and Forms of Control

It was mentioned above that as the manifestation of the 'nation', women's role in biological reproduction served the purpose of legitimating the Soviet system and so of the central elite. But women were central to the reproduction of forms of control in more direct ways. The form of control over the Soviet population can best be described as 'authoritarian paternalism' (Clarke et al.. 1994) . While on the one hand, the population was atomised and severely restricted in relation to freedoms of movement and association, they were at the same time provided by the state, with social services and goods, however limited this provision was. As a result of the policy of nationalist militarism, the social sphere was neglected and underfunded. This in turn meant that the provision of social services and goods became a useful tool to fragment and so to control the population. Not only were the elite given access, by virtue of their position, to shops, clinics and so on, that ordinary people were denied, but also within and between workplaces, certain groups had greater access than others.

This was most apparent in relation to the social function of the workplace. The workplace in Soviet Russia was not only a place of employment but was also a distribution service for the workers. The services provided extended beyond those required to allow employees to engage in paid labour, such as kindergartens but also included medical facilities, cultural facilities, the provision of holidays, education and training, and housing. In this way it is clear why the Soviet workplace was regarded as 'a state within a state' (Clarke et al.. 1993: 24). In addition to these services, the workplace was also responsible for the distribution of benefits such as sickness or maternity benefits.

Finally, it acted as a retail outlet for the purchase of consumer goods, clothes, food etc. For individual employees, access to supplies of housing, consumer goods, medical supplies etc was very limited and the wage received was not sufficient means by which to secure the provision of the goods and services needed for their daily maintenance. Thus the employees were dependent on their workplace for the provision of the necessities of life and as such the management had a powerful form of control over the workforce. For instance in relation to attempts to curb labour turnover in industry, the value of sickness benefit paid was tied to the length of uninterrupted work within the enterprise.

Gender relations can be understood as an integral element in authoritarian paternalism. Firstly, in relation to their role in biological reproduction, women received benefits and services which were not given to men. Primarily this refers to maternity benefits which can be seen to represent a specific form of control over female

workers since eligibility was tied to union membership and length of service with the enterprise. Similarly, leave to care for children was only granted to women. They were allowed a basic 112 day paid maternity leave with an option for one year's unpaid leave. In addition to this women had the statutory right to extra days off for family matters, extra holidays and to choose a more flexible work schedule. These latter benefits were rarely provided by workplaces highlighting the difference of interests between the centre and the managers. However, to the extent that they were implemented, it can be seen that the gendered nature of the enterprise's social distribution function served to entrench further the subordinate position of women. In particular, the eligibility requirements for maternity benefits and leave served not only to make women dependent on the enterprise, but it also gave credence to the idea of women as less reliable, second class workers and so their placement in the lower division of the labour hierarchy.

Secondly and related to this, gender was inherent in the hierarchical structuring of the labour force and so its fragmentation. The Soviet planning system was characterised by a bargaining process between the centre, the ministries and the workplace and also in the relations between management and employees. So not only were employees dependent on the workplace for their reproduction, but their ability to bargain for a share of the facilities, goods and benefits provided by their workplace depended on their position within the labour hierarchy. Gender was therefore also a key aspect in the ability of workers to bargain with the management for their share in the distribution of services and goods.

2.1 The Labour Hierarchy

The labour hierarchy was ingrained in the nature of the Soviet system. As was noted, the nationalist militarist policy left the social sector underfunded. This created a hierarchy within the economy as a whole between the industrial and the service sphere, which was reflected in the pay and provision of goods and services to employees. Those industries most closely tied to the service sphere, for example textiles, were similarly neglected and employees suffered lower pay and worse conditions than their counterparts in heavy industry. Within workplaces, there was also a hierarchy between different categories of employees. Divisions existed in relation to the level of skill attributed to particular occupations and in relation to the level of responsibility associated with it.

What is most significant here is that the labour hierarchy was also a gender hierarchy. The majority of the 'labour surplus' involved in unskilled manual work in heavy industry were women.[5] In light industries such as textiles, though women predominated on the shop floor, control was in the hands of male managers and it was men who held the most prestigious posts involved in repair and regulation of

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[5] Within heavy industry, there existed a labour surplus of unskilled workers involved in auxiliary work. They were a labour surplus in the sense that their jobs could easily have been made redundant with basic mechanisation. Their positions were maintained because of the role that they played in end of the month 'storming' to meet quotas, and because by hoarding labour the management could raise the wage fund and so pay the skilled workers more. In conditions of a labour shortage and high labour turnover, this was the primary means by which enterprises could attract and keep labour.

machinery, including regulating the pace at which the women worked. Women composed the overwhemling majority of employees in the service sector. Their employment, and low pay in this area, provided a functioning service sector at minimum cost to the state, which then allowed more to be ploughed into heavy industry. Within particular occupations in the service sphere, women predominated in the lower skilled work, for example as will be discussed in more detail in later chapters, within medicine almost all nurses were women, and while the majority of doctors were women there was also a strict gender hierarchy in relation to specialisations within the medical profession. The gender hierarchy within the Soviet economy can therefore be seen to operate at two levels, that is, at the level of the workplace, and at the level of the system as a whole.

There are several aspects involved in an understanding of the gendered nature of the labour hierarchy. Firstly, the labour hierarchy was ingrained in the nature of Soviet central investment and planning. One consequence of nationalist militarism was the development of an economic hierarchy which focused investment on heavy industry and the military at the expense of light industry and the service sector. This created a hierarchy between these sectors of the economy. In addition, within the workplace, the labour hierarchy served the purpose of fragmenting the workforce and also enabling the management to give concessions to the most skilled workers. Given the problems of labour shortage and high labour turnover, it was essential for managers to be able to sustain their workforce and so to meet output targets and retain their own privileged position (Clarke 1992: 20-2). Labour hoarding was common practice by workplaces in part because the centralised allocation of the wage fund,

calculated according to the number and grade of workers employed, gave workplaces the incentive therefore to employ as many low grade and so low paid workers as possible without negatively affecting production, in order to receive a higher wage fund and so have the means with which to pay higher wages and bonuses to the skilled labour force.

It is not clear from this why it was women who filled the places at the lower end of the hierarchy. In part this can be explained in relation to the employment patterns that developed in pre-revolutionary Russia. Within industry women were prominent in textiles while men dominated in metal working, and within the service sector women were prominent though only within the less prestigious areas, for example as nurses but not as doctors. In the post revolution period, women entered the labour force with fewer qualifications and experience than men. For male workers therefore, the options were wider and a reordering of the work that was desirable to them took place. As was noted earlier this pre-existing hierarchy was reinforced directly by the protective legislation employed by the central elite to address the contradiction between women's productive and reproductive roles. Women were barred from work in many occupations regarded as the most highly skilled and functioning within the most prestigious sectors of the economy. This limited the choices that women could make regarding the type of work they wanted to do.

For managers, protective legislation was regarded as an obstacle to their main aim, that is, meeting their performance requirements. While the legislation was often flouted by managers, it nevertheless

meant that women were limited in the work they could do and so were regarded as less reliable than men, as second class employees. In addition, women's domestic responsibilities also reinforced the idea of women as unreliable workers. As a result, women were often denied, by managers, the provision of training to improve their skills and so allow them access to the male dominated skilled jobs.

The relationship between male workers and managers also played a role in the creation and maintenance of the gendered labour hierarchy. On the one hand, by the mid-late 1920s the collective power of the unions was destroyed. Nevertheless within industry, the workers retained a form of individual control and the managers and trade unions, as managerial appendages, sought to appease them through the payment of higher wages, but also by maintaining the prestige of their work, by limiting the number of women within it. The pre-existing gender hierarchy therefore fitted neatly into the production relations that emerged within Soviet industry.

The situation was very different in the male dominated professions. The lower place that the service sector was accorded in the investment hierarchy and the aim of the central elite to destroy the power of the professions meant that the once prestigious occupations such as medicine, became very unpopular among men given their wider options in skilled work within the new industries. Therefore, while male workers did not directly prevent women from entering skilled work, their actions within the system often meant that this was exactly what happened. Either through labour turnover or through the avoidance of certain occupations, women's choices were to a certain extent structured by men's choices.

The attitudes of male workers and managers and indeed of women themselves can in part be seen as a reaction to the reorganisation of the economy in the Soviet system, but also as a reflection and perpetuation of the prevalent ideology in Soviet Russia that women are to some extent inferior to men particularly in the field of paid labour and as such are regarded as second class workers.[6] There were clear distinctions between what should be men and women's work in the eyes of both men and women, for example, it was generally believed that men should do heavy work and women light work because women were physically weaker and heavy work may endanger their reproductive capacities. It was also generally believed that women were less able to work with technology than men (Bowers 1996). However, while ideology must be regarded as a significant factor in understanding gender inequality, ideology does not exist in isolation but stems from the relations of production and reproduction, which take a highly gendered form in class society, so it is only within that context that it is possible to examine the significance of ideology.

Gender ideology in Soviet Russia took the material fact of the biological difference between men and women and from this presented the gender division of labour as natural and universal and moreover as the foundation of social organisation. Consequently

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[6] There is a huge debate within Marxism concerning the nature of ideology. Here I employ the definition used by Miles (1989) which refers to ideology as "any discourse which, as a whole (but not necessarily in terms of its component parts) represents human beings and social relations between human beings in a distorted and misleading manner. Thus ideology is a specific form of discourse. The discourse need not be systematically or logically coherent, nor be intentionally created or reproduced in order to deceive or mislead, even though that is its consequence".

women's natural role in life was presented as related to childrearing and household chores in the domestic sphere. Women's involvement in work outside this sphere was therefore regarded as secondary to men who are seen to be the 'real' workers. Thus nature served to mystify the complex social relations involved in the oppression of women by providing some form of justification for the continuing existence and instigation of processes that maintain it (Miles 1989: 87).

The labour hierarchy was central to authoritarian paternalism. On the one hand it fragmented workers, within individual workplaces, between industries and between sectors of the economy. On the other hand, it served as the basis for the bargaining power of ministries, workplaces and workers. In both these respects, gender was a central element in the labour hierarchy as the workforce divided along male/female lines and women's bargaining power was limited by virtue of the occupations and sectors within which they worked. In industry the gendered labour hierarchy enabled managers to attract and hold onto skilled male labour in conditions of the labour shortage because the surplus labour positions that women filled contributed to the wage fund. In the service sector, most notably in health care, managers and ministers were keen to raise their status, and associated with this was reversing the male/female ratio in the medical profession. Women were channelled into the less prestigious occupations and specialisations such as nursing or pediatrics in order to free what was regarded as the best work for men. By limiting the number of women in such work, the idea of men's work as the most skilled was perpetuated.

As gender was wholly integrated into Soviet production relations, this in turn further complicated the attempts to resolve the contradiction between production and reproduction. While on the one hand the labour hierarchy was central to control, women's position within it often meant that they were engaged in work that was contradictory to the protection of their role as reproducers. This highlights the fact that gender inequality was not necessarily functional for control. The position of women within the labour hierarchy can be seen as contradictory firstly in relation to the involvement of women in work which violated the protective legislation designed to minimise the impact of women's labour on generational reproduction. Secondly, the unmechanised work women were engaged in, in heavy industry, was wasteful for the economy as a whole. Thirdly the low pay and so low morale of workers in the service sector meant that standards of work were often low. In some areas, this was extremely problematic, for example in medicine, low quality work had an impact on the health of the labour force and so on production.

Conclusion

In this chapter I have tried to explain the structures within which women in Russia had to take decisions and not merely describe their circumstances as a dual burden. This involved an examination of the significance of gender for different aspects of reproduction and the contradictions between production and reproduction. It has been shown that by clarifying the specific meanings and usage of the concepts production and reproduction it is possible to arrive at a framework for understanding the nature of the Soviet system and the position of women within it which neither marginalises gender

relations by detaching them from the context within which they operate nor marginalises them as theoretically insignificant.

It was shown that 'reproduction' cannot be used indiscriminately because women are involved in biological reproduction. The concept must be defined and the relevance of its specific meanings examined. Social reproduction in Soviet Russia referred to the state's strategy towards biological reproduction and the reproduction of the form of control. The concern over biological reproduction was composed of two elements. Firstly, in relation to the reproduction of the nation, the place of the USSR within the world system, as a communist state in perpetual competition with the capitalist world established and maintained the need for a strong economy and military sector. This world competition also fostered the 'appearance of nationhood' as Soviets were distinguished from the outside, capitalist world. The implication of this for women was state policy directed towards women's obligation to reproduce the new Soviet citizens on the basis that 'people are power'.

This ties into the second aspect of biological reproduction, that is, the reproduction of the labour force. The reproduction of the next generation was particularly important in relation to the economy and the demand for a labour force. The demands were primarily quantitative, so the pressure on women was to have more children. For example, the Soviet health labour force was compared that of the USA or the UK in terms of the ratio of doctors per 1000 population. There is no question that the USSR was numerically stronger, yet the quality of care and of training of the army of doctors was so poor as to make the quantitative victory a sham.

Nevertheless, women's role in generational reproduction was contradictory for the central authorities in Russia since on the one hand the full participation of the female labour force was essential for production, while on the other hand this was problematic for the long term reproduction of the next generation as the falling birth rates clearly indicated. Consequently, policy towards women was double sided in line with the attempt to utilise fully the potential of women as direct producers while at the same time ensuring their role in generational reproduction was maintained. The use of protective legislation was particularly important in this respect.

The second aspect of reproduction refers to the reproduction of forms of control. Gender was significant in relation to authoritarian paternalism in part because of the particular forms of control exerted over women in the attempt to control their biological reproduction and their labour. But gender was also significant in relation to the labour hierarchy. The essence of authoritarian paternalism lay, on the one hand, in the fragmentation of the workforce and on the other hand, in their dependence on the workplace for the provision of social services and goods. The labour hierarchy was central to both elements and in turn gender was the key feature of that hierarchy.

The gendered labour hierarchy between different sectors of the economy meant that prioritised sectors could be subsidised by those regarded as 'peripheral' to the economy as a whole. Within individual workplaces, the labour hierarchy meant that concessions could be given to the skilled workers who were in greatest demand in the context of the labour shortage. Places were reserved for men in the

'best' or most 'skilled' positions and in turn this came to define male work as skilled work regardless of the actual nature of the work itself.

This was not the result of collective action on the part of the male workforce, but rather can be understood as a combination of the impact that protective legislation had on limiting the type of work women could do, the portrayal of women as second class workers, which protective legislation reinforced, and the desire of managers to protect or improve their own positions by ensuring that they met their targets for the plan. This meant that they would try to secure their workforce any way they could. So, if as in industry, skilled workers were hard to retain, in addition to offering the concessions and higher wages mentioned above, they could also limit the number of women in certain positions. Similarly, in medicine, the 'reservation' of surgery as a male specialisation was designed to encourage men into the female dominated profession. As a result, women's choices were constrained by their segregation into the peripheral sectors of the economy as a whole and within enterprises and as such, gender was a central component of Soviet production relations. However, this in turn acted upon the attempts to balance women's role in production and reproduction by establishing women as central to the productive process not just quantitatively but also qualitatively.

The contradiction between production and generational reproduction and the importance of the labour hierarchy also had implications for the position of women in the family. Their status as second class workers not only limited their economic independence by ensuring they were paid on average one third less than men, but also further

entrenched the idea that women were primarily responsible for all domestic chores and so established for them the ubiquitous double burden. This in turn acted upon the production relations by limiting women's commitment to paid labour and by validating the gendered nature of social benefits and so indirectly validating the form of control over workers.

Moreover, the reproduction of the form of control and biological reproduction must be understood as interrelated. Nationalist militarism engendered structural costs in the form of a neglected social sphere. This created shortages of social services and goods and in turn these shortages served as the means by which the population could be fragmented and controlled. However, as a result, Soviet people experienced bad living conditions, working conditions, poor quality health care and so on. This was inherently contradictory for the central elite and for the economic 'race' with capitalism because, the poor health of both men and women had an impact on their productivity and Soviet economic success.

At the same time, the constant concern for a strong economy, arising in part to give the illusion of success to the capitalist west and in part to secure the positions of the central elite, had implications for the reproductive capacity of both men and women. While in relation to, women the connections between their work in harmful conditions and with hazardous substances and problems with fertility, pregnancy and infant illness are clear, there is also a connection to be drawn between men's working conditions or environmental pollution and their fertility, or the birth of sick and deformed children. The fact that this was ignored highlights the fact that while the central elite sought

to resolve the contradiction posed between women's productive and reproductive role, the concern for women's reproduction, was a concern for the idea of the nation which women, as those who gave birth, were seen to represent.

It is clear therefore that we must move away from an understanding of the position of women in Soviet Russia in terms of their dual burden. The ways in which gender relations became enmeshed with labour relations during this period are both complex and contradictory and indeed lay at the root of the system itself. With this in mind, this is an area that deserves further study and debate particularly in view of the burgeoning interest in Post Soviet society.

WOMEN IN SOVIET MEDICINE

In the following chapters, the key points in the theoretical discussion will be illustrated through an examination of gender inequality within the Soviet medical profession. From this discussion it will be shown that the patterns of gender inequality in Soviet medicine should be understood in relation to the state's strategy of social reproduction and the reactions of women to this.

Chapter 3 seeks to explain the horizontal segregation of women in medicine in relation to state policy towards women's paid labour in the formative years of the Soviet system and and in relation to the control sought by the new regime over professionals. On the one hand the strategy of social reproduction transformed the medical profession from a relatively prestigious, autonomous occupational group to one of the lowest paid categories of state employee, and at the same time it necessitated the use of women in all areas of the economy where men were lacking. The reduction in status of medicine in the Soviet era deterred men from entering and created a labour shortage that women were expected to fill.

Chapter 4 continues this discussion and demonstrates that while women predominated in the medical profession, their work was often hard or dangerous and their reward was very low. This was contradictory for social reproduction in two key ways. Firstly, in relation to biological reproduction since the underfunding of health care meant that women's working conditions could be dangerous, but also that their low pay was in itself a deterrent to increasing the birth rate. It also highlights the ways in which protective legislation often

served the purpose of controlling the allocation of women in the labour force rather than genuinely protecting them. Secondly, low pay and poor working conditions were also contradictory for social reproduction in relation to the role that doctors were expected to play in regulating production and reproduction.

It was argued in Chapter 2 that it was not only state policies that were important in understanding the patterns of gender inequality, but also the reactions of women towards this and how indeed such reactions shaped future state strategies. In Chapter 5, the way women themselves explained their choice to enter medicine and the choice of specialisation will be examined. In addition women's explanations for patterns of vertical segregation will be discussed. While the medical profession as a whole was low paid and held little power within the system, there was a distinct hierarchy of pay and authority within medicine which was also a gender hierarchy. It will be argued that the exclusion or limitation of the numbers of women, from certain specialisations and career paths within medicine served to bolster the position of these groups in relation to the wider labour hierarchy.

3

THE SOCIAL TRANSFORMATION OF THE MEDICAL PROFESSION

In order to understand fully the position of women within the medical profession in Russia it is essential to place this in the context of the changing nature of health service organisation and the work of the medical profession that occurred during the formation of the Soviet system. It is possible in this way to look at how the medical profession was shaped in line with the demands of the new leadership and what role they were expected to play. Central to this is an understanding of how gender relations influenced the formation of the new Soviet medical profession. Two key questions will be addressed in the course of this chapter. Firstly, what changes took place within the medical profession during the post-revolution period? Secondly, how can the resegregation of medicine from a male dominated to a female dominated field be explained in relation to these changes?

There is considerable discussion within western literature on the sociology of the professions concerning the changes taking place with the heath service in America and Europe and the impact this is having and is likely to have on the status of the medical profession and the nature of their work (Relman 1980, Starr 1982, McKinlay and Stoeckle 1988). McKinlay and Stoeckle argue that a proletarianisation and corporatisation of physicians is taking place. The practice of

medicine is being channelled into large bureaucratic settings and physicians are forced to become salaried employees. As a result it is the directors of corporate medicine rather than physicians who will control medicine. Friedson argues that while these trends are apparent, the internal stratification of the medical profession, that is the division into the administrative elite, the knowledge elite and the ordinary practitioners, will enable the profession to maintain its control (Friedson 1984).

Given the increasing number of women in medicine, there are also attempts to give this analysis a gendered focus and to address the ways in which gender relations are related to what McKinlay calls "the social transformation of doctoring". Elston argues that while interesting, these accounts are gender blind. She questions the extent to which the process of feminisation is related to the proletarianisation which McKinlay refers to. She argues that changes arise both from external pressures on the medical profession and from within and while the changes have resulted in more women being admitted, there has also been a strengthening of gender segregation. In particular there is an increasing gap between practitioner positions often held by women, offering a more flexible work schedule, and mainstream positions.

While not directly relevant , given the very different contexts, the nature of the questions being asked in this debate are instructive when applied to the medical profession in Soviet Russia. There were two key changes which took place in the post revolution period - deprofessionalisation and feminisation. The relations between these are complex and radically altered the social character and the nature of

the work carried out by the medical profession in Russia. From a male dominated, prestigious and relatively powerful social stratum, under Soviet rule the medical profession emerged as female dominated, low paid state employees with no autonomy vis-a-vis the state. Gender relations are central to the understanding of these processes and indeed became an integral feature in the reconstruction of the medical division of labour in Soviet Russia.

Deprofessionalisation of the Medical Profession

Any new regime must face the task of establishing itself in power and this necessarily involves addressing its policy priorities, the involvement of particular social groups to achieve those aims, and quashing of any opposition. In this respect, for the Bolsheviks, specialists, including doctors, were of key strategic importance. The success of the new system was seen to lie not only in the development of new technologies for industry but also the establishment of a comprehensive system of health care, to ensure the health of the new industrial workforce. Specialists were a potentially powerful group in the new system by virtue of their specialised knowledge. As Bailles notes, "from the Marxist point of view, the engineer and scientists represented a threat more dangerous than the capitalists themselves. If control over the means of production is the key to political power, then the historical role of the capitalists would come to a predetermined end with the abolition of private property. It was much more difficult to foresee the day when the technical intelligentsia might disappear as a unique and indispensable group" (Bailles 1978: 119).

Since many specialists, prior to the revolution had supported the Provisional government, the Bolsheviks were in an ambiguous position, classifying them as opponents while at the same time requiring their skills. Lenin recognised this point when in 1917 he said, "we must immediately without awaiting help from other countries, increase the forces of production. To do this without the bourgeois specialists is impossible" (Schecter 1992: 55). Doctors were classed as part of the bourgeois specialists. Not only had they catered for the upper class, but they were also themselves part of the elite. Lenin made his attitude towards doctors very clear, when at a meeting with physicians in 1917 he said, "you sit in your offices and laboratories worrying about your salaries, your apartment and where to go for an evening's entertainment..It is the workers that are the strength of our country and it is for them that we will take power from you and put it in the hands of the people. Soviet medicine will not only be for the rich" (Knaus 1981: 75-6). Yet at the same time Lenin recognised that the health situation in Russia was appalling, so much so, that it could endanger the development of the new system itself. As he said, "either the lice will defeat socialism or socialism will defeat the lice"(Ryan 1989:7).

To a certain extent the ambiguity of this position was reflected in the dual nature of policies towards doctors as individuals. On the one hand, monetary incentives were offered for work. This in turn created resentment among the rest of the population and led to 'specialist baiting'. But on the other hand, property was confiscated and food or accommodation rights withheld (Field 1957: 49-50). But towards doctors as a group, the policy was far more straightforward. There could be no professional groups operating independently from the

Bolshevik state, indeed the whole concept of professionalism was at odds with Bolshevik ideology.[1] The central aim of the Soviet state regarding doctors therefore was a policy of deprofessionalisation. There were many aspects to this which will be examined in turn.

Firstly, attention was turned to the Pirogov society.[2] After the February revolution in 1917 the Pirogov society set up the Central Medical Sanitary Council, to oversee health care. This re-established the society as a power base for doctors. At the same time, doctors set up a new union, the All Russian Soviet of Professional Associations of Physicians, to defend their interest. Both organisations were targeted by the Bolsheviks for elimination, in their attempt to undermine the collective power of physicians. The Medical Council was abolished, the Pirogov society forbidden to hold meetings and the union declared illegal. The Bolsheviks set up their own union incorporating all medical personnel from auxiliary workers to professors (Field 1957: 45-62).

Secondly, there was a conscious attempt to widen access to the medical profession. In part this was required in order to fulfil the demands of the newly created socialised medical system. If there was to be universal health care provision, the number of doctors would have to increase. As Knaus points out, "in a desperate effort to correct the deficit caused by war, famine, epidemics and emigration...the Soviets opened the medical institutes to all comers. Peasants who had graduated from secondary school - and who could frequently not read

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[1] A professional occupation can be defined as one which is self regulating, involves specialised training and operates according to a code of ethics and corporate responsibility. Their specialised knowledge lies at the root of their power.
[2] The Pirogov Society was an organisation for doctors prominent from the 1860s.

or write- became medical students" (Field 1957: 79). However, widening the profession was also closely related to the policy of deprofessionalisation. If control over access was denied to the medical profession, and indeed access was made ridiculously easy, the mystique that surrounds professionals on the basis of their specialised knowledge would be severely undermined.

The rapid growth of the medical profession was based on two processes- proletarianisation and feminisation. The latter will be examined in more detail shortly. The proletarianisation of medicine was the key to the attempt to resolve the ambiguity that doctors posed for the central elite. If a new breed of socialist, Bolshevik supporting, doctors could be established, then advantage could be taken of their specialised knowledge without any concern for their potential power as specialists. In 1918 a decree ended entrance exams for medical institutes and institutions were set up to prepare workers for entrance to medical institutes. In 1924, children from non proletarian backgrounds were subjected to fees in order to discourage them from entering university.

While the proportion of proletarian medical students did increase they never became the majority as was planned. Moreover, many of those students simply did not have the educational requirements to complete the course. In 1926 entrance exams were re-introduced. The reason for the failure of proletarianisation was not only the educational ability of the working class students, entering university with very little training, but also the low priority given to medical faculties. The planned proportion of proletarian students in medical faculties was set far lower than other more important faculties such as

engineering, making it easier for non proletariat students to enter medicine. One women said she went into medicine because her father had been a kulak and she would not have been able to enter any other faculty (Field 1957: 64-72).

However, it was not until the 1930s and the onset of industrialisation that the labour intensive strategy began in earnest. A decree was issued in 1930 which stated that "the numbers of persons completing medical *vuzy* [3] lag far behind the demand for qualified medical workers : this shortfall is explained by the inadequate targets for admission to medical *vuzy* and the duration of study in them" (Ryan 1989: 9). In 1934 quotas for increasing the number of doctors being trained were set. It was intended that all medical *vuzy* should double their intake in the period 1934-7 (Ryan 1989: 10). In this period of repression, this could not be resisted by the teaching staff, even though many were opposed to it, since they were already labelled as a group, as bourgeois specialists, and so in a vulnerable position.

The policy of widening the profession also led to the reorganisation of *vuzy*, the institutions of medical education, and their subordination to the Commissariat of Health rather than the Ministry of Education. In 1936 medical faculties were detached from universities and became vocational schools. As Schecter points out, this had major implications for the status of the profession. "By turning medical schools into vocational schools the message of the leadership was not equivalent to other sciences" (Schecter 1992: 66). As result medicine lost much of the prestige associated with science.

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[3] Vuzy refers to all higher education institutions.

The loss of prestige associated with the reform of medical education was also reflected in the educational level of the students and the extremely low exam requirements. One women who trained in 1936 noted, "I was amazed at how easy the instruction was. All the professors wanted the students to do well. They asked very simple questions and said that as long as we read each lecture..we would pass. Many of my class mates had trouble with reading because their secondary school education had been so poor, so I helped them with their lessons" (Knaus 1981: 83-4). The inability of teaching staff to protest and the continual demand for new doctors created an extreme case in which exam marks were the success indicators, not only of the students but of the teaching staff. The emphasis was on increasing the numbers who passed regardless of the levels of knowledge of the students. So just as in industry where the positions of the managers were based on output quotas regardless of whether the items actually served the purpose they were intended for, in medical *vuzy*, the positions of teaching and administrative staff were based on output quotas of pass marks with little concern for whether the new doctors were capable of performing their duties.

Thirdly, deprofessionalisation was accomplished by increasing political controls over the medical profession. An essential element in the reform of medical education was its politicisation. Often, political lectures accounted for one third of lecture times and student requirements in this area were taken more seriously than their medical achievements. Failure to complete political studies assignments brought the threat of expulsion whilst failure to complete ordinary course work met with no form of punishment (Schecter 1992:69). This politicisation was another form of control

over doctors, ensuring that all students would toe the party line and were aware of the impact of political controls from their earliest days of service. As graduates, doctors were aware of party controls at the workplace in the form of party physicians. Such doctors were resented but treated cautiously for fear of any reprisals. One doctor noted that "if a physician was a party member, he was distrusted because a party physician was always forced or obligated to serve his party and nothing else. But this distrust could not be expressed. You just had to behave politely" (Field 1957: 126).

The political control over doctors was also determined by the allocation of graduates to posts. Although the distribution of doctors throughout the country, in particular into the rural areas was an essential component in the development of a universal health service, under Stalin it was more important as a means of control over doctors. By separating doctors spatially, communication was prevented and so made any possibilities of doctors establishing a corporate identity unlikely. This form of control was necessarily contradictory however, since exemptions for rural service were given to women with families and given the fact that the majority of doctors were women, most managed to evade their call up.

The industrialisation strategy also increased the level of political control over doctors. Not only did industrialisation draw funds away from health care, but doctors were charged with the responsibility of ensuring the workforce remained healthy enough to allow for constantly increasing productivity. This responsibility led to the creation of health stations within the factories, with doctors regarded by the state as a key element in the fight to control labour. In this

respect doctors were themselves controlled by the state and were often held responsible for accidents or ill health among workers.

Political control over the medical profession reached its peak in the 1930s with the purges. It is estimated that 5000 medical professors were executed during the 1930s, primarily as a result of their criticism of the reforms in medical education. The purges also had a huge impact on research interests, creating an environment of fear in which only acceptable projects could be carried out. For example, the study of genetics was abandoned and removed from the curriculum for thirty nine years because the idea that characteristics could be formed from genes contradicted the Soviet belief in the social or environmental improvement of the population (Knaus 1981: 85).

Nevertheless, following the purges there was a re-assertion of the authority of certain sectors within the medical profession, not necessarily in their relations with the state but in relation to the position of other doctors. As will be discussed in the next chapter, the organisation of the Soviet health service served to bolster the position of the academic and administrative elites within the medical profession.

Deprofessionalisation was accomplished through the combined use of the removal of corporate identity and denial of collective representation, the widening of the profession by increasing the number of places in medical faculties and making examinations a mere formality, and by increasing political controls over doctors. While the medical profession was officially classed as part of the

intelligentsia[4], they were, as Churchward argued, the general intelligentsia, the lowest category and held no power. Indeed he argued that they were "restrained by the party machine just as the masses themselves [were]" (Churchward 1973: 18).

The social transformation of the Soviet doctor was characterised not only by deprofessionalisation but also by its feminisation.

Feminisation of the Medical Profession

At the end of WWI only 17% of doctors in Russia were female. By 1928 the figure had risen to 45%, by 1940, 61% and from the 1950s the figure stayed relatively stable at around 70%. Within a short space of time therefore, the sex ratio of the medical profession was almost reversed. It is essential to address fundamental questions relating to this change. Was there a deliberate state policy to include women in the medical profession or was this a result of the deprofessionalisation control strategy of the state? Before going onto do this however it is worthwhile giving a brief background to the entrance of women into medicine in pre-revolutionary Russia.

Women's entrance into medicine 1854-1917

The entrance into medicine during this period was a significant step forward for women and it is important to understand the origins and the development of this movement. By doing so it is possible to appreciate the fluctuation in the balance of forces involved in the issue of women's education and employment and the shifts from a strategy of exclusion to one of segregation.

[4] In the Soviet Political Dictionary the intelligentsia was defined as "a social stratum consisting of persons professionally employed in mental labour", in Churchward 1973 p4.

Largely due to the role that nurses played in the Crimean war [5], it was argued that women were not only capable of working in medicine, but were also extremely useful in this capacity in times of national crisis. Since entrance to the medical profession was determined by access to university training, the admission of women to higher education was of paramount importance. Women's education, as a topic of controversy, became a pawn amidst the political machinations reflecting the power struggles which characterised this period.

There was considerable support at that time, for women's admission to universities. Only Moscow and Dorpat University Councils failed to agree to the admission of women in a poll in 1861 (Johanson 1979). While for some education was the key to women's liberation and so had to receive full support, Pirogov, a prominent figure in Russian medicine noted that,

> "it is not the position of women in society, but her education - including as it does the education of all humanity- which needs to be changed. Let the idea of educating herself for this goal and of living for the inevitable struggle and sacrifice thoroughly penetrate the moral fibre of woman; let inspiration illuminate her will. Then she will know where she must seek her emancipation" (Stites 1990: 32).

Nevertheless far from everyone agreed with Pirogov's ideas. There were many objections to the education of women in general and to their involvement in medicine in particular. Warnings of social chaos echoed through the universities at the suggestion of women's admittance. One doctor recalls the reaction in her grandfather's class

[5] See Curtiss 1966 for an account of the role of the Sisters of Mercy in the Crimean War.

to the admission of the first woman student, Nadezhda Suslova, in 1861. "They were angry that a woman had been admitted to the institute. They considered medicine an improper profession for females" (Knaus 1981: 67). The objections tended to be expressed in essentialist terms, stating that women's character rendered them incapable of working as doctors. Mention was made of a study carried out in 1850 which claimed that Russian women were innately sensitive, loving and modest, while men were characterised by honour, energy and intellect (Knaus 1981: 68).

Women were regarded as naturally suited to caring and men to striving towards new achievements and new work. To some extent the work of the Sisters of Mercy may have provided ammunition for this argument. While they worked extremely hard in terrible conditions, due to lack of training their work was primarily as carers. This led to the arguments that, while women were useful in medicine, the natural gender division of labour was such that women were suited as nurses and men as doctors.

The widening of the medical profession at this time can in part explain the opposition to women's admittance to medical faculties, particularly among ordinary doctors and students.[6] At that time there was great concern over the social position and prestige given to the medical profession and the resulting remuneration. There is no doubt that many believed the admission of women, regarded generally as of second rate intelligence and capacity, to their profession could only serve to worsen their position, particularly since women had not been admitted to any other profession at that time (Knaus 1981: 72).

[6] The number of physicians more than doubled in the period 1864 to 1913 (Navarro 1977:12).

However, doctors had little collective or individual power under the reign of Alexander II, when the issue of women's education was most contentious. Rather, decisions were often made, not on the grounds of debate or public pressure, but as a result of inter-ministerial rivalry as ministers sought to protect their own positions within the volatile power structure of the autocratic system. Women were denied access to medical universities and turned to Zurich to fulfil their ambitions abroad. In 1867, Suslova became the first women in continental Europe to receive the full degree of Doctor of Medicine, Surgery and Midwifery. In response in 1868 the Russian Medical Council allowed Suslova to sit exams for foreign doctors and subsequently granted her the right to practice in Russia. From 1868 to 1873 over 100 women followed her example and went to train in Zurich (Johanson 1979).

However, political opposition associated with the Zurich community meant that the government demanded the return of the women training there. They were threatened with exclusion from any further education or employment regardless of their degrees, if they did not return immediately. Such threats were compounded by appeals to public opinion that the women in Switzerland were being subjected to loose morals and were being trained to perform abortions on each other. With little choice, most of the women left Zurich by the deadline, failing to complete their studies. Upon return they were offered places at the newly established advanced midwifery courses under the War Ministry. It was argued that the midwifery course offered gainful employment to unmarried or widowed women who may otherwise have turned to prostitution.

The first move of women into the male dominated field of medicine in Russia must therefore be understood in relation to the political concerns at the time, the professional concerns of the medical profession and wider questions of women's liberation. Women's entrance into medicine was controlled by reinforcing the correlation between women and children, as their natural role. It was not until the reign of Nicholas II that the establishment of the St Petersburg Medical Institute for Women in 1897 was approved. Nevertheless, women doctors were by no means the equals of their male counterparts. On the contrary though women gained access to medical education, not only was this education in separate institutes, but their work opportunities were also far narrower. The exclusion of women from medicine gave way to their segregation.

Female doctors in post -revolutionary Russia

The widening of the medical profession as a response both to the needs of socialised medicine and the desire to control physicians was noted above. In the years immediately following the revolution in 1917, there was a deficit of doctors. Partly this was a result of the increase in the number of posts being created, but there was also an exodus of doctors from the new state. Many left because they feared reprisals for their support of the Provisional government and many saw no place for themselves as independent professionals within the new system. During the civil war, the number of doctors also declined as thousands were drawn into military service, many of whom lost their lives. At this time, there were also severe health crises such as cholera and typhoid and it was estimated that in St Petersburg alone 46% of doctors died between 1917 and 1920 (Knaus 1981: 78).

Since it was primarily men who were occupied in the war as doctors and as soldiers, the deficit in medicine was necessarily filled by women. The same had taken place during WWI when the number of female physicians doubled from 2322 to 4000 (Ryan 1989: 38). By 1923, there were more women than men qualifying as doctors. Nevertheless while feminisation characterised the changing nature of the medical profession at this time, I have found no evidence that it was a deliberate strategy of the state. The aim of the state was to provide sufficient doctors and to exert control over them, so proletarianisation rather than feminisation lay at the heart of their proposals. It could be argued that women were targeted for inclusion in medicine because they were more passive and so easier to control. However, the experience of the Bolsheviks with female factory workers would have demonstrated that this was by no means true. The participation in and even instigation of strikes by women in the period preceding the revolution highlighted the fact that it could not be assumed that women workers were easier to control.

However, the state's policy towards women's employment in general contained the basis for the patterns of occupational segregation found in medicine. Women were actively encouraged to enter the labour force. Within the rhetoric of liberation under the new socialist state, their labour force participation was a vital element in their emancipation. In reality however the loss of men during WWI and the Civil war meant that women's participation in all sectors of the economy was essential. At the same time however, limits were placed on this participation, both in the form of ideological manipulation and more materially with protective legislation. The concern for women's primary 'duty' as mothers or potential mothers ingrained a

gender division labour into employment policy that would last throughout the life-span of the Soviet system. Certain occupations deemed unsuitable for women were drawn up and even Lenin himself spoke of the need for women's employment to be a 'continuation of motherhood' (Lenin 1965).

One of the clearest divisions that arose from this was between industry and services. While women were employed in both areas, the proportion of women in the service sector was far greater than men. On the one hand, work within the service sector fitted in with the image of what women's work should be, that is, an extension of their work within the home into the public sphere. On the other hand, it was also argued that this type of work was less harmful for women than work within industry and so allowed women to combine production and reproduction more harmoniously. However, service sector work is not necessarily 'safer' than industrial work. Rather, it depends on the nature of the work being done. For example, work in a laundry would be physically exhausting given the low level of mechanisation.

The movement of women into medicine reflected these tendencies. As part of the service sphere medicine was regarded as suitable employment for women. The work was seen to involve caring and nurturing rather than scientific research and as such fitted in with the image of women in employment. As one doctor said, "I suppose you could say we were more than nurses but less than doctors" (Knaus 1981: 89). However, within medicine, the contradictions and pretence of protective legislation is also highlighted. Work as a doctor in Soviet Russia was not only extremely physically demanding,

particularly in the countryside where conditions were appalling, but also very dangerous. The frequency of epidemics and the inability of the regime to control them meant that doctors were often themselves victims. Work as a doctor or a nurse could be as potentially damaging to women's reproductive capacities as work in industry.

Therefore, the employment policy of the Soviet state shaped women's labour force participation in a number of ways. Pronouncements on women's role in society focused on her dual functions as reproducers and producers and in line with this, certain types of work were recommended within the framework of 'motherhood'. The service sector typified this type of work. At the same time, protective legislation limited women's opportunities for employment, particularly within the more skilled jobs within industry. Such controls served to channel women into particular areas of employment, within the service sector and within unskilled work in industry, rather than performing any real protective role.

The high proportion of women in the service sector and in particular in medicine must also be understood in relation to the development strategy and investment priorities in the building of the Soviet system. Most basically, if women had not entered the labour force, in all capacities, industrialisation could never have taken place. In medicine, the huge increase in the number of doctors would have been impossible without the employment of women. This is clear from the fact that even during WWII and the massive losses incurred, the number of doctors rose substantially. At the start of the war,they had one sixth the number of doctors that the US had, but by 1949 the numbers were equal. Without the participation of women

such massive increases would have been impossible. The feminisation of medicine was therefore also shaped by the needs of the war.

In terms of investment, both the military and industry were from the start given top priority. This was reflected in the pay levels of the workers in these areas. The service sector was regarded as a vital component in the working of the economy yet was neglected in favour of what was seen as primary sector work. Medicine is a clear example of this, with consistent underfunding resulting in low standards and low pay. The priority given to industry, in particular heavy industry and to the military also served to shape the nature of the labour force. As was noted, women were banned from many skilled jobs within industry, but the other side of this was that men did not want to work in the low prestige sectors of the economy, such as medicine. Within higher education, a hierarchy emerged between different institutes reflecting the hierarchy within the economy (Fitzpatrick 1979: 5). For men therefore, within reason, the options were open to enter whatever profession they chose and for those who believed in the building of socialism, engineering was seen to serve a much more immediate and relevant function. As Sigerist said, "because their achievements were far more conspicuous than the physicians' work, engineering was more attractive to many intelligent young men than medicine" (Sigerist 1937: 66).

For those less ideologically motivated, the question of pay was also very influential. It was noted above that doctors were relatively low paid in comparison with other professions and even when compared to industrial workers and semi-professionals their pay levels were not

high. This situation worsened during the formative years of the Soviet system, as part of the deprofessionalisation strategy was to level out the pay for all medical workers and doctors were to receive little more than nurses or *feldshers*.[7] Keeping pay levels in medicine low, also allowed for further investment into other priority areas such as engineering. In addressing the question of whether pay levels were low because medicine was female dominated or whether medicine became female dominated because pay levels were low, evidence seems to point to the latter explanation. Not only was low pay a feature of medicine prior to massive female involvement, but it also acted as a deterrent to men, for whom higher pay in other areas was more accessible, resulting in higher female involvement.

The policy of the state in many areas therefore shaped the nature of the medical division of labour and its resegregation from a male dominated to a predominantly female labour force. Economic policy, the need for political control over labour and their treatment of the 'women question', all served to create a feminised medical profession.

Conclusion

The large-scale movement of women into medicine occurred during the foundation years of the Soviet system. During this period rather than being excluded from medicine, as in the earlier period, women's opportunities to enter medicine were widely available. The prevalent occupational control strategy at this time was therefore one of inclusion rather than exclusion. Deprofessionalisation and feminisation occurred simultaneously, but were not necessarily

[7] Feldshers were the equivalent of the American physician's assistant, being ranked between a nurse and a doctor.

dependent on each other. In particular, feminisation was not a deliberate strategy of the state to facilitate control over the medical profession. In the early 1920s the state was more interested in the class character of new recruits, that is in proletarianisation, as a means of widening the profession than in feminisation.

Therefore deprofessionalisation was a deliberate state strategy imposed from above which resulted in fundamental changes to the nature of the medical profession. Feminisation was a consequence, in part of this strategy, but also as a result of the wider controls over women's labour and the concerns over women's role in both production and reproduction. In the postrevolution period therefore, there was a degree of crowding of women into medicine to fill the gaps left as a result of the reluctance of men to enter the newly created posts. As this process continued, the profession became a female sex-typed occupation. The two key processes that occurred within the medical profession during the formative years of the Soviet system - deprofessionalisation and feminisation - established medicine as a poorly paid and underfunded, female dominated occupation. These aspects of the medical profession will be examined further in the following two chapters.

4

SOVIET DOCTORS AND THE STATE

It was established in the last chapter that the medical profession underwent a process of deprofessionalisation and feminisation in the early years of the Soviet system. In order to understand fully the implications of these processes, this chapter will examine the relationship between doctors and the state in Soviet Russia. The medical profession was in an ambiguous position vis-a-vis the state. On the one hand doctors worked within difficult conditions in an underfunded sector, were low paid and were predominantly women, who however erroneously were regarded and treated as second class workers. On the other hand, the medical profession was seen to play an invaluable role in Soviet society, in facilitating the state's strategy of social reproduction.

The relationship between doctors and the state is illustrative of the often contradictory role that women's labour played within the Soviet economy and the failure of state policy to resolve these contradictions. Women were enlisted into medicine, in view of the lack of interest amongst men, in order to provide an army of doctors and nurses that could rival that of the western capitalist states. The lack of wider options for women meant that they, unlike their male counterparts were willing to accept the poor pay and working conditions in that field. However, these conditions meant not only that standards of care were low, but that women's work in medicine posed difficulties for

their expected role in biological reproduction. While in industry, considerable concern was voiced over the dangerous and hard working conditions for women, little attention was given to women in health care. This highlights the fact that the 'protection' of women was closely tied in with economic needs and priorities and the role of female labour in attaining these.

In the first section, the role of female doctors as regulators of production and reproduction acting on behalf of the state will be examined. Secondly, it will be shown that female doctors supported the health service by accepting low pay and poor working conditions. There are two main questions which must be addressed in the discussion of how low pay relates to the gendered nature of the medical labour force. Firstly, why are levels of pay lower than average within medicine as a whole and does this relate to the feminisation of the medical profession? Secondly, how can women's lower pay in relation to men within the medical profession be explained? The discussion of these questions will illustrate the way in which skill can be understood as a social construction, rather than something to be objectively measured and judged. It will also demonstrate the juxtaposition of female doctors as state employees playing an important role within the system and as a marginalised occupational group.

The Role of the Physician in Soviet Russia

The health care system, and so the medical profession within it was directed by the central elite towards two key roles.. Firstly, at the level of central policies and of the individual workplace, health care provision was an important element within the paternalistic form of

control. The health care system was used not only to raise the status of the USSR in the world in ideological terms, but also to address the problems of labour turnover, productivity and discipline. Secondly, while the relationship between health care and the form of control had an impact on both men and women, doctors were also expected to turn their attention more directly towards matters relating to women. In particular they were involved, at different levels, in establishing guide-lines for women's participation in the workforce, addressing demographic issues and carrying out propaganda work amongst women.

The medical profession and forms of control

There were several ways in which health care provision, and so the work of doctors was an important element in the paternalistic form of control characteristic of the Soviet system. Firstly at the state level, propaganda about the health service served to reinforce the ideological campaign of Soviet superiority vis-a-vis the capitalist west. This is most apparent in relation to the frequent references made to the achievement in raising the doctor:patient ratio to a higher level than in western capitalist states (Ryan 1978: 34). This was fodder for the propaganda campaign as it was made to appear as though the Soviet state cared more for its citizens than was possible under a capitalist system and as such life was not only presented as better under the Soviet system but also that as the more just system, with free, universal health care, it was also morally superior. It was argued by candidate of medicine, Lidov that

"the moral and ethical consequences of free and accessible medical care are very great.....The possibility of profiteering is eliminated, the arbitrary setting of a price

on medical services and a marketable basis for medical practice are prevented...In the USSR the interests of the state and the physician fully coincide. Relations between physicians and the patients are free from material interest, there are no antagonistic contradictions dividing them and their relations are based on mutual trust and respect" (Knaus 1981: 334).

In the Principles of Legislation of the USSR and Union Republics on the Health Service it was noted that "the system for protecting the people's health in the USSR, which is one of socialism's greatest achievements, has made it possible to improve greatly the state of the population's health" (Ryan 1978: 143). In turn, the propaganda of the superior Soviet health care system was used ideologically to legitimate the central elite's position.

The ways in which the organisation of health care reflects the centre's priorities is most clearly illustrated by the departmental system. While most health care centres fell under the jurisdiction of the Ministry of Health, a minority of them operated independently and can be termed 'departmental systems'. They were organised and administered by the individual Ministries concerned, the most notable being the Ministries of Transport, Defence, Internal Affairs and Civil Aviation and the KGB. Each of these offered separate health services for their employees. In 1975 there were 60 000 institutions involved in 'departmental' health care, employing 126 000 staff (Ryan 1989: 112). Yet there were problems in this form of provision, for example, often the clinics for the workers were further away than their local clinic would be (Ryan 1989: 112).

The most obvious of the departmental services was that involved in the care of the elite. The Fourth division was that division of the Ministry of Health solely concerned with organising and running clinics, sanitoria, hospitals and so on, for party and government elite. The care within these centres was superior to that within the main service or within the other departmental services because they employed the best specialists on a consultancy basis.

The close correlation between the organisation of health care and the operation of the economy was clearly highlighted by the emphasis placed on the provision of medical services within the workplace. This idea was first developed during World War II in the armaments factories in order to ensure the workers were physically able to maintain high productivity in such a strategically important area.In the period 1950-68 their numbers doubled as they quickly became a key component in the attempts to raise productivity. Indeed these health care units were subordinated to the enterprise and their functions were to enable the enterprises to fulfil their production plans (Ryan 1989: 115).

However, while the provision of on site or privileged health care may have been beneficial for individual enterprises in attracting and holding onto labour, it was problematic for production as a whole since individual enterprises, in competition with each other for labour, directed resources to building health centres rather than improving or expanding production. In 1967, a new policy was proposed, stating that health units should have no fewer than 400 beds and that industrial enterprises situated in the same area should

combine resources. However, such policy statements were widely disregarded by enterprise managers (Ryan 1978: 16).

Divisions in relation to health service provision not only reflects the concerns of the central elite to maintain their own privileges and to raise the productivity of the workforce, but also to ensure the reproduction of the next generation. This is reflected in the division of mainstream services into adult care, public health and maternal and child care. As potential reproducers of the future generation, women were conferred special status within health care, with their own clinics and were, as will be discussed shortly, the focus of much attention in the medical world.

The provision of health care was therefore divided in line with both economic position and gender. Workers in the prioritised industries were offered easier access to resources with a health service tailored to their needs. They were offered these services by virtue of their position within the economy and within the labour hierarchy. For women, the situation was somewhat different. The range of women's clinics providing services for women were not intended to serve as incentives, but rather reflected the concern of the central elite over women's health in relation to her reproductive function. As was noted earlier, this special status for women served to reinforce their lower position within the labour hierarchy by separating them from their male counterparts both ideologically and materially.

In organisational terms therefore, the health service reflected the priorities of the centre concerning economic development. Moreover, the contradictory nature of the Soviet development strategy, created a

situation in which the provision of health care was used by enterprise managers as a means of attracting and tying the labour force to their workplaces, and so as a means of addressing the problem of labour turnover. It was noted in the last chapter that the emphasis of the nationalist militarist strategy was on building industry and the defence sector. As a result, the service sector of which the health service formed a part was underfunded throughout the Soviet period. Yet such underfunding was inherently contradictory given the nature of the demands placed on the health service to raise and maintain the general health of the population.

More directly the health service and so the doctors within it were charged with the responsibility for raising labour productivity and improving labour discipline. In this respect, rather than being persuasive with health care provision acting as an incentive, doctors took on a more coercive role. It was expected that doctors would not only ensure that the labour force was fit and able to work, but that they would also police the labour force through their control over sick leave certification. Doctors were expected to treat patients, not as individuals but as members of society with duties to fulfil and that duty was primarily to raise productivity.

The health of the workforce was regarded as of paramount importance in relation to labour productivity and in this respect the work of doctors took on greater significance. As one Soviet social scientist noted, "the results of the work of medical personnel are not directly materialised in any tangible visible product. However, under the conditions of today, their work creates the necessary premises not only for normal but also for optimum functioning of production and

of all the forms of physical and mental labour. The recreation, reproduction of health is a distinctive form of creation of a very special form of the material and nonmaterial wealth of man, his ability to work"(Tsaregorodtsev and Izutkin 1982).

While ensuring the health of the workforce is an important matter in any economy, it was of even greater significance in the USSR given the problem of labour shortages. The main role of health care provision in this respect was to ensure the existing labour force was able to carry out their functions within the economy, but also, as will be discussed further later, that a sufficient labour force is produced to allow production to continue in the future. Romashchenko, the Ukranian Minister of Health during the mid 1980s noted that, "the party and the government today is directed towards opening up the freedom for initiative and creativity of people and then rouse them towards solving the country's main social and economic goals...and towards this end, health care will successfully solve the questions of the maintenance and reproduction of labour resources" (Romashchenko 1986).

Particular attention was paid, in this respect to preventative measures of health care. It was noted that commonly occuring conditions such as high blood pressure, cardiological illness and respiratory problems accounted for significant work losses. It was the responsibility of both doctors and managers to address these problems and bring about improvements. "The development of medical science and health care must actively influence the lowering of labour losses and deathrate from these illnesses. Success in this, to a large extent depends on the professional level of managers, the qualifications of doctors and the

understanding of the medico-social significance of this problem" (Romashchenko 1986).

It is clear from this that the population's health was not an individual matter and that people were first and foremost regarded in this respect as labour resources. Doctors were expected to act alongside enterprise managers to raise production capacity by improving the health of the workforce. Indeed the savings that a healthy workforce could bring about were estimated by Strumilin. According to his calculations, for every 100 rubles spent on health care, 220 rubles of national income were created (Tsaregorodtsev and Izutkin 1982). Similarly it was estimated that a reduction in just one day per worker per year in the illness rate among industrial workers and in job absenteeism because of sickness would make possible an additional 32.5 million workdays per year. This concern with savings to be made by improving the health of the population reflects the view that the individual's health is a social matter. In fact, "a person's health is not only his personal wealth but also social property. The state spends large sums on health improvement measures and it has a right to demand that its citizens take a sensible attitude towards their health" (Tsaregorodtsev 1976).

This concern for the savings to be made through health care was nowhere more apparent than in relation to sick leave. The amount of time off for illness was a highly contentious issue and in this respect doctors found themselves in conflict between their responsibility to their patients and their responsibility as state employees to maximise workers' potential. There were several ways in which doctors were expected to reduce the amount of time off on sick leave.

Firstly, there were insufficiencies in the organisation and treatment of acute and chronic patients (Romashchenko 1986). It was noted that a more efficient and quicker treatment of conditions would reduce the amount of time that workers had off from their job. Secondly, it was argued that the care of patients could be reorganised with more emphasis on outpatient care allowing people to return to work earlier, though in a reduced capacity (Pereskok 1986).

But most attention was given to the actual issuing of sick leave certificates by doctors. Field noted that sick leave certification "constitutes an important hinge between the medical profession and the social system" (Field 1957: 146). Certification had financial implications both in terms of the doctors' role as the gatekeepers to state benefits, but also due to the work losses that resulted from time off due to illness. As a result, the expertise of doctors in this respect was both a necessary tool for the state and a power that had to be controlled.

The greatest concern was with false claims for sick leave, in cases where the doctors were either tricked into issuing a certificate or colluded with the patient to issue a certificate for reasons other than illness. In Field's interviews with emigre doctors he found that false claims for sick leave certificates were most often the result of malingering, that is the simulation or aggravation of symptoms, or a more direct plea to the sympathy of doctors to produce false certificates.

Field argued that malingering was common during the Stalin era, as a means to obtain sick leave certificates, in response to the harsh labour

laws. As Field noted, "it is held here that a society (or social group) which, for any number of reasons, cannot offer its members sufficient incentives or motivation for the faithful and spontaneous performance of their social obligations must rely on coercion to maintain such performance. Because of the presence of coercion, such a society will also generate a high incidence of deviant behaviour to escape coercion. Simulation of illness (technically known as malingering) will be one form of such behaviour" (Field 1957: 147). One doctor he interviewed estimated that 50% of the cases he saw at his clinic were malingerers. There were various methods employed to simulate illness including rubbing salt, alcohol or peppers under the armpits to raise the temperature reading, injecting milk to cause swellings, or taking foodstuffs or medicines that caused an allergic reaction (Field 1957: 154-5).

There were also cases where no attempt was made to fool the doctors and instead, appeals were made to their sympathy or their financial needs. Often doctors were placed in a position where they recognised the difficulties people were faced with and wanted to help but by doing so were themselves committing an offence. As one doctor noted, "let us say that a patient comes to your office and says, 'look here doctor, I am healthy but I have four children and a wife to support and we are starving. If you write a certificate stating that I have gastritis, I will then be entitled to a better kind of food." The result of this for the doctor was a "conflict between your professional conscience and your human feeling" (Field 1957: 157).

For other doctors the reasons for taking part in this type of activity were more materially orientated. Given the low salaries of doctors,

particularly the *terapevty* [1] who would most often by the ones to issue sick leave certificates, it is not surprising that they were often encouraged to issue a certificate by means of a bribe. This was either explicitly done as was the case with a woman who needed time off because her son was visiting. She paid the doctor 10 rubles per day she was off work, in total 13 days and received 200 rubles sickness benefit (Kurasov 1981). For others it was more of an unspoken agreement, considered to be a payment for a favour rather than a bribe. One doctor made this point. "The doctor received...300 or 350 rubles a month...Now lets say that there comes a worker who needs a few days off. He says, 'doctor I have to gather some grapes, kill some pigs, please give me two or three days'. When this fellow comes back he brings food to the doctor. At that time a suit cost 2000 rubles, butter was 63 rubles a kilogram. What could he do?" (Kurasov 1981).

Special attention was paid to the amount of time that women workers were off sick, including the time off when their children were sick. A study amongst women farm workers found that 53.3% of their time off was for illness, 35.4% for pregnancy and childbirth and 11.3% for care of the sick (Kurasov 1981). There was little that could be done to reduce the amount of time off for pregnancy and childbirth, considering the demands on women to raise the birthrate, but this highlights the contradiction that female labour posed. On the one hand, women were expected to give birth, and were actively encouraged to have more children, and this meant that they would be off work for some time. But at the same time, there was a growing concern that too much time was lost among male and female workers through time off. Attention was therefore turned to the two other

[1] The role of the *terapevt* was similar to that of general practitioners in Britain.

causes of women's time off - their own illness and that of their children. Discussions on women's health focussed heavily on reproductive problems and even in the case of working conditions the greatest concern was with the impact on women's reproductive functions. This will be discussed in more detail shortly.

In relation to their child care responsibilities there was concern that "the national economy suffers greatly due to the fact that thousands of mothers of 'kindergartens' must go on sick leave in order to stay home with their ailing children". One solution to this problem was that a system of incentives should be introduced to inspire kindergarten teachers to take more care with young children and so to protect their health (Losoto 1980).

It was argued that the amount of time off on sick leave and the amount of money paid out on such benefits could be reduced if tighter control were exercised in issuing certificates, by the doctors themselves and over the doctors (Pereskok 1986). On the one hand as professionals, doctors may not have welcomed being tricked, but on the other hand, they were aware of the difficulties that they and others faced in day to day life in Soviet Russia. Given their low salaries they no doubt welcomed some extra income or the 'gifts' that producing certificates could create. Nevertheless, the work was no without risk and doctors caught were often imprisoned and their licence revoked. As such it was unrealistic to expect doctors to police themselves.

Regulations were in place to check up on the work of doctors. Certificates were only to be issued for three days, renewable for a

further week and then the case was reviewed at the Medical Consultative Committee. The trade unions also employed physicians to check up regularly on their counterparts in the clinics. There were also norms for the issuing of certificates, for example temperatures had to be above a set level, and quotas for the number of certificates to be issued in set periods. Doctors who exceeded the quotas would draw attention to themselves and risk investigation. During the Stalin era, there was even a form of socialist competition encouraged amongst doctors to produce the least number of certificates. As Field notes, "the essence of such pressures is that the interests of the factory, the collective farm, the community and the state must have priority over the welfare of the single individual in case of a conflict between them" (Field 1957: 166).

The work of doctors was therefore integrally tied to the development of the economy and to the paternalistic form of control over the workforce. In ideological terms it served the purpose of feeding the image of a progressive and morally superior society and was used in the competition with the capitalist west. Health care provision also acted as a form of incentive by which the managers, in conditions of a labour shortage, were able to entice workers to their enterprises and to persuade them to stay. Moreover, doctors were expected to contribute directly to labour productivity and discipline by virtue of their role as mediators between the state and the workforce in relation to sick leave.

The medical profession and biological reproduction

The second aspect of the role that the health labour force were expected to fulfil within the Soviet system related to biological

reproduction. It was noted earlier that there was an on-going concern with the birthrate and in this respect health care was regarded as particularly important (Grigoryan 1986). As one doctor noted, "in order to improve the demographic situation, special attention must be paid to health care. The system of health care must become a constituent part of economic and social development" (Kamalov 1986). The concern over the birth rate stemmed firstly from a need to supply sufficient labour resources to the economy. As Grigoryan noted, "the influence of health care is particularly apparent in the important phase of reproduction - in the process of the production of the labour force, when it has a place in the reproduction of the labour capacity of people and also the production of the new labour force of the necessary quantity and quality" (Grigoryan 1986).

But the concern over the birth rate also related to the support of the Soviet nation, both in material terms through the armed forces and in a more ideological sense by supporting the 'idea of the nation'. This was made clear when concern was expressed by Sorokin over the impact that the falling birth rate and divorce in particular would have on the quantity and quality of army recruits.

"Such unfavourable demographic trends in our country as the drop in the birthrate, the halt in the growth of average life expectancy, the development of irrational migration patterns, the formation of disproportionate age and sex structures in the population in some regions and the systematic rise in the divorce rate all have their impact on the Soviet armed forces. These demographic trends manifest themselves in the size, geographic distribution and national make-up of contingents of draftees and men subject to military call up and they have also led to a marked increase in the number of draftees who have been brought up in so-called 'problem' families without

one or both parents....Efforts must be made to surmount and offset the consequences of the country's unfavourable demographic situation and to prevent them from affecting the combat capability and readiness of the Soviet armed forces" (Sorokin 1983).

Doctors contributed fully to the debate on the birth rate by recommending what they regarded to be the proper number of children per family. The optimum number of children was believed to be three because any more would reduce women's work capacity and any less would endanger the reproduction of the Soviet population at a suitable rate (Hyer 1996: 115-6). In connection with this optimum number of births, it was argued by the Ministry of Health's Commission for Medical Demographic Problems that the family must be strengthened in order to create the conditions for the birth of three children. It was argued that "in the family the main social wealth is created - people...The stability and security of the family is the prerequisite for guaranteeing the growth of the population and bringing up a healthy physical and moral attitude of the next generation of Soviet people. In connection with this the socio-economic significance of health care has grown" (Komicii Po Meditsinskoi Demografii Minzdrava RSFSR: 1986).

The main role of doctors in this respect was to improve generally, the health of the families, but more specifically to address attention to relations between couples, sexual problems and problems of infertility (Nauchna Prakticheskaya Konferentsiya 1985). It was intended therefore that through further research, counselling and treatment, each couple would fulfil their natural destiny, that is, to have children. While attention was to be paid to couples, in reality it was regarded as primarily a woman's issue. For instance in discussing

sterility, it was argued that women were deprived of their essence, of their womanhood. "Sterility is a disease of a special type. No it does not involve physical pain, but it is the source of profound mental suffering. The family that had no children is frequently unhappy..By putting off the birth of her first child, a woman is apart from anything else, robbing herself of a great deal, forfeiting a sense of fulfilment" (Kadzhaya 1977).

There was considerable debate over the question of illegitimate births. Indeed it was estimated that every sixth child was born outside of marriage (Artyukhov 1985). It was argued by some that, given the imbalance in the ratio of men to women, it was unlikely that every woman would be able to find a long term partner. According to Professor Bedny of the Ministry of Health research laboratory, women can't wait to find a man for life because "the instinct for the continuation of life that characterises all living things works its will" (Bedny 1983). Nevertheless the birth rate still had to be maintained so these women should be encouraged to take a partner and conceive a child even if it was not within the 'normal' conditions of married family life. It was even argued that motherhood was some form of replacement for marriage in terms of bringing women a degree of happiness (Urlanis 1980).

Nevertheless by the 1980s the gender imbalance resulting from the war losses was no longer apparent for women of fertile age. It was no longer the case that women in these age-groups outnumbered men to such an extent that they would find it difficult to marry if they chose to do so. The fact that such arguments remained in use indicates that the impact of the war losses on the nation had taken on an almost

mythical status. The implied continuing demographic impact can be understood as the glorification of the war losses in the discursive construction of the Soviet nation. Women's role in the reproduction of the nation was also glorified - they were to rebuild the nation in the aftermath of its courageous role in the war.

There were others however who argued against encouraging women to have children outwith marriage. They pointed out that while quantitatively the birth of children outwith marriage might be beneficial to the birth rate, in qualitative terms, it was problematic because these children tended to be less healthy than those brought up in a 'family' setting. Professor Bedny argued that the stress of bringing up a child, as a single parent was reflected in the 'abnormal physical and mental development' of the child (Bedny 1983). Similarly Petrakov argued that encouraging the birth of children outwith marriage endangered "the proper reproduction of the next generation in terms of the inculcation of proper values and behavioural patterns" (Petrakov 1986).

It is noticeable therefore that there were not only quantitative but also qualitative concerns. In the 1920s, Prof Liublinski noted that "the state is by no means interested only in the growth of its population; the qualitative improvement of the population has significantly greater value and it can be achieved through eugenic birth control and through cutting back disorderly reproduction" (Hyer 1996:118). This eugenicist trend was relatively common and was based on ambiguous statements concerning producing children from 'physically and morally healthy families' (Current Digest of the Soviet Press, Vol.31, no.26 : 13). The role of doctors in the qualitative regulation of births

was also apparent in the 1980s. It was argued by some that their role in this respect was to weed out the unsuitable families first of all on health grounds. For example, Kamalov advocated that "medico-genetic consultations must redirect all their work towards inspecting the population, actively preventing undesirable reproduction by stipulating sick parents' (Kamalov 1986). Similarly in relation to the setting up of a new family research council in 1979, it was noted that

"The prevention of mental retardation, feeble-mindedness, mental illness and other ailments that remain very difficult to cure is a key aspect of the task of upgrading family life....For one, persons with problematic heredity can be identified and informed of the possible consequences of the decision to have a baby. Second, in as much as medicine is presently capable, within certain limits of neutralising the effect of factors that create a danger of abnormal development of the fetus, maximum use should be made of these techniques. And third, due attention should be paid to the statistically established relationship between alcoholism or drug addiction in the parents, on the one hand and mental or physical abnormalities on their offspring on the other" (Current Digest of the Soviet Press Vol. 31 no26: 13).

The questions of both quantity and quality in relation to births were the focus of debates within the medical profession on perhaps the most controversial issue of all - abortion. It was noted in the last chapter that even though during most of the Soviet period abortion was legal it was never advocated. Doctors played a key role not only in actually performing the operation but also in carrying out propaganda against abortion. After the legalisation of abortion in 1955 it was argued that " a large army of doctors and midwifes must lead the sanitary-educational work among the population concerning the harmful influence on abortion on the female organism. The forms of

this work are extremely diverse: individual and group talks, lectures, magazine advertisements, newspapers, radio question and answer sessions and so on"(Nikonchik 1959).

The main focus of this propaganda work was to be counselling women on the risks involved in abortions (Saninkov, Likunskaya and Solovtsov 1987). Abortion was associated with increased risk of infertility and gynaecological disorders (Bardina 1987). Shutskaya found that 20% of the women he studied suffered acute or chronic inflammation of the sexual organs after abortions (Gvin 1981). While these risks were applicable to all women undergoing abortion, particular attention was given to first pregnancy abortions. It appears that the right to have an abortion was in fact tied to the number of children a woman had. For those with two or three children, it was accepted that they had performed their social duty to reproduce and that while abortion may still damage their health, this was not as significant for those who were yet to give birth. Indeed it was argued by a Candidate of Medicine that "those who abort a first pregnancy belong in a special group. In my view, refusing to bring one's first pregnancy to term is a crime against morality"(Gvin 1981).

The role of doctors in this respect was to address the issues which determined a woman's decision to have an abortion and in the case of a first pregnancy to undermine them and so to persuade them that an abortion was not the best option. As Candidate of Medicine Polchanova argued, " a heart to heart talk can succeed if the midwife or doctor first hears out the patient's arguments in justification of the abortion and then attempts to show their groundlessness pointing out

that the difficulties she has cited are transitory and the dangers of sterility very real" (Polchanova 1984).

There was pressure on women, particularly those that had not yet given birth, to avoid abortion and doctors, as those regulating the procedure were expected to exert this pressure. Indeed in 1975 a regulation for doctors from the Ministry of Public Health stated that women should be strongly advised to carry pregnancies to a full term (Popov 1988). As is often the case in abortion debates worldwide, emotional blackmail was also advocated as a means by which to persuade women. Urlanis, a demographer argued that the job of sexologists in clinics was to explain to women "the possible consequences of a mistake, to help her realise the importance of the step she wants to take and stop her before its too late. They must make every effort to influence her so that later on she won't spend her nights counting 'he would have been five.' Only when the specialist sees that all possibilities have been exhausted should he say 'all right you can exercise your right' "(Urlanis 1980). This type of individual work with women was regarded as all the more important because it was acknowledged that the majority of women were well aware of the danger that abortion posed to their health and to their future chances of having children (Saninkov 1987).

In the fight against abortion, doctors also played a crucial role in informing the population about contraception. It was hoped that by encouraging the use of contraception, the use of abortion, as a form of birth control would be minimised. However, not only were contraceptives never made widely available to women, but their options and knowledge were limited by the medical profession, who

acted in this respect as the state's gatekeepers. By the mid 1980s only 1-3% of women used the pill as a form of contraceptive. This was a direct consequence of the negative propaganda relating to its use. In a study carried out in Moscow in 1986, 93.6% of women thought the pill was harmful to women (Remennik 1987). It is no wonder that women had this attitude when the doctors and the Ministry concentrated their efforts on educating women on the most unreliable forms of contraception, such as the rhythm method and warning them against the pill. A letter published in 1974 by the Ministry of Public Health 'On the side effects or oral contraceptive use' had the effect of a virtual ban on prescribing the pill (Popov 1988).

The reasons for this seeming aversion to the contraceptive pill most likely stemmed in part from the concern that it was a far more efficient means of contraception and so it was believed would place the birth rate in even greater jeopardy. But it also related to the situation of the doctors themselves. The low pay of doctors in Russia meant that any way to supplement their income was welcomed. For obstetrician-gynecologists, abortions were a common way to supplement their incomes. While abortions were legal there were still many instances of illegal abortions, performed outwith hospitals for money. Many of these were young women frightened to go through the official channels.

In addition, the Ministry of Public Health also had an interest in perpetuating the use of abortions rather than contraceptives. A vast amount of money was spent on the process of abortion, nearly 5% of the USSR health budget. On the issue of family planning therefore, the Ministry "has been dragging its feet..viewing this service as a

potential competitor. If such a system were to begin to operate, what would the ministry do with its army of specialists" (Popov 1993).

Nevertheless there were concerns about abortion, not only in terms of the health problems discussed above, but also in terms of its impact on production (Goldman 1993: 289). Bronislavovna noted that abortion was the sixth leading cause of temporary disability among women(Gvin 1981). The concern with time taken on sick leave was often tied in with abortions, primarily because of the secondary complications that resulted from the operation (Romashchenko 1986). This point also serves to highlight the interrelation between biological reproduction and production. On the one hand women were expected to give birth yet at the same time they were expected to participate fully in the labour force.

Doctors were involved in all aspects of this contradiction since they were expected to encourage women to give birth and at the same time ensure they were working in jobs which would not endanger their reproductive function. Even at times of unemployment, during the NEP period, doctors did not recommend the withdrawal of women from paid labour (Hyer 1996: 112). Rather, their concerns were with ensuring working conditions were not a danger to women's health and advocating on medical grounds the type of work that women would best be employed in and that which they should avoid. There was a considerable amount of research carried out on the impact of paid labour, particularly manual labour, on women's health in general and their reproductive function specifically (Artyukhov 1985; Shapvalov 1987).

But it was not only in relation to their involvement in paid labour that women's behaviour was assessed within the medical profession. Alcoholism was and continues to be a huge problem in Russia, but the way in which this problem was addressed in relation to men and women differed considerably. For men, the central issue was that of the limits alcoholism placed on their labour capacity, while for women, greater concern was given to the dangers it posed for the birth of future children. Research carried out demonstrated that alcoholic women bore retarded children ten times more often than non alcoholics (Lupandin 1980).

Similarly in relation to smoking, women's behaviour was criticised for the impact it would have on any children they might conceive. Professor Uglov of the Academy of Medicine noted that, "men smokers are problem enough, but women smokers are twice as bad because they are threatening both their own health and that of their offspring." Statistical analysis showed that mothers who smoked were twice as likely to give birth to babies who weigh less than 2.4 kilos as did non smokers. This was problematic, he said, not only for the birth rate, but also in terms of the resources because "doctors usually wear themselves out with these babies, who are weak and vulnerable. Yet the mothers feel no guilt toward society. Time and again one sees them sneak out into the hospital corridor out of sight of the doctors and nurses and light a cigarette" (Uglov 1981).

It is clear from the discussion above that female doctors were expected to act as the state's regulators of the population's health to maximise their potential in production and in women's case, in reproduction. Yet, as will be discussed below, the very conditions

within which women worked in medicine limited their own capacities in these areas.

The Soviet Physician : Pay and Working Conditions [2]

Underfunding in Soviet health care meant that doctors were expected to work with outdated equipment, and in conditions that were often dangerous to their own health. Investment in the construction and maintenance of buildings was not adequate to provide enough facilities to cope with growing demand. For example, between 1965 and 1978, to cope with demand for outpatient polyclinic services a three billion investment would have been required but only one billion was spent. Similarly, the capital repair financial norms of 37.5 kopeks per cubic meter was only one quarter of what was needed to compensate for depreciation (Davis 1983: 253).

Doctors were highly critical of the lack of modern equipment. When asked what they would change about their job, this was nearly always mentioned. Though with the reforms there are now private clinics with the latest modern equipment, most clinics still use extremely basic and poor quality equipment and facilities from the Soviet era, which has not been updated since the reforms began. During perestroika such equipment was often criticised for being inadequate. Prof Kulakov, head of the All Union Research Centre for Protection of the Heath of Mother and Child noted that in obstetric and gynaecological examinations " a ruler and a stethoscope - a wooden tube of sorts- are all the equipment available. There are no

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[2] While the interviews with doctors were carried out in 1996 they were asked to talk about their work in the Soviet period and then to assess the ways in which it had changed. The discussion of doctor's work sometimes refers to both the Soviet period and the present day, in cases where there was little change. Whenever possible a comparison will be made between the two periods. Further discussion of the Post Soviet period will be given in Chapter 7.

instruments to listen to foetal heartbeat or ultrasound equipment" (Kulakov 1987).

Even when of a more advanced nature, the equipment was often very poor quality, as a chief physician noted, "of more than 2000 instruments, fully one third either don't work at all and are waiting to be written off, or work from breakdown to breakdown, so to speak. Today the instruments that work without fail in each ward can literally be counted on one's fingers; most of them are extremely unreliable and constantly break down" (Fyodorova 1987). One problem was the bureaucracy involved in repairs. This can be illustrated by the example of hospitals in Moscow. Repairs took place at Moscow's Medical Equipment Electromechanical Plant. "First you have to submit a request for an instrument's repair (and only during business hours) and then wait until the foreman can come..Yet the hospital operates around the clock; a breakdown can occur at any hour and sometimes it has to be fixed in a matter of seconds " (Fyodorova 1987).

Moreover, it was often the case that new machinery brought with it as many problems as it was hoped to solve. Often goods were sent from the factory with the stamp of approval and yet were not fit for the job they were designed to do. Even in cases where machinery did work, there could be problems regarding its suitability for existing equipment or surroundings. "It frequently happens that an enterprise sends an instrument that works perfectly well and that we need very badly, but just try and use it. Such was the case, for example, with a disinfection chamber for respiratory anaesthesia devices that is manufactured by the Saransk Medical Equipment Plant. It turned out

that the series produced chamber assembled at the plant wouldn't fit through the doors into the freight elevator of our standard design hospital building. When we asked the producer how we were supposed to install it in the ward, it was recommended that we take the building's roof off. The technical manual, diagrams and operating instructions for the device were packed inside the automatically sealed chamber - which could only be opened after consulting those instructions" (Fyodorova 1987). Finally, it was often the case that when new machinery was in working order and could be installed, its life-span was necessarily limited because vital components needed for its continuing operation were irreplaceable. "For example, the reagents intended for use with the Enzyme analyser soon ran out. We couldn't get more of them anywhere. And so the analyser has been sitting as a dead weight in our hospital for five years now waiting to be written off when its service life expires" (Fyodorova 1987).

The problem of poor standards in equipment and facilities was not only of consequence in terms of quality of care, but was also significant for the health of the doctors working under such conditions. One doctor noted this problem when he said, "we dress for work the best we can and only dream about comfortable special clothing for medical work" (Sukhov 1989). This was particularly important when work requires protective equipment and clothing. In 1989 more than 192 000 workplaces within the health sector failed to correspond to the norms and rights for the protection of labour. 25% of radiology units failed to reach safety norms and in many surgical and maternity units, the bacterial and chemical indicators in the air were not within permitted limits. There was an inspectorate to check on conditions, but the fines it imposed were small and closure of all

below standard institutions would not have been serious options given that this would have withdrawn so many from the health service as to render it incapable of functioning (Chikin 1990).

The failure to provide modern, efficient and safe facilities and equipment within health care was the direct result of the peripheral nature of the health service within the Soviet system and its resulting under-funding. This was recognised by the head of a burn unit, faced with the reality that its work was extremely limited given the nature of its resources. "There is something extremely humiliating to our national dignity in our situation where medical equipment is concerned. It is all very well that we have surpassed the whole world in the number of industrial robots per capita and are now boldly setting out to spread computer use throughout the population. After that evidently we will solve the problem of flying to the nearest galaxies. However, some sense of protest against these grandiose plans is unavoidable when you walk past miserable burn victims who are defenceless in the face of misfortune" (Gogol and Mosin 1989).

Therefore while it may have seemed that doctors' work was less taxing than work in industry, they often had to work in dangerous and physically tiring conditions. For most female doctors the official working day was between six and eight hours and this has remained the same today. This varied depending on whether work was in a polyclinic or hospital. In specialisations such as the *terapevt*, the workday was shorter than work in the hospitals, but it was nevertheless no less hard. As one *terapevt* said of her normal workday, " work in the clinic is very hard. Sometimes in four hours we see thirty or forty people. After this I feel like a lemon that has

been squeezed. It is very intense. Every five or six minutes it is necessary to see the patient, make the diagnosis and recommend medicine"[3].

For *terapevty,* their working day was split between a shift in the clinic and a shift of home visits. This placed a great strain on them as it entailed travelling through the city, often on foot and regardless of the often adverse climate. One hospital doctor noted this difference between this and her work, "work in the clinics is more physically demanding. They have to go out a lot more. Work in the hospital is easier and more comfortable. We work with the sick while they are in the wards, in the beds so we don't have to go out in the rain and the snow"[4].

In the hospitals, the working day was longer, often up to ten hours and there was also the requirement to undertake night shifts on call. Doctors were obliged to take three 24 hour on call shifts per month and could supplement this if they wished with extra night duty in order to raise their wages. For many hospital doctors, night duty was the main means by which their pay was improved, so as in industry, it was unlikely that women would want to abandon such practices. For many doctors, the long hours in the hospital were still never enough to complete all the work that was needed, as one doctor pointed out. "It is often not enough time to do everything because we have a lot of paperwork in addition to basic consultations. We aren't a factory and we don't have a plan! After everything has been finished I can go, but if not I have stay. I also go to the diagnostic centre to work.

[3] Interview with respondent 16.
[4] Interview with respondent 9.

This is my second job . We can also earn more by taking on extra shifts on 24 hour call. In addition to this I am doing some research which I am not paid for. Often there are not enough hours in the day!"[5]. While under the Soviet bureaucratic system, there was considerable paperwork involved in every task, the shift to insurance medicine means that this has not changed today. However, it may be that the significance of working in a second job has altered in the period of transition. This will be discussed shortly.

The nature of work within the medical profession therefore is particularly illuminating in relation to protective legislation for women. There was considerable discussion, particularly during Perestroika, about the conditions women in industry were working under (Ivanov 1989). One of the main characteristics of female employment in Soviet Russia, was their use in manual labour. While in 1989 in the USA the proportion of women employed in physical labour was 11.3% and in Germany 13.1%, in the USSR the figure stood at 56.3% (Mezentseva 1994 :92). Moreover, more than half of all manual workers in industry were women and in agriculture, nearly all were women (Shinyeleva 1989: 64; Maslova and Novikova 1991: 13).

For example, sixty five thousand women worked in heavy labour for the railways. Orlova, the secretary of a local party section noted that "the labour of women on the railway lines is exclusively heavy. The work is physical and in most cases manual...They work under open skies, in the winter and cold, in the rain and snow." When asked how the railway sleepers were moved, one female worker replied "when

[5] Interview with respondent 4

we need to pull them out from under the tracks, we tie them with a rope and pull them out...Six women pull together." When asked whether it was always women who carried out this work, she replied, "who else?" (Barishev 1988: 17).

But it was not only women's manual labour that was of concern. Their work was also characterised by the harmful conditions within which it took place. 4.5 million women worked in harmful conditions, among which 3.8 million worked on night shifts, more than 800 thousand suffer high noise levels and vibrations, 688 thousand worked in poor lighting conditions, over one million in dust and fumes and one million in unfavourable temperatures (Shinyeleva 1989:63).

As noted in chapter 2, protective legislation was enacted to limit women's involvement in work designated as dangerous or harmful to their health. In this respect, medical evidence was used to demonstrate that "heavy physical labour and the morbidity rate are directly correlated and that working conditions influence the birth rate "(Boldyreva 1988). In the rubber industry, the frequency of complications in childbirth and miscarriages was 1.5 times higher than the average. In non ferrous metallurgy, the frequency of premature births was 4 times higher than normal. In the chemical industry, 36% of newborns had low birth weight or birth defects. In addition, "unfavourable working conditions have a direct influence, not only on the female body and the childbearing function, but also on the health of children" since "parents' health, especially the health of the mother has a weight of one third among the factors

determining a child's health". The USSR was fiftieth in the world rating for child mortality (Boldyreva 1988).

However, it was not only to actual mothers that concern was addressed but also to potential mothers, that is, to all women. "Experience shows that it is impossible to be concerned about motherhood when women are already waiting the birth of their child. It is necessary to do everything possible for defending and strengthening the health of girls, young women and women as potential mothers" (Ivanov 1989:66). In this way, legislation towards women treated them as a single category, and "society's demands on women appeal to their qualities as a *social sex*." (Mezentseva 1994: 79).

Nevertheless, while there was indeed concern over biological reproduction, amongst the central elite, protective legislation was also a means by which the distribution of women's labour could be controlled. The lack of attention to poor working conditions within the medical labour force illustrates this point. There was very limited acknowledgement of the physicality of medical work, and of the dangers women, as reproducers faced when coming into contact with diseases and with treatments often without the proper equipment. Women were needed in the medical labour force since, as was pointed out earlier men were reluctant to enter such a low paid low prestige profession. On the other hand, there were intentions from the 1960s, which came to a head under perestroika, to rationalise industry, and so to remove the mass of female labour involved in manual work. Protective legislation therefore, while ineffectual much of the time, nevertheless was indicative of the way women's labour

was regarded as being open to manipulation in line with economic needs.

Women's Low Pay in Soviet Medicine

In general in Soviet Russia, women were paid on average two thirds of the pay received by men. There are several possible explanations for this. Firstly, there was a form of rate discrimination, that is, men and women were paid differently for the same work. Secondly differential wages resulted from the processes of occupational segregation, that is, men and women were paid differently for different jobs. Thirdly, women's lower wages could be explained in terms of differential participation of men and women in production, for example in relation to overtime, or secondary jobs (McAuley 1981). These will be examined in relation to the medical profession.

As early as 1953 questions of doctors' pay rates were being raised. In a letter to *Literaturnaia Gazeta* in 1953 a doctor wrote in to complain. He noted that the "very questions of the material standard of living are so intimately tied with questions of production [here meant as medical work] that they cannot be solved separately. [Thus]...at the time he finishes the institute the doctor receives 600 rubles a month and after ten years 800 rubles...Is that fair? I think it is quite wrong. But then is all this not known to the Ministry of Health...to the Union of Medical Workers? It is clear that they consider it 'indelicate' or as they sometimes like to put it, 'untimely' now to take up these thorny questions" (Field 1957 :107).

While doctors in the west were able to command a relatively high reward for their expertise therefore, in Soviet Russia, the medical

profession were paid on average less than many categories of skilled workers in industry. In part this was a reflection of the inability of the medical profession to protect its position via organisations like the British or American Medical Associations. It was noted in chapter three that after the revolution in 1917, the medical profession were stripped of their own professional body and were deliberately categorised and paid as medical workers. The specialist knowledge which they held and which was a threat to the new regime was kept in check in this way.

Low pay within medicine can also be understood in relation to the sectoral hierarchy within the Soviet economy. On average between the years 1950 and 1986 the average monthly earnings in health care ranged from 19% to 31% below the average wage in the economy (Ryan 1989: 22). On the one hand the peripheral status of health care within this hierarchy, as a non-productive field, meant that health care as a whole received inadequate funding. Health spending in the USSR did not rise, relative to the national wealth during the period 1958-74 (Ryan 1978: 18-19). Indeed the share of the budget allocated to health care fell from 6.5% to 5% from 1965-80 (Davis 1983: 251). In turn this meant that wages were low.

On the other hand, wages were lower in health care than in other priority sectors because the work of physicians was categorised as of less value than that of workers in industry. While the educational levels of engineers, teachers and physicians were equivalent, the work of engineers in industry was rated more highly and rewarded accordingly (Chapman 1978: 231). In relation to the distribution of women in branches of the economy and pay in those sectors it can be

seen that "one is practically the mirror image of the other", for example in construction, where female participation was low, wages were higher than the average by 24% while in health, where female participation was high, wages were 29% below the average.(Gruzdeva and Chertikhina 1987: 74-5) This highlights the way in which skill rates and so wages were not tied objectively to education, experience or technology, but were more a reflection of the social engineering which was characteristic of the Soviet system and the economic priorities of the central elite.

It is clear from this discussion that women's lower wages in medicine can in part be explained by their horizontal segregation in an low priority sector of the economy. It should not however be argued that the feminisation of medicine was the cause of the low wages. The medical profession was stripped of its representation and access to it widened prior to its becoming a primarily female occupation. Moreover, while in pre-revolutionary Russia, physicians were members of the intelligentsia they nevertheless faced financial insecurity and often had to work in two jobs to survive.

In comparison with other professions physicians' pay was quite low. In 1905 lawyers' average annual pay was 2000 and 33% earned over 5000, whereas the average annual pay for doctors was 1200 (Frieden 1981: 212). In his 'Notebooks', Chekhov, who worked as a doctor, noted the problem of low pay when he said, "badly paid physicians even miss the satisfaction of thinking they are exclusively serving an ideal because they are always thinking about their salary and where their next meal is coming from" (Frieden 1981: 210).

Nevertheless, in comparison with other occupations, physicians were quite well off. School teachers earned on average 180-400 rubles and industrial workers earned 180-360 rubles (Frieden 1981: 217). It was not however, with such occupational groups that physicians would compare themselves. Rather they sought acceptance and respect from the upper echelons of society. In addition to their financial insecurity therefore, physicians felt their social status to be lower than they deserved. One doctor noted the attitude of the upper class to doctors, saying, "it is impossible to conceal that even people of so-called educated society frequently treat physicians quite discourteously at each step pursuing them with mistrust and assuming they can be regarded as simple artisans" (Frieden 1981: 123). To a certain extent this attitude had a material base in terms of the social origins of physicians since the medical profession had far fewer students from the nobility or bureaucracy than other professions. These lower social origins were felt by physicians to be reflected in the low pay that they received and the attitude that arose amongst doctors as a result is expressed by Chekhov when he said, "the son of a serf, a former grocer, choirboy, schoolboy and university student...[who] squeezes the slave out of himself drop by drop" (Frieden 1981: 51).

Therefore while the medical profession was deprofessionalised by the Soviet state, there is evidence that in pre-revolutionary Russia, the doctor was not as well paid or prestigious an occupation as other professions. This is not to say however, that the social position of doctors was not severely undermined by the Soviet state. It is argued here that there is no simple causative relationship between low pay and feminisation.

In addition, it was not only in relation to their concentration in a low paid sector that women's low pay in medicine can be understood. In addition to medicine being low priority and so medical personnel receiving low pay as a whole, there were wage differentials within the medical profession. While it is very difficult to find exact details on differences between specialisations and positions, certain trends are apparent. Between 1955 and 1965, the average monthly pay of doctors of medical science was 600-800 rubles; managers and administrators of health institutions received 120-200; heads of departments received 77-120; and doctors received 74-110 (Navarro 1977: 73). The more prestigious position of the academic and administrative elite was therefore represented by their higher pay. It was in these posts where women were most under-represented.

There were also differences between doctors' pay in terms of their length of service and qualifications. While to a certain extent women's length of service may have been slightly less than men's due to time off for childbirth, it was in relation to qualifications that the differences were greater. Women had fewer opportunities than men to raise their qualifications and so had fewer chances to raise their pay. Nevertheless, the increase in pay awarded after the attainment of a higher qualification, was often quite small and so offered women little incentive. Similar patterns were noted for women in general. Khotkina found that after training to improve skills, 90.7% of women remained on the same grade and so pay (Khotkina 1994: 94-5). Men on the other hand almost automatically received a higher grade (Rimashevskaya 1991:40).

The processes of horizontal and vertical segregation which characterised the medical division of labour therefore were key factors in understanding women's lower pay. The extent to which rate discrimination took place, that is, that men and women were paid differently for the same work, is very difficult to ascertain. It was never mentioned during the interviews. However McAuley notes that there was considerable scope for bias in the way that wages were calculated. He points out that a range of wage rates were set for particular jobs and it was left to the discretion of managers and trade union officials to decide what grade each worker was set on. He concludes that this "resulted in systematic bias against women workers" (McAuley 1981: 15). It is very difficult to assess the extent of this practice, but it is reasonable to assume that it did take place, given the overall secondary place of women within the workforce, the fact that most senior managers and union officials were men and the way in which gender was used to segregate the workforce. The clear divisions between men and women in medicine in relation to their occupation in the most highly paid posts, may have acted to minimise the need for rate discrimination.

Finally, there was evidence within medicine of differential participation between men and women which contributed to their lower wages. The income of many doctors, was increased by working two jobs. This arrangement, known as *sovmestitel'stvo,* acted as a supplement for doctors wages. Often this was in a different specialisation than their primary work, for instance a *terapevt* worked as a masseur in the evenings. For many doctors a second job was an important way of raising their wage to a higher and more acceptable level. In a study carried out by Romashova, 40% of

surgeons and 32% of *terapevty* worked in two jobs (Romashova 1990 : 48). Men more often worked in second jobs and in overtime and often they worked a sixty hour week compared to the normal forty hours worked by women (Field 1975). Nevertheless, while men worked longer hours in the hospital or clinic and are paid for it, women worked equally long hours, but in the unpaid field of domestic labour.

Today, it may be that more female doctors are taking on a second job. It was quite common amongst the doctors that I spoke to that they held two jobs. With increased pressure to earn more, as doctors pay becomes increasingly inadequate in the face of price rises and inflation, doctors working hours may indeed be lengthening. The issue of low pay amongst doctors in post Soviet Russia will be discussed in more detail in Chapter 7.

In addition, men were able to earn more within medicine through private practice. This was very limited and tightly controlled and it was the elite of the medical profession serving the political and economic elite of Soviet society. Those who worked in private practice were the highest qualified, especially those from academia and so there were unlikely to have been many women included in this group (Field 1957: 103).

Women's low pay within medicine can be understood therefore primarily in relation to their segregation in a low priority sector, and within that sector, their exclusion from the academic and administrative elite. This highlights the fact that these groups within the medical profession were able to shield themselves from the effects

of deprofessionalisation and maintained their privileged position vis-a-vis ordinary physicians through their higher pay.

Nevertheless, it was not only in the form of an official wage that doctors' received payment. There was also an established system of 'gifts' from patients that contributed to doctor's earnings. This was illegal throughout the Soviet system but the practice was widespread and regarded by most doctors as an essential component of their wages. These 'gifts' took two forms. They were either a small present, most commonly flowers, chocolates or champagne or they were monetary contributions more directly recognised as a bribe (*vzyatky*).

Most of the doctors I spoke to admitted to accepting presents but not *vzyatky,* though most knew of people who did. It was felt that there was nothing wrong with accepting a present because it was simply a sign of gratitude for their work, and since this gratitude was lacking from the state, it inevitably had to come directly from the patient. The timing of the gift was particularly important in this respect, as one doctor pointed out, "presents are really a gesture of good will. Patients are grateful that I have helped them, but they don't bring presents in the first place so that I would help them".[6] Nevertheless many doctors feel some shame that they are forced into such a position and find the experience of accepting these gifts humiliating. "This is a regional polyclinic, so many of the patients are farmers and they most often bring food as a present. It is humiliating for the patients and the doctors. If a patient brings a gift, even chocolate, then you feel obliged to them, you owe them something".[7]

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[6] Interview with respondent 5.
[7] Interview with respondent 2.

The system of 'gifts' to doctors was essential, not only to increase doctors earnings, but also to improve the patient's chance of better care. Within a health care system starved of resources and staffed by underpaid and under-motivated personnel, the quality of care very quickly came to depend on the connections the patient either had or could acquire through gifts and bribes. As one doctor said, "people who have never worked as doctors often say to me that they want to have a friend who is a doctor so that they will have fewer problems when they or their children are ill. Presents are another way of creating such a 'friendship'".[8]

In hospitals *vzyatky* appeared to be more common than in clinics since the care was more complex and more prolonged. "Doctors who work in hospitals receive bribes (vzyatky) in order to treat patients better. This again relates to the question of low pay. In order for patients to attract the doctor's attention and to ensure they will be cared for, it is natural that they will give presents and also money. So, if you have money you have a much better chance of recovering from your illness because you can bribe the doctors and nurses to care for you and because you can afford the medicine you need".[9] One man described his experience of the payment system in hospital when his father was ill. "First it was 100 rubles to get him admitted into a small room in Botkin. Twenty rubles a day for the nurses - my father was old and couldn't control his bowels very well. Then 350 rubles so that a certain professor performed the surgery..The antibiotics were another two or three hundred rubles. In the end however all of it was wasted. Father developed an infection and died" (Knaus 1981: 136).

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[8] Interview with respondent 4.
[9] Interview with respondent 1.

There were greater opportunities for *vzyatky* in some specialisations than in others. As was mentioned earlier, stomotology, gynaecology and surgery brought the greatest opportunities whilst *terapevty* were more likely to receive flowers or chocolates than money. A *terapevt* in a clinic for teenagers complained about her situation in this respect. "I work with teenagers. In order that I will do something for them they bring me something, for example, one time a young girl came with her mother and I gave her an injection. They brought me a bar of chocolate. And that was all. Sometimes I receive flowers but not very often. It is necessary to work in departments dealing with more serious illness where the treatment is more serious, in order to receive more substantial presents". However she did note that *terapevty*, can make use of their role in allocating sick leaves. "There is also the situation in which doctors sell sick leave certification. This is also a form of bribe. It is necessary sometimes for doctors to do this even though it is against the law" .[10] It is difficult to say whether there is a difference between men and women in income received from *vzyatky*. While surgeons are predominantly male, gynaecologists are predominantly female, so the situation was quite balanced.

The system of bribery was endemic in the Soviet system, in part as a result of the shortages and in part as a result of the atomisation of all sectors in society which fostered the development of individual connections as a survival strategy within the system, rather than collective protest directed at the roots of the problem. Doctors were unable to protest or to bargain with the state in relation to their low pay and so supported and encouraged a system of unofficial payments which would supplement their incomes. The system of gifts remains

[10] Interview with respondent 1.

in operation today despite the shift to insurance medicine. Like many aspects of Russian life today, the Soviet legacy is still clearly apparent.

Many doctors were also themselves on the other side of the equation when, as students, bribes became an essential component in their success. In their final exams students had to answer on three questions out of a possible one hundred that they were presented with beforehand. Obviously if a student knew the questions he or she would be asked, their chances of success were hugely increased and the amount of study required was hugely decreased. So from their initial days as medical students bribery was seen, while perhaps not as natural, certainly as commonplace. "If nobody from the institute's administration condemns or censures, then without question it is perceived by our students as a proper style of establishing relationships" (Brzhesky 1973). While obviously not all students or doctors were involved in bribery, it was nevertheless a feature of the system of health care in Soviet Russia.

The attitudes of doctors to their low pay was overwhelmingly negative. The reaction of one *terapevt* was typical. "I'm offended by such low pay and the fact that I have worked 17 years and think that in my profession I know a lot and am at a high level. I can easily solve problems, give diagnosis and cures, but I only get a miserly wage".[11] Nevertheless, many were quite fatalistic reflecting the powerlessness of this group to control or change their position. For example when asked why she thought doctors received such low pay, one woman answered, "how to explain our low pay? I don't know. This isn't a

[11] Interview with respondent 16.

question you should ask me".[12] Or referring to the historical roots of their low pay, one doctor replied that, "this is a question for Lenin!".[13] A similar negativity combined with fatalism was prevalent in the concerns doctors felt about the conditions within which they worked. The extent to which doctors pay and working conditions has changed in the post soviet period will be discussed in Chapter 7.

Conclusion

Women's labour within the medical profession was characterised by low pay and poor working conditions. By providing the state with a cheap source of labour to fill places in medicine, the central elite was provided with a functioning health care system at a minimum investment, allowing finances to be directed towards other, priority, sectors of the economy. The work of women in medicine was central to the development strategy of the Soviet system by facilitating investment into the core industries at the expense of the peripheral sectors such as health.

The work of the women in the medical profession was viewed as an important element in the state's control over reproduction and production. While on the one hand, women were generally lower in the labour hierarchy than men, female doctors were nevertheless expected to address the problems of the low birth rate by regulating reproduction and to facilitate the plan to raise productivity by ensuring the health of the workforce and minimising work losses due to illness.

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[12] Interview with respondent 8.
[13] Interview with respondent 9.

Low pay and poor working conditions for women in medicine was contradictory for a number of reasons. Firstly, the under-funding of health care was contradictory in relation to the predominantly female workforce. For all health workers, including doctors, constantly working in dangerous conditions without adequate protection posed a risk to their own health. Not only was this contradictory in terms of their own ability to work, but also in the long term, as women, such conditions were contradictory to their ability to reproduce. There is no doubt that daily exposure to harmful chemicals, radiation and disease can create difficulties for women in the form of miscarriages and birth defects. Therefore, while the under-funding of the health service may have allowed resources to be directed elsewhere, most notably into the military and into heavy industry, this was contradictory for biological reproduction. This illustrates the questionable basis for the 'protection' of women. Protective legislation may have been designed to address the difficulties for reproduction when women were engaged in production, but was used to control women's labour force participation.

In addition, female doctors were also expected to play a significant role in facilitating the state's strategy of social reproduction. Yet the devalued, underfunded nature of the medical profession hampered their ability to do so, both materially and in relation to their morale and interest in their work. Low pay and poor working conditions created a climate of despair and low motivation within the medical labour force and so had implications for the quality of care. Poor quality health care meant a lower standard of health amongst the population, which in turn had implications for the level of production with increased time off for the diagnosis and treatment of

illness. However it was not only underfunding of health care that lowered the morale and standards of care amongst the medical profession. The medical division of labour was also detrimental since women were often denied access to the education to improve their position. It is to this that we will turn next. In the following chapter the reasons behind women's choices of career path will be discussed.

5

THE MEDICAL DIVISION OF LABOUR IN SOVIET RUSSIA : WOMEN'S CHOICES AND CONCERNS

It may appear as though medicine is a qualification which gave equivalent human capital to those who qualified to practice it. However it will be shown in this chapter that the acquisition of human capital in medicine is harder for women at all stages from admittance to university, choice of specialisation and career advancement. This resulted in part from practices of segregation among the medical establishment, but also from wider pressures on female doctors, as women, relating to their role in reproduction. These structural constraints on women's choices were reinforced by gender ideology in the form of stereotypes of women's nature and the type of work suitable for them.

Therefore while gender was significant in understanding the labour hierarchy within the economy as a whole, it was also significant within the medical profession. The segregation of women into particular specialisations left certain areas of medicine as a primarily male domain and these were accorded higher rewards as a result. The reasons behind this will be examined in this chapter. As with poor pay and working conditions, this internal division of labour was

contradictory in relation to the role of doctors as regulators of production and reproduction.

In this chapter therefore, the structures which shaped women choices and their reactions to them will be examined in relation to women's choice to enter medicine, their choice of specialisation and their career advancement. By doing so it will be possible to understand the processes and significance of occupational segregation within the medical profession in Soviet Russia. Before going on to discuss the gendered character of occupational segregation within medicine this will be placed in the context of the organisation of Soviet health care.

The Organisation of Soviet Health Care and Divisions of Labour Within the Medical Profession

The health service in Soviet Russia was both a product of the policy of the leaderships and of significant importance in the implementation of policy measures. While immediately after the revolution severe health epidemics placed the need for better health care at centre stage, the development priorities of industrialisation meant that throughout the whole Soviet era, health care was a neglected sector of the economy. Nevertheless, the organisation of the health service was shaped to reflect priorities of the centre and the health labour force were expected to meet increasing demands being placed on them despite limited resources.[1]

Like all administrative structures within the Soviet system, health care was a centralised hierarchy. At the top of this hierarchy was the

[1] For an examination of Soviet health care organisation see Ryan 1978; Navarro 1977; Field 1957.

Ministry of Health though the Ministry itself was responsible to the Party for the implementation of its health policies. The actual running of the health service in terms of standards of care and working norms was the responsibility of the Ministry with guidance from the academicians of the Semaschko Institute. The Ministry also oversaw the national health budget in conjunction with Gosplan. Below the Union Ministry lay the Republican ministries though the authority of these bodies was minimal.

The more detailed administration of the health service was carried out at the oblast (regional) level. Each health department was governed by the executive committee of the local Soviet, of which the Chief Medical Officer (CMO) was a member. The CMO was also the director of the oblast hospital and responsible for the administration of health care at that level but also at the lower, rayon (district) level. The rayon co-ordinator and chief physician, appointed by the oblast CMO was responsible for the administration of the rayon hospital and of the polyclinics. At each level, the health departments or ministries have dual lines of responsibility. On the one hand, they were answerable to the equivalent Soviet, but on the other hand, they were accountable to the health administration of the immediately higher level.

In addition to the emphasis on increasing the number of doctors in the Soviet Union, attention was turned in the 1930s to increasing the divisions by specialisation within medicine. This in turn created an increased need for more doctors. A decree in 1934 established the pattern for medical training by dividing medical institutes into three faculties - curative, paediatric and sanitary-hygiene. Stomotological

(dental) faculties were included later in 1936. These four faculties produced 15 broad specialisations which were then subdivided into narrower specialities. For example, surgery was a broad speciality within the curative faculty, which is then subdivided into a number of specialities such as anaesthesiology, traumatology and so on.

The degree of specialisation in Soviet medicine was greater than in western medical systems. In part this resulted from the influence, as in the west, of Flexnarian or Scientific medicine. This was based on the belief that disease was caused by a dysfunction in the machinery of the body. It was a very mechanistic approach which easily led to specialisation according to the function of different elements within the body machine (Navarro 1977). However, the specialisation of Soviet medicine was also a product of the nature of industrialisation and the perceived role of the health service in this respect. The faculty division reflected the focus on certain groups of the population, most notably on workers and on children, as the new workforce. The curative faculty was designed to provide doctors to care for the adult population in general, but workers in particular. This was complemented by the sanitary hygiene faculty which would allow improvements in working conditions, particularly for women. At the same time special attention was turned to children and the paediatric division reflected this concern.

The expansion in the range of specializations led to calls in the late 1960s for a halt to the incessant division and subdivision. This was prompted by concern over the very nature of the 'specialist'. Indeed as Popov noted, "most frequently, the decision about which speciality this or that doctor should be assigned to is taken by the statistician

when compiling the statistical return for an institution". There was concern therefore that being a specialist did not necessarily mean that a doctor had received a particular post-diploma qualification in that area. Many doctors at this time, upon graduation, were employed in specialities for which they had no particular training (Ryan 1978: 57). This led to changes in the medical education system in 1968. From this point, students entered a faculty and received 5 years of general medical education relevant to their faculty. In the sixth year they undertook their subordinatura course, at which point they specialised, for example into surgery. In their seventh year they proceed to their internship for one year and can specialise further. It was hoped in this way that doctors would receive better specialist training and that the categorisation of specialists would be easier to control.

Divisions within the health service were also based on the stage of care, that is whether it was primary, secondary or tertiary care. Primary care was mainly provided by the *terapevt*, for adults and the paediatrician for children. The *terapevt* was a general physician working either within one polyclinic or in the case of sector *terapevty*, they were responsible for a larger area. Some doctors choose to become *terapevty* after their medical training, while for others it was more of a forced choice following failure in their chosen specialisation. It was easy for such students to work as *terapevty* because of the labour shortage in this area. One of the reasons for the reluctance of many to work in this field was its low ranking within the medical profession. The hierarchy within medicine sets the least specialised work at the bottom, that is, primary care work, and the most specialised work involved in tertiary care and research at the top (Paikin and Salina 1978). Unlike general physicians in the UK, the

terapevt only dealt with the adult population and often not with women. At the primary care level children were treated by paediatricians in special children's clinics and women were often treated by obstetrician-gynaecologists in women's clinics.

The work of *terapevty,* and paediatricians and gynaecologists at the primary care level, tended to consist of referrals of patients to specialists with only limited treatment being carried out. Heitlinger makes this point in relation to Czechoslovakia. "The specific structure and organisation of primary medical care is characterised by physical isolation from specialist work in polyclinics and hospitals, weak technological foundations, high patient loads, routinisation and monotony of work, dilemmas posed by 'dirty work', limited intellectual stimulation, excessive paperwork, low pay and low esteem from both the general public and colleagues in other specialities" (Heitlinger 1991: 217). This is contrasted with the work of tertiary care specialists within hospitals who have more control over patient care and work in a more complex area.

To a large extent the divisions between primary, secondary and tertiary care were mirrored by the divisions between hospitals and polyclinics. Those working within clinics did not work in hospitals and vice versa. Primary care took place solely within clinics, secondary care within district hospitals and tertiary care was carried out in the regional hospitals. There was an attempt in the post war period to move towards the creation of an integrated service with the hospital as the focus for health care. It was argued that hospital care ensured more effective care for patients in terms of continuity of care and the use of technology available only at the hospital.

Under the Polyclinic Hospital Reorganisation Act, there was a move towards the creation of an integrated service with the hospital as the focus for health care. Under this legislation, polyclinics were absorbed into hospitals and later in 1956, sanitory-epidemiological stations were also integrated into the hospital structures. Nevertheless, the 1947 legislation did not end the sharp demarcation between hospitals and polyclinics in terms of personnel and indeed actually exacerbated divisions by demoting the polyclinic to the status of hospital subsidiary. This was reflected in the weighting of resources in favour of the hospital.

The reasons for this integration are complex. On the one hand, it was argued that hospital care ensured more effective care for patients in terms of continuity of care and the use of technology available only at the hospital. On the other hand though the predominance of the hospital which resulted from the integration can only be understood in terms of the relative power bases held by different elements within the medical profession. In particular this must be understood in relation to the role played by the medical academicians.

The need to control the industrialisation process led an increasing bureaucratisation and centralisation of society in the 1930s. In relation to health, 1936 saw the establishment of the Ministry of Public Health as the central administrative authority. The centralised system of decision making in health care that emerged will be discussed in more detail shortly. What is most significant here was the growing importance of the technocrats since "in the health sector, the specialised medical experts - the medical academicians - comprised the chief health technocracy that was responsible for establishing norms

and standards for that sector." Since "for academic medicine, good medicine was hospital medicine", their key position, in the context of increasing centralisation, saw the "predominance of the hospital over all other services" (Ryan 1978: 50-1).

What is apparent from this description is that the health sector was characterised by its disperse and multi-layered structure. However there were many problems in the provision of health care that arose from these organisational complexities. Ryan noted that there was a poor level of communication between different levels and specialisations which made continuity of care very difficult. It also meant that the implementation of centralised directives were not always carried out. A study reported that over 50% of orders were never fulfilled because the orders failed to reach their destinations (Ryan 1978: 13). This could be taken at face value that indeed the orders never did reach their destination, or it could be that the personnel involved could not or simply did not want to carry out orders and so denied knowledge of them. As in industry it was the case that health care personnel had their own agendas which were often very different to those of the Ministry.

Finally in relation to the division of labour in medicine, it is worth noting the subjective evaluation of prestige associated with particular specialisations. While one third of respondents said that surgery was the most prestigious specialisation, one third also mentioned gynaecology and dentistry. The reasons for surgery's prestige tended to focus on the nature of the work. One doctor noted that "surgery is the most prestigious speciality because it involves very complex work and long hours". She also pointed out however, that prestige also relates

to the supply of a labour for a particular speciality. "The shortage of some specialities, particularly surgery, is an influence on prestige and lets them be paid more" .[2] This is in contrast to *terapevty,* whose work is regarded as less important and of whom there is no shortage. One terapevt reviewed her work in this respect. "*Terapevty* are not prestigious and we are paid very little. I think this is because it is often possible for people to put off a trip to the *terapevt* until the last moment or to try to cure themselves. But when it is a more complex operation, or a problem with teeth or the birth of a child, it is not possible to put off and the patient must go to the specialist. Our work is not as urgent as the others".[3]

The high level of prestige for dentistry related primarily, to the additional earnings available in this type of work. One doctor noted that, "many people want to enter the dental faculty because of the 'unofficial incomes' that they can earn".[4] Dental work presented many opportunities for doctors to increase their earnings by offering different levels of care at a price, for example the use of anaesthetics during treatment. Similarly in gynaecology, the high rate of abortions in Russia was the source of extra income for doctors. Again treatment could be varied, for example no anaesthetic, provision of a local or a general anaesthetic, or the timing of the operation could be brought forward with a contribution from the patient. While to an extent such opportunities were available in many specialisations, it appears that dental and gynaecological work presented the most lucrative opportunities due to the frequency with which treatment was required by the Russian population.

[2] Interview with respondent 14.
[3] Interview with respondent 1.
[4] Interview with respondent 2.

In gynaecology however, it was not only in terms of the incomes received that prestige was determined. In direct contrast to the fact that a significant proportion of gynaecologists' incomes comes from abortions, many doctors said that gynaecological work was the most prestigious because it serves the purpose of enabling the creation of the next generation. "The most prestigious occupation is gynaecologist because a lot of women need them and because they are essential for brining the next generation into the world and ensuring they are healthy".[5] Nevertheless even in this respect, remuneration is an important consideration. As one doctor noted, "gynaecology is a prestigious occupation because the birth of a person is a miracle and the parents are so happy that they want to thank the doctor in many ways, including financially".[6]

Therefore the prestige given by doctors interviewed to specialisations, depends to a large extent on their earnings, both official and unofficial. This can in part be explained by the greater significance placed on higher earnings in the new market Russia. However, even in the Soviet period the opportunities to earn more with certain specialisations, in the form of goods, services and favours as well as money, were still apparent. It appears therefore that while in general, primary care work such as gynaecology is deemed to be lower in the medical hierarchy, this does not take into account the peculiarities of the payment system in Soviet health care, nor of the elevated status of gynaecology as a result of the high abortion rate. As will be shown, while it is certainly true that in general the female dominated specialisations remain lower in prestige than male dominated areas of

[5] Interview with respondent 10.
[6] Interview with respondent 16.

work, gynaecology is an exception to this. Both in the Soviet and Post Soviet period, work in gynaecology offered opportunities to receive additional payments, for the provsion of aneasthetics, privacy, the speed with which abortions can be carried out and so on. While there is a demand for abortions among women in Russia, there will be opportunities for doctors to earn extra money by offering a service that claims to be better than the regular service provided.[7] Nevertheless, even within this field, there are divisions between male dominated hospital work and female dominated clinic work, so even within this area there are limits to women's involvement.

The Gender Division of Labour in Medicine

In this section the question of how gender relates to the division of labour within medicine will be discussed in terms of women's choice of profession and specialisation.[8] Table 2 presents an outline of the proportion of women at the various levels of health care. It is clear from this that women were under-represented in the most prestigious areas of medicine. The predominant role of academicians was noted above, and here it is possible to see that while around 70% of doctors were women, only 10% of the top researchers were women. While the figures cited here are relatively dated, based on evidence from 1974, more recent data provides a similar picture. No women were elected to the Academy of Medical Science in the 1986 elections and at that time they comprised only 5 out of 48 corresponding members (Shecter 1992 :154). Similarly, tertiary care within hospitals

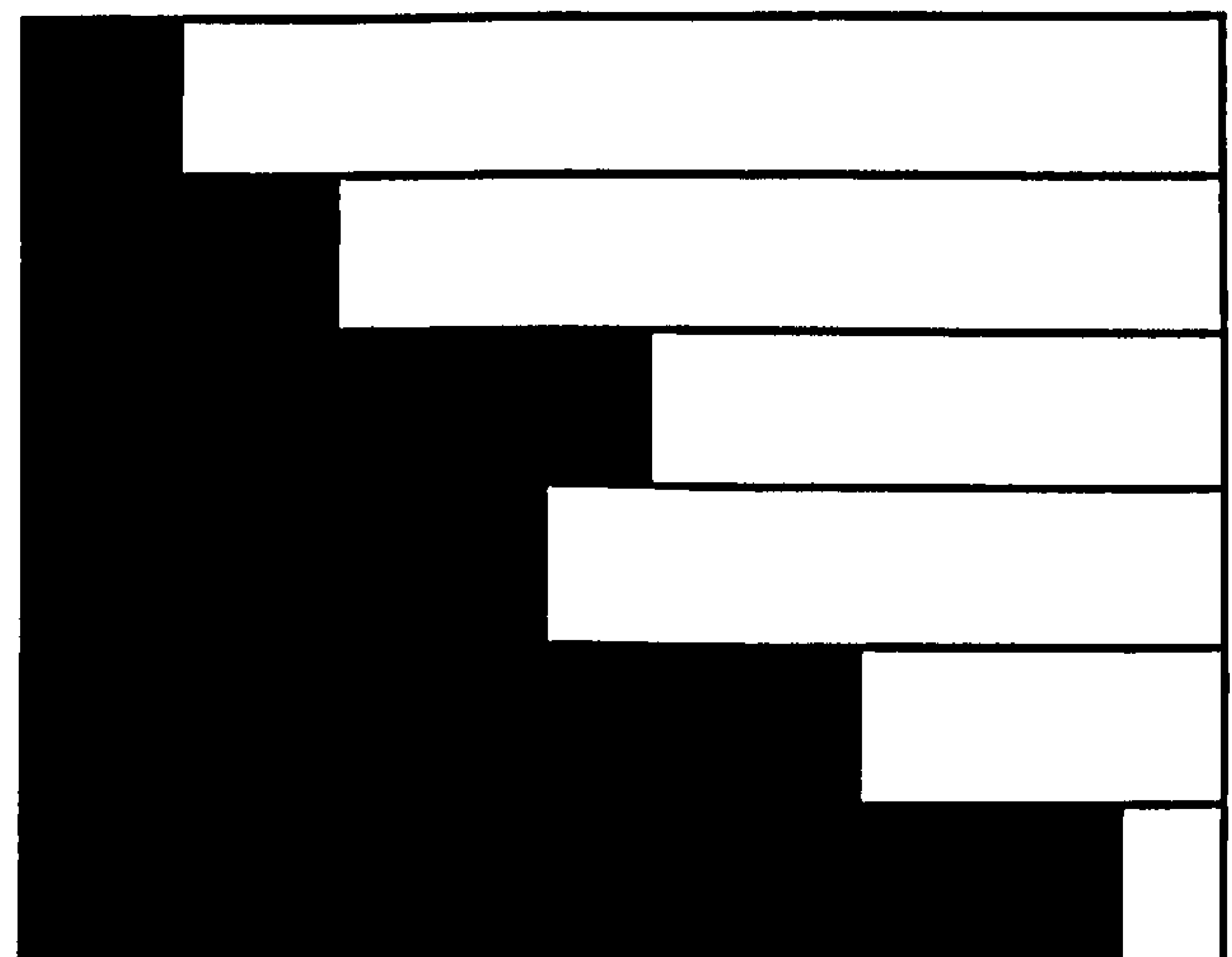
[7] Based on coversations with women in Voronbezh, it appears that there is still a tendency to pay extra for what is regarded as a better service. Whether the service is in reality better than a statndard state service, or whether these women are used to believing that it was essential to pay for a painless abortion, it is dificult to know without further research.

[8] For an examination of the gender division of labour in medicine in the West see Riska and Wegar (eds) 1993.

was a predominantly male domain with women only accounting for 40% of doctors working at this level. On the other hand women were over-represented in primary care work.

Table 2 : Vertical Segregation in the Medical Profession %

WOMEN	
Academy of Medical Sciences	10
Professors	20
Managers and Administrators	50
Tertiary Care Physicians	40
Secondary Care Physicians	70
Primary Care Physicians	90



Source: Adapted from Navarro (1977).

A similar pattern emerges when different specialisations are examined more closely (Table 3). Primary care specialisations such as paediatrics were overwhelmingly female. 93.3% of doctors working in this field were women. At the other end of the spectrum, tertiary care specialists were predominantly male. Only 25% of neurosurgeons were female (Navarro 1977: 78).[9]

[9] Regional figures are similar. In Tula Oblast in 1992, 66.9% of doctors were women. 88.4% of pediatricians, 24.3% of surgeons and 55.3% of managers were women (Manerova etal 1993).

Table 3: Proportion of Women in Specialised Fields of Medicine

BRANCH OF MEDICINE	%
Paediatrician, obstetrician-gynaecologist,cardio-rheumatologist, endocrinologist, laboratory doctor, bacteriologist.	> 90
Terapevt, infectionist, opthalmologist, hematologist, dietician, physiotherapist	80-90
Epidemiologist, neuropathologist, doctor-statistician otolaryngologist, stomatologist, physical-culture doctor, ECG doctor, phsyiologist gastroenterologist	70-80
Oncologist, psychiatrist, roentgenologist, medical qualified sanitarian, nephrologist, health education doctor	60-70
Cardiovascular surgeon, health care organiser, toxicologist, patho-anatomist.	50-60
Anesthesiologist-reanimator	< 40
Surgeon, traumatologist-orthopedician, urologist, chest surgeon	30-40

Source: Navarro 1977: 78.

Why did Russian women choose medicine?

It is clear from the historical evidence presented in the Chapter 3, that women were keen to enter medicine in the pre-revolution period and after. But why did they want to enter an occupation that was low paid and low status in the hierarchy of the Soviet economy? The first aspect in the explanation of this is the class character of women in medicine. One of the most notable features of the women interviewed was their class background. Two thirds of the respondents' parents were professionals, primarily doctors, engineers or teachers. 18.7% were workers and 12.5% were military officers. One doctor whose parents were teachers noted the importance of their

parents influence and the desire to remain within professional occupations. "My parents were teachers and they wanted me to be a teacher. But I didn't want to teach because I thought it would be a boring job. They suggested that I enter the medical faculty because that was also a respectable job for a woman and I thought that it was a good idea".[10] 55% of respondents said that they chose to become doctors as a result of their parents' influence. While the survey was not large scale enough to be representative, indication of similar findings is presented in other work. Field noted that the proletarianisation of medicine was never very effective and so even in the early stages of the Soviet system, doctors tended to come from professional families (Field 1957: 65).

The strongest source of influence in this respect came from respondents whose parents were doctors. One third of those interviewed came from doctors families. Contact with doctors in the family from an early age seems to have been very influential in their decisions. One woman said, "Medicine was a family tradition because my mother, grandmother and aunt were all doctors. I therefore had daily contact with doctors and knew a lot about their work from childhood".[11] Even in some cases, where doctors did not want their children to follow in their footsteps, the influence of the family tradition was still strong. One doctor remembered arguments with her parents over this issue. She said, "my parents are doctors, in fact five generations of my family are doctors. But my parents didn't want me to be a doctor because of the low pay. But I was brought up with it and it just seemed natural".[12]

[10] Interview with respondent 13.
[11] Respondent 39 questionnaire.
[12] Interview with respondent 4.

The desire for girls from professional families to remain in the professions is reflected in the other occupations they considered. While the majority only considered medicine, for those who were less certain, the other occupations considered were all professions, including acting, art, teaching, journalism, languages and oceanography. Most occupations considered therefore were professional jobs in female dominated areas. There was a definite tendency for girls from professional families therefore to remain within their own class.

But it is also notable that the limitations on women in their choice of career were also a factor in motivating women towards medicine. If they wanted to enter a profession, medicine was often the best option. It was noted earlier that medicine was quite low within the higher educational hierarchy, so initially would have been an easy option for women. As medicine became feminised, it became the best professional choice for women. One woman noted that "for women, doctor is the most prestigious profession" .[13] What is important here is not that she argued that medicine was the most prestigious profession, but that for women, whose choices were far narrower than men's, it was.

One woman expressed the perceived limitations on women's choice of occupation. For her, "the majority of doctors in Russia are women because women have to work and where else would they work but in medicine? What better options are there for them?".[14] Medicine seemed like the only choice for many, for a number of reasons. When

[13] Respondent 25 questionnaire.
[14] Respondent 12 questionnaire.

entrance to other professions was considered, they were either regarded as less prestigious than medicine or as harder to enter. For example, one doctor had considered entering the science faculty to study physics, but "I thought it would be easier to enter medicine because there are more women in the medical institute....There are fewer opportunities for intelligent women than for men".[15] Compared to other non professional occupations, medicine was also a good option. "Probably it is easier to work in medicine than in a factory. Women are keen to become doctors because the conditions and the work is better than a lot of factory work even though the pay is less".[16]

In addition to limits on women's occupational choices, there were direct segregationary practices which limited women's options to enter medicine and within medicine. There were indications that the central elite was not content with the feminisation of the medical profession. An American delegation visiting Russia in 1970 noted that among administrators and faculty members the ideal ratio was 30% women and 70% men. The reason given for the desired reversal was the difficulty women had in combining work with raising a family (Ryan 1989: 45). Between 1960 and 1970 the percentage of women in medicine dropped from 76 to 70 and the femal students admitted to study medicine was reduced from 85 to 65% between 1966 and 1967 (Field 1975).[17]

[15] Interview with respondent 13.
[16] Interview with respondent 8.
[17] This trend was mirrored in industry in the 1950s and early 1960s, when attempts were made to remove women from skilled work which they had entered during WWII.

Preference was given to men on entering the medical institute. The director of a medical institute made this point when he said, "there are more female candidates than male, but we try to ensure there are equal numbers of male and female students in the institute in order to comply with equality legislation".[18] 79% of the interview respondents said that it was easier for men to enter the institute than for women. One woman who trained in the 1960s noted the preference towards men. "When I entered the institute 30 years ago, there were very few men so if they had less points than women they were still admitted. Men were given priority because they wanted to encourage more men to be doctors".[19] In particular it was pointed out by many doctors that men were given priority after returning form the army. This is the cause of much resentment among women doctors. "I think it is easier for men particularly when they have been in the army. Then they are given priority even when they are stupid. Such men finish the institute and are working and I don't think this is helpful for the patients. I had such men in my class and no matter how bad they were the lecturers just let them pass".[20]

The preference for men to enter the medical profession stemmed from a number of factors. In part there were concerns about the distribution of the medical labour force between urban and rural areas. On the one hand, medical recruits were desperately needed in rural areas and the system of 3 year compulsory service after graduation was intended to relieve the shortage. Since the majority of doctors were women, it was women who were to be sent all over the country often far from their home and family. On the other hand

[18] Interview with respondent 3.
[19] Interview with respondent 6.
[20] Interview with respondent 15.

such a situation is problematic for reproduction. If women are separated from their partners for a minimum of 3 years during their prime childbearing years, reproduction would surely suffer. This was the argument of the demographers and led to the compromise that married women were exempt from assignments. In turn, many women married before the end of their course in order to be eligible for exemption (Field 1957 "91). The implications this had for the labour shortage of doctors in areas outside the large cities was central to the attempts to increase the number of male doctors. Male doctors would be more flexible, not only because they could father children at almost any age, but also because it was believed that their wives would follow them to their placements whereas the husbands of doctors would be less inclined to do so.

The preference given to men was also explained by some in relation to the distribution of men and women within particular specialities within medicine. There were distinct characterisations of certain occupations as more suitable to men and for this reason more men were needed to enter the profession. One doctor said, "the preference is given to men in order that they will fill places in surgery and re-animation. They have to be strong and masculine for such work, so men must be encouraged into medicine".[21] The influence of gender stereotyping will be examined shortly. What is clear from this is that certain specialisations, in particular surgery were kept male in order to persuade men to enter the profession.

The desire to reverse the sex ratio within the medical profession must also be understood in relation to the wider concerns over women's

[21] Interview with respondent 10.

labour force participation. The demographic problems of the 1960s sparked renewed debates over containing women's participation in paid labour in favour of their motherly duties. This was cited by many doctors as the reason for the state's encouragement of men into medicine. As one doctor said, "it is easier for men to enter the vuz because girls are potential mothers and this takes up a lot of their time and energy".[22] A prominent doctor also warned women, "Don't forget that..being a woman, you must not only be a doctor, but also a wife and mother and that is far harder than being a husband, a father and a doctor" (Ryan 1989: 46).

While little reduction was made to the proportion of women in medicine, it remained easier for men to enter the profession than women. Moreover, within medicine there was evidence of the channelling of women into particular specialisation and away from others. For some, the choice of specialisation was the direct result of their being encouraged into particular specialisations by lecturers at the medical institute. The influence of teachers cannot be underestimated, for Medvedskii found that 21% of students cited teacher influence as the most important factor in their choice (Medvedskii 1990). This influence could be a positive and encouraging one, as was the case with one doctor who decided to enter gynaecology, in part because of the good relationship she had with her teacher in this area. As she said, "I really enjoyed the classes and she made it seem like a very interesting area of work. She was always keen to talk to us about her work".[23]

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[22] Respondent 33 questionnaire.
[23] Interview with respondent 11.

However, the influence could also be a negative and limiting one. One doctor who entered the curative faculty and was initially unsure as to her specialisation remembered a conversation with a lecturer when she suggested to him that she would like to be a surgeon. "Even though this was only a suggestion, I was surprised at the forcefulness of his reply. 'Surgery is for men and you should not waste your time thinking about this'. This did put me off because at that age you are very impressionable, especially when it is with people who are teaching you".[24]

There were pressures on women therefore from those within medicine to enter certain specialisation within medicine. But there were also external pressures that influenced women's choices. For many women the choice of medicine as a job and of their particular specialisation within medicine was influenced by their responsibilities within the family. The flexibility of the work schedule in medicine was noted by many as an incentive to enter medicine. "The work day is short. There is shift work which is flexible so it is easier for women to fit their work around their family".[25] This was an important consideration for many women given the quantitative and qualitative inadequacies of child care facilities in Russia.

The work regime was also a factor in the choice of speciality within medicine, most notably in relation to the predominance of women working as terapevty - the Russian equivalent of the general practitioner. This type of work offered short shifts and was seen as the most convenient for women. The time spent on their family duties

[24] Interview with respondent 9.
[25] Respondent 39 questionnaire.

deterred women from entering some specialisations. "There are some specialties which are complicated in terms of gaining qualifications , for example surgery. If women are not married then they can give a lot of time to their work, but if women have a family and they don't have the possibility to hire someone to help them in the home, they must spend a lot of time with children and as housewives. Therefore, women find work which will not be taxing in the physical and emotional sense".[26]

This doctor went on to explain that this was the main reason why she chose to be a *terapevt*.. "Personally I work in a polyclinic and this work suits me. While at work I attend to the sick and the rest of the time I have time for work in the home.If I worked in a hospital I would have to go to work in the morning, for 6-8 hours and then I could be called back to work on the phone if one of the patients got worse. I would have to go to the hospital and that would distract me from my work in the home".[27] The more flexible work schedule offered in clinics, and so in specialisations at the primary care level, was therefore an influential factor for many women.

Another feature of hospital work which influenced women's choice of specialisation was night shifts. In Medvedskii's survey, 36% of students mentioned this as a factor in their choice (Medvedskii 1990). One gynaecologist in a women's clinic noted the influence of this factor in changing the sex ratio of gynaecologists in hospitals and in clinics. "In our clinic all the gynaecologists are women, but in the hospitals many are men. This is because in the hospitals the work is

[26] Interview with resondent 1.
[27] Interview with respondent 1.

heavier.In the hospitals there is a lot of night work because most births happen at night and also they are on call a lot, so it is physically demanding and better for men".[28] Again, this is another reason for the hospital/clinic distinction. For men, work in specialisations offering night shifts, that is in tertiary care hospital based specialisations, may be the most desirable since this offers the opportunity for increased earnings. For women on the other hand, family responsibilities make night shift work far less appealing and often impossible.

Finally, some specialisations were said to be too dangerous for women. One doctor noted that "there are certain specialisations which are dangerous for women, for example working with x-rays. Nevertheless in our hospital all such doctors are women".[29] It is interesting to note that in medicine as in industry, the regulations concerning the protection of female labour were consistently flouted. In an occupation deemed suitable for women's health and so for reproduction, less attention is paid to the dangers posed by the very nature of medical work, than to the heavy work of industry. Yet working with x-rays, and indeed working with infectious diseases in a poorly protected environment, has as much if not more significance in relation to the potential impact on women's health.

The material factors therefore which shaped and sometimes limited women's choices and concerns were reinforced by a gender ideology based on essentialist notions about women's character and its suitability to certain forms of employment. This ideology was heavily

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[28] Interview with respondent 14.
[29] Interview with respondent 4.

grounded in the image of women as reproducers. The fact that many saw medicine as a natural choice for them as women, was indicated by the fact that many saw it as their vocation. One doctor spoke emotionally about her love of her work. When asked why she chose to become a doctor, she answered, "this was a dream of mine since childhood. After school I knew I wanted to be a doctor. My parents were teachers but my dream was to be a doctor. It was a call from my heart".[30]

The prevalence of the idea of a natural division of labour between men and women was highlighted by the response to the question, 'why are the majority of doctors in Russia female?'. 52.7% of respondents gave female characteristics or nature as their explanation. The director of a medical institute also cited women's character as the reasons for their prevalence in medicine. He said, "women are keen to enter medicine because it is an interesting profession and because it is well suited to their character. Women are more suited to being doctors or teachers than to being engineers or technical specialists".[31]

Most doctors mentioned characteristics such as kindness and gentleness, all aspects of caring, as the key features of women that make them most suitable for work as doctors. For example, "women are naturally very giving and caring people so they want to help the sick".[32] This was often compared to what were regarded as male characteristics or more often failings. "Women love to protect the weak and be close to people. They are honourable and hard working.

[30] Interview with respondent 10.
[31] Interview with respondent 3.
[32] Interview with respondent 13.

Among men there are fewer of such character" .[33] Characteristics such as the ability for lateral thinking, intelligence, determination etc as aspects also essential to work as a doctor were rarely mentioned. This not only reflects the traditional stereotypes of what is 'male' and 'female' but also the nature of medicine in Russia. It was noted above that very quickly after the revolution, the emphasis was placed on care rather than on science and research with doctors becoming 'more than nurses but less than doctors'.

The characteristics attributed to women were clearly related to their role as mothers. This was made explicit on a number of occasions in the interviews when doctors expressed a connection between women's reproductive capacities and their proclivity towards medicine. "Women are more suited to being doctors because they are more kind, responsive and attentive. They take illness very close to their heart and are very empathetic. This is because they are mothers and it is in their nature".[34] Women's ability to reproduce was not only seen to make women more gentle and so on, but also gave them an innate tie with nature, which men could never achieve,and which made them more capable of understanding biology "Medicine is a human profession and it is necessary to know about the organism. Women are closer to nature and so know more about this than men".[35] It is interesting that despite the characterisation of the physician in terms of their kindness and so on, the public complaints raised against doctors would indicate that in reality the situation is very different. Doctors are frequently accused of being rude,

33 Respondent 18 questionnaire.
34 Interview with respondent 7.
35 Respondent 38 questionnaire.

thoughtless and generally unfriendly, in the fact the antithesis of the 'ideal doctor' image presented in the interviews.

Similar responses were given when the women were asked why they chose their particular specialisation. There were definite distinctions made between what were regarded as 'male' and 'female' specialisations. As Schecter notes,

"One traditional bias in western medicine is that men are better curers while women are better carers, thus men should be the doctors of science, while women make good nurturing nurses. This bias has carried over into Soviet society and has taken on a Soviet twist. Women are nurturing doctors (but do not specialise in male areas) while men who are considered more detached and less emotional are better surgeons and administrators" (Schecter 1992: 171).

The interviews highlighted clear patterns concerning the gender stereotypes in relation to certain specialisations. The most frequently mentioned sex-typed specialisation was paediatrics. The reasons given for this centred on women's reproductive functions and the greater understanding of children this provided her with. "Because women give birth to children they have a special bond with them that means they can treat them much better".[36] Moreover this does not only seem to apply to women who have children but to any woman. One paediatrician noted this in saying, "women are suited to being paediatricians most of all because they are mothers and so are more closely tied to children. As mothers or potential mothers all women want to help children".[37] Women's essential nature was also the

[36] Interview with respondent 6.
[37] Interview with respondent 7.

reason given by those who said that gynaecologists should be women. For example, "gynaecologists should be women because they understand women better than men and female patients feel more at ease with them. When I was at school there was a male gynaecologist to examine the girls and they all ran off. Women are self conscious of men".[38] Finally mention was frequently made of the work of *terapevty*. Again women were deemed as most suitable for this work because of their innate characteristics. "Therapists should be women because this work is formed by all female characteristics like kindness and compassion and patience".[39]

The type of work involved in the primary care specialisations of paediatrician, gynaecologist and *terapevt* was therefore seen to be the most suited to women's nature. The other side to this was the emphasis on specialisations as unsuitable for women. In this respect, the only one mentioned was surgery . As one doctor noted, "women should not be surgeons because they do not have the strength, endurance or skill necessary".[40] It was argued by many that men were far more capable of working in this area than women. "Surgeons have to be men because surgeons have to be very courageous and strong. They have to be like true men. Some women are surgeons but they are exceptions".[41]

There were some exceptions however, in which it was felt, that women could make good surgeons. Most notably, in line with the role of women in paediatrics, it was felt by many that women should

[38] Interview with respondent 7.
[39] Respondent 30 questionnaire.
[40] Interview with respondent 6.
[41] Interview with respondent 5.

be paediatric surgeons, "because they understand children and can soothe them when they cry".[42] Even at the level of surgery therefore, women's role seemed to be one of caring and nurturing. Only in one instance was women's physique cited as an advantage for surgery. "There are some types of surgery which is more suitable for women, in particular micro surgery, because they are more delicate and so may be more accurate in such work".[43] Nevertheless, on the whole they were believed to be too weak, both mentally and physically for such work.

It is clear from this that there were definite ideas concerning the type of work women doctors were most suited to. Such ideas were clearly influential in shaping the decisions of women when making their choice of specialisation. The gender stereotypes of women's work in medicine were based therefore on the Party line concerning women's role as mothers and the characteristics such as kindness, affinity towards children, and patience that this was seen to engender.

Medicine - job or career?

So far, gender divisions according to specialisation have been examined, but it is also essential to look at the way in which Russian doctors develop their careers and the extent to which gender divisions are apparent in this respect. Throughout their careers, it was compulsory for Russian doctors to attend continuing education courses every 5 years. These were intended to keep doctors up to date and to improve the quality of care to patients. They did not directly raise the qualifications of doctors however. Rather this took place

[42] Interview with respondent 7.
[43] Interview with respondent 8.

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[42] Interview with respondent 7.
[43] Interview with respondent 8.

through a series of exams which doctors could take, on a voluntary basis and which would enable them to pass through the hierarchy of II, I and Higher category of doctor. Pay was increased accordingly, though the difference in pay between the categories was quite small. As one doctor noted, "we raised our qualifications every 5 years, but our pay did not rise at the same time. Such educational trips do not raise pay, they only provide new information to allow us to work better as doctors".[44]

It is perhaps as a result of the minimal pay increase that relatively few doctors raise their qualifications. A survey carried out in the region of Tula, found that only 30.6% of doctors had been awarded any of the graded qualifications.10.2% were category II, 15.1% category I and 5.3% were higher category.[45] The proportion of doctors with such a post graduate qualification varied between specialisations. While 44.9% of surgeons had a category rating, only 21.2% of *terapevty* did (Manerova et al 1993). This points to the fact that there may indeed be a difference between male and female doctors' opportunities to raise their qualifications. As Pilkington notes, 83% of women workers in general did not raise their qualifications after marriage (Pilkington 1992: 200). In the interviews, 62% said that it was indeed easier for men to raise qualifications.

There were several reasons given for this. Firstly, and most prominently it was argued that women's time was used up caring for their family, while men were freer to devote themselves more fully to their work. "It is harder for women to improve their qualifications

[44] Interview with respondent 6.

[45] Amongst respondents of the interviews, 40% of doctors had a qualified category: 22.5% were category II, 12.5% category I and 5% Higher category.

because they have less time to spend on improving their careers as their time is spent looking after children. They also have to care for their husband. It is easier for men when they have little to do in the family and everything is done for them".[46] It was also noted that raising their qualifications was more difficult for women because this often entailed study trips away from home and again their family responsibilities made this very difficult. "If women study on courses in other cities it creates family problems. They have to consider who will look after their children and their home. They certainly cannot rely on their husbands to do this".[47]

Similar reasons were given when women were asked why there were fewer women than men in top positions within medicine. Initially many pointed out that they worked under or knew female head doctors, but when it was pointed out that very few women were professors or members of the Academy of Medical Science, they seemed to shrug it off as if such matters were of no relevance to them, or one that it was too difficult to explain. As one doctor replied to the question, "as in all other areas, women are in lower positions. Who knows why?".[48] For those that sought to explain the lower proportion of women in leadership positions within health care, two explanations predominated. Firstly, women's family responsibilities were cited as limiting women's career opportunities. The director of a medical institute noted this problem stating that, "women are distracted by their families and children and so have less time to spend on their own growth. It is far easier for men to follow a career

[46] Respondent 24 questionnaire.
[47] Respondent 17 questionnaire.
[48] Respondent 19 questionnaire.

path. Both are equal in terms of the talents god gave them and both can have equal success".[49]

However, it was not only family responsibilities that restricted women from raising their qualifications and being promoted. For many who wanted to raise their qualifications, permission was denied by their superiors. Indeed Manerova found that 41.7% stated failure to receive authorisation as the reason for not raising qualifications, while only 27.2% mentioned family responsibilities (Manerova et al 1993). One *terapevt* confronted this difficulty when she wanted to attend courses to prepare her for her exams. "I was denied permission to attend courses because they said there was no-one to do my work while I was away. When I told them that my colleagues had agreed to distribute my work between them, I was still denied and I was told that I should try to improve myself as a wife and mother and worry more about my family and less about my work".[50] This was part of the prevailing attitude towards women careerists who tend to be labelled as 'amazons', to depict them as masculine because they are interested in a career (Knaus 1981: 97). [51] Similar patterns were noted for women in other areas of the economy. 78% of managers said they were not interested in training female workers (Posadskaya 1994b).

Throughout the Soviet period, the extent to which doctors were granted permission to undertake study trips, also depended on party membership. The privileged position of party members is clear from the fact that the small percentage of graduates who went on to further

[49] Interview wth respondent 3.
[50] Interview with respondent 16.
[51] Knaus op cit p97. Such a portrayal of women who have succeeded in career advancement can be seen in the film, '*Sluzhebnyi Roman*' in which the section head of an accounting team is a woman. She is presented as a cold, ruthless and plain woman who is successful but unhappy.

study for post graduate degrees, tended to be party dominated. As Field points out, "in theory, the best students (academically speaking) receive these coveted positions. In practice there are deviations from this rule in which non-professional or non-academic considerations may intrude in favour of party and komsomol members" (Field 1957: 91). This is also likely to reinforce the gender hierarchy since far fewer women than men were party members.

Women were disadvantaged from the outset in their careers. The first appointment was particularly significant in relation to career advancement. As Storey points out, "position availability...becomes determinant of the likelihood of and the rate of progression of a physician through the categories of a given medical speciality, a characterising quality that in turn determines his ultimate eligibility for leadership in the profession (Storey 1971). When asked whether it was easier for men or women to receive appointments in the best positions, the majority of respondents said it was easier for men. While some pointed out that this was related to the shortage of specialists in 'male' fields, women's role in reproduction and the impact of protective legislation was also significant in this respect. Employers regarded men as better choices because they would not have to take time off for childbirth and child care. "It is easier for men to receive the best posts because there is the opinion that women are less capable of working because of maternity leave, sick children, everyday life and family problems".[52]

It is interesting to note that this was not regarded as a form of discrimination by the women interviewed. Some believed that

[52] Respondent 25 questionnaire.

success depended very much on the individual. One typical response was that "the word discrimination is too strong in general and everything depends on the individual qualities of the doctor and their professional qualifications".[53] Even for those who said it was easier for men to get into university, to get better jobs and to raise their qualifications, this was mostly not regarded as any form of discrimination against women, but rather as the natural outcome of male/female nature or as the result of women's family responsibilities. "If there are two candidates and one is a woman with a family and the other is a man, they will choose the man. But this isn't discrimination. Its just the way things are. Men work harder than women because women have families. It is also easier for men to go on business trips or to conferences. This isn't discrimination, but simply the situation of women in our country".[54] Nevertheless there were some doctors who believed the position of women in medicine to be a form of discrimination. One women noted that "there is discrimination in our society as a whole. In medicine it is the same. Sexism limits women's careers - it is very widespread".[55]

It was not only in terms of the time available to women to pursue their careers or the attitudes of employers, that their promotion prospects were seen to rest, but also in women's characteristics, or lack of, in relation to leadership positions. It was pointed out by many respondents that women were not as capable of organising and leading as men. One doctor made this point, noting that "leadership positions are not only specialists but also administrators and men are

53 Respondent 33 questionnaire.
54 Interview with respondent 14.
55 Respondent 27 questionnaire.

more decisive than women and so better in these positions".[56] Furthermore, it was argued by one doctor that women were less suited to working with the technology required in top research positions so such posts should be given to men. "There is also a difference between men and women in terms of working with equipment. Men work much better with technology and understand it better than women, so higher posts that involve using new, modern equipment should be given to men. In general, if there is a man and a woman with the same education and experience then the preference should be given to the man".[57]

It was also argued that women should not consider developing their career. Rather while women should, or had to, work, their time doing so should be kept to a minimum and therefore no time should be spent on raising qualifications that could be better spent at home. This was contrasted with male careers, which were deemed to be not only more important but also more justified given the superior minds of men. "Men have more distinguished, analytical minds and they are more ambitious. It is for men to rise up in his profession. I think it is enough for women to have a good job that they like. They should not spend all their time studying or working because they need to spend time having a family. If they are too busy working when can they do this? Also if they are too busy working, especially in some specialities eg with x rays, they might damage themselves and not be able to have children. Work should not be the most important thing in a woman's life, the family should be".[58] Again women's role in reproduction can

[56] Interview with respondent 10.
[57] Interview with respondent 4.
[58] Interview with respondent 8.

be seen to lie at the heart of the gender stereotypes operating within the workplace and which influence women's decisions.

Conclusion

The medical division of labour was characterised by distinct patterns of gender segregation not only horizontally in relation to the feminisation of medicine, but also vertically in relation to divisions by specialisation, by level of care, between hospitals and clinics and according to degrees of authority. While deprofessionalisation affected all of the medical profession to a certain extent therefore, it had more of an impact on certain sectors than others. The academic and administrative elite within medicine still played an important role in decision making and commanded not only more authority and prestige, but also higher pay. However women were underrepresented within these sectors of the medical profession and so to a large degree the impact of deprofessionalisation was felt primarily by the ordinary, female physician.

The extent to which these patterns can be understood as resulting from women's lower human capital is limited. It is true to say that women in medicine tended to have lower qualifications than men, and so apparently less chance at promotion. Moreover, for most of the women interviewed, their work as a doctor was a job, for some a vocation, but for very few was it a career. Despite the desire of girls from a professional background to remain in that occupational group, their ambition was relatively low. Again this highlights the differences between the medical profession in the West and in Soviet Russia.

While frustration and anger were expressed at the poor working conditions and low pay, there was a degree of resignation and powerlessness in this respect. Most of the doctors were interested in going to work, coping with the problems they faced and going home again, rather than trying to tackle the authorities in the hope of bringing about change. Similarly, most of the women interviewed rarely considered their position within the medical hierarchy in relation to men or indeed in relation to other women. There was evidence therefore that women in medicine had limited ambitions and expectations regarding their work.

However, this does not explain their initial choice of specialisation, often at the lower end of the hierarchy, nor indeed why these specialisations were at the lower end of the hierarchy. It was noted earlier that according to the human capital approach women had lower human capital because their family responsibilities meant they were unable or unwilling to devote as much time to their careers. It is clear from the interviews that this was a factor in shaping the choices women made, and it is in practice difficult for women to devote a lot of time to work and to her home life. However, this is not an adequate explanation. It was also the case that, as a result of women's family responsibilities, employers tended to see women as less reliable, needing time off for childbirth and child care. This attitude acted as a barrier to women's advancement in their career when it came to promotion and training opportunities. This must be understood as part of the state's demographic concerns and the attempts to tie women more closely to the family and to encourage reproduction. Family responsibilities did not therefore simply act as an influence women's decisions, that is, it was not simply that

women decided to devote less time on their careers and more on their families. Rather, women's role in reproduction shaped employers attitudes to the female workforce and in turn women's choices were limited.

Secondly, both women's domestic and employment status was reflected in and perpetuated by stereotypes of women's essential nature and the type of work she should and should not do. Women's reproductive role is central to the images of women as carers, nurturers, being gentle and patient which influence women's choice of specialisation to those closest to such characteristics, or rather have kept them away from specialisations and positions deemed to involve work furthest from women's nature. To a large extent therefore women's work within medicine was regarded as secondary to that of men. It was men who predominate in tertiary care work and who were in leadership positions. Yet this was justified as being natural given women and men's nature.

Moreover, the forms of occupational segregation within the medical profession were shaped by segregationary tactics of the medical establishment. There was, to a certain extent, a direct channeling of women away from the most prestigious academic work and away from certain prestigious specialisations such as surgery. It is not being argued however, that there existed some kind of patriarchal conspiracy. Rather, I would argue that such tactics grew out of concern about the status of the medical profession in Soviet Russia.

This is reflected in the desire to reverse the gender ratio within the medical profession. Since throughout the Soviet economy, the most

powerful, well paid and prestigious occupations were male dominated, it is no wonder that the attempt to raise the proportion of men within medicine was associated with an improvement in the position of the medical profession as a whole. It was noted earlier that in order to entice men into the profession, the best positions were to be 'reserved' for them. This resulted in fewer opportunities for women in the choice of career and fewer opportunities in developing their careers. It also demonstrates the role of gender in allowing concessions to particular groups of workers, in this case to men within the medical profession.

It was no doubt recognised that such a reversal of the gender ratio was unlikely, given the wider opportunities available to men. Nevertheless, there was concern among the medical elite, in particular, members of the Academy of Medicine that they remain somehow detached or dissociated from the ordinary physicians. One way to maintain its status, or at least avoid a drop in status, was to retain its virtual exclusivity with regards to female members, who were in reality regarded as second class citizens and so as second class academicians. While the medical profession may have been female dominated, only the 'best', that is, male intellects were members of the Academy. It is very doubtful that this was a collective male exclusionary policy or concern, but rather operated at the level of the individual, given the atomised nature of Soviet society. Nevertheless, gender was a key element which defined the status of the medical profession in Soviet society.

Finally there is also the question of what defines the hierarchy between specialisations. Are female dominated specialisations

necessarily low in status and pay because they are female dominated? Navarro argued that within a system based on Flexnarian medicine, regardless of the sex ratio, primary care specialisations are always placed lower on the hierarchy (Navarro 1977: 79). According to the Flexnarian system, rather than understanding the body from a holistic perspective, it is broken down into different components, the care of which requires relevant specialisations to be learnt. From this perspective primary care is the least skilled since it is the least specialised and remains closer to the holistic approach. It would therefore follow that such occupations as *terapevt* were not low in the labour hierarchy because they are female. On the contrary, women were encouraged to enter such types of work because of their lower status.

Indeed there is evidence that this is the case. As general physicians, *terapevty* were needed in greater numbers than other specialisations and as such there was a persistent labour shortage in this area. At the same time, as was noted in the last chapter, there was an implicit policy directed at increasing the proportion of male doctors. Since the medical profession as a whole was relatively low status, to encourage men to enter the profession, their future role would have had to be within the most prestigious specialisations. Women were therefore encouraged to enter primary care work in order to fill labour shortages but also to create space for male students to enter specialisations such as surgery.

Nevertheless, the fact that certain specialisations were feminised to a greater extent than others, cannot be denied as an influential factor in the reproduction of the labour hierarchy. While the nature of

Flexnarian medicine may have established the hierarchy, gender quickly became an integral feature of this and it is very difficult to separate the two in terms of cause and effect. It should be recognised that gender was a central element in the social construction of the labour force.

Therefore, the gender division of labour within medicine cannot be understood simply as a matter of women's lower human capital, nor as the result of a patriarchal strategy of segregation. Rather, the choices women made to enter medicine and regarding their careers were shaped by a number of factors involving their role in reproduction, the impact this had on employers' attitudes towards female labour and the concerns of the medical establishment over the position of medicine within Soviet social structure. The limits posed to women's career advancement in medicine were reflected by their lower expectations and ambitions. In turn this reinforced the gender division of labour.

GENDER AND REFORM

In the following two chapters, the extent to which changes took place in relation to both the state's policy towards women's paid labour, specifically that of female doctors, and in relation to the experiences of women in the period of transition, will be examined. To this end, the policies directed at women during the final years of the Soviet Union and under post-communist leadership and the way in which women have reacted to them will be addressed. It will be shown that the period of transition not only has had a significant impact on women's lives, but also that gender is a key aspect in understanding the very nature of the reforms.

6

PERESTROIKA AND WOMEN'S WORK

The period of Perestroika 1986-91 marked the end of the Soviet Union. While the original intentions of the Gorbachev regime were far less radical than their end results, the economic and political reforms nevertheless laid the foundations for the collapse of the communist system and onset of the period of transition. During Perestroika, the secrecy of the Soviet era was to a large extent disbanded, the monopoly of the Communist Party was renounced and there was a shift towards the introduction of new non-state forms of property. However, the policy towards women remained firmly rooted in the Soviet pro-natalist tradition and was quite conservative when compared with other policy areas. While the Brezhnev era was condemned during Perestroika for resulting in economic stagnation and corruption, its policies towards women were replicated. What differed was the context of the economic reforms during Perestroika.

In this chapter, the impact of Perestroika on women's work, specifically the work of female doctors will be examined. During Perestroika, the work of doctors was subjected to a high level of criticism, the reasons for which lie in part in the problems of underfunding and mismanagement inherent in the Soviet health sector, but also as a result of the gendered character of the medical profession. In order to understand why this was the case it is essential

to firstly examine the policy towards women's work in the context of the reforms.

It will be argued that the traditional 'protection' of women was again the focus of policy. Increasing concern was shown during Perestroika for the conditions within which women worked in in industry and the implications this had for the demographic crisis and for social problems such as juvenile delinquency. The proposed solution to this, and to wider economic problems, was the mechanisation of industry, and the removal of women from dangerous or heavy manual work. However, as will be shown, the women's attitudes themselves, presented difficulties in bringing that about. The main difference during Perestroika was the shift away from the correlation between women's employment and their emancipation, towards the possibility that women could choose the stay at home and raise a family is they wanted. Much of the protective legislation was designed to encourage this.

Secondly, the position of female doctors must be understood in relation to social policy during Perestroika. At the the same time as the 'return to the home' initiative, there was also an attempt to redistribute women in the economy, away from industry and into the service sector. It was argued that such work was more suitable for women. The proposed redistribution of women into the service sector must be understood as part of the attempt to expand and raise the profile of the service sector in relation to the policy of social justice which lay at the heart of the reforms. It was argued that better consumer goods and services had to be offered as incentives to workers to make them more productive. Yet limited resources were

targeted for the service sector and as a result the emphasis lay on the labour force to improve its work in this area.

During Perestroika therefore the occupational segregation of women was set to widen as it was intended that women would be withdrawn from industry and moved to the service sector. In this way what was regarded as 'women's work' moved away from the traditional Soviet image of the happy female worker engaged in building Soviet industry. Moreover, the 'protection' of women further limited their chances of advancing in their careers and so limited their options for increased pay. The wage reforms during Perestroika did little to change the low pay of women generally and certainly not in health care. Indeed the basis of the reforms - that pay be based on the quality and quantity of work performed in socially useful areas - discriminated against women in relation to the sectors of the economy they were concentrated in and the amount of time they could devote to paid labour.

During Perestroika, women were increasingly viewed as a flexible workforce to be moved as required by the economic reforms. The concern for women in industry occured simultaneously with the aim to reduce the size of the industrial labour force and to expand the service sector. The work of female doctors was important in that respect as it highlights the contradictory pressures women experienced. There were demands on doctors, during Perestroika, that they carry out their work with a higher degree of professionalism and commitment in order to address the difficulties posed by the reforms, but as women, their status within the labour force was in question.

Finally, it is not only in terms of the impact on women that Perestroika should be understood. Gender relations should be regarded as a central component in the economic, political and social policies that characterised the Perestroika reforms.

Women's Work and Perestroika

There were two key aspects to the concern expressed about women's involvement in paid labour during Perestroika. Firstly, the type of work they were involved in was condemned as dangerous to their health and so as potentially damaging to reproduction. Secondly, the extent of their involvement, particularly in shift work, was questioned in relation to the impact this had on the family and society was a whole. These will be examined in turn.

It was noted earlier that there were concerns expressed over the involvement of women in manual work and in night work in industry. A representative from the AUCCTU stated that it is "in the interests of the health of mothers and the future generation to save women from exhausting work in the night shifts, furnace sections and other heavy jobs"(Trud 6/12/89). The concern lay in part therefore with the dangers of certain work for the health of women as reproducers and for the health of their children.

The net population increase of the USSR had fallen from 18 per 1000 in 1960 to 8-9 in 1976 and further decreases were expected (Pilkington 1992: 205). The birth rate itself was regarded as "one of the most acute problems of the demographic situation" (Trinko 1986: 3). By 1984 it had fallen to 78.7% of its 1960 rate (Trinko 1986: 4) and fell further during the Perestroika years from 20 births per 1000 population in

1986 to 17.6 in 1989 (Goskomstat 1990: 91). In the Russian republic, the birth rate was lower than the Union average and stood at 17.2 in 1986, while in Uzbekistan the figure was 37.9 (Goskomstat 1990: 91).

The differentiation of the birth rate across the Union was central to the state's concerns for it highlighted not only racial issues relating to the proportion of Slavs to non Slavs, but also concerns over the labour shortage since the largest population increases were taking place in the least industrialised areas. This meant that where labour was most needed there was a deficit and where it was not, there was a surplus. This led to recommendations for the adoption of a three child policy to redress the balance. "In this way, fertility could be increased where it was low (European Russia) and be reduced in areas where it was high (the Asian Republics)" (Davin 1992: 86).

The birth rate was important therefore in relation to the wider economic strategy. As one demographer noted, "at the present time, the study of the population is being given considerable attention...in particular questions about the social-political regulation of the natural reproduction of the population. The socio-political character of this regulation is determined by the fact that the population is the foundation and the subject of the whole social process of production" (Koregin 1985: 1). As such, "the birth of children is a demographic process, but if you take into account the fact that the renewal of labour resources depends on it, then it is clear that it has a socio economic character" (Chetvernikova 1987: 18). The onset of Perestroika led to calls for closer "demo-economic interdependence" (Steshenko 1991: 10) because the "intensification of social production and the revolutionary restructuring of all social life has led to great demands

for the reproduction of the population, its qualitative and quantitative characteristics and also to the management of this process" (Medkov 1991: 21-2).

Secondly, there were concerns that women's participation in paid labour was having an impact on the family and creating problems for society. Women's work in night shifts was seen as particularly problematic in this respect. Although officially banned from working in night shifts, around four million women were regularly employed in such work (Pravda 2/7/88). Moreover, it was primarily women who work at nights with two to three times more women than men working the night shift (Rimashevskaya 1991:41). Some journalists pointed to how hard this type of work was for women (Levina 1988). However, others were more concerned with the impact it had on the family as a whole. Morosov, from the socio-economic research institute in Ivanovo noted the consequences for families with "a large number of divorces in families of women who work in textile enterprises" and "men in these families abuse themselves with alcohol and there is a high illness rate among women working the night shift compared with women in other branches" (Levina 1988: 14). Morosov seemed to equate women's work at nights with male alcoholism which seems a somewhat simplistic if not dubious assertion, but nevertheless highlights the main concerns surrounding night work, that is, the impact it has on women's health and the impact it had on family stability.

Indeed attention was turned towards the family for within it seemed to lie the solution to many problems, most notably, the low birth rate and social problems such as alcoholism and crime. Gorbachev himself

noted that "we have discovered that many of our problems - in children's and young people's behaviour, in our morals, culture and in production - are partially caused by the weakening of family ties and slack attitude to family responsibilities" (Gorbachev 1987: 117).

Within Russia, the rate of marriage had dropped from 11.1 per 1000 population in 1979 to 9.4 in 1989 and the rate of divorce remained around 4 per 1000 population. In effect therefore, the ratio of marriage to divorce was lower than 3:1 (Goskomstat 1990). Poet, Larisa Vasilyeva noted that "the family is the unit from which society is formed, yet it has been forgotten. No thought is given to it in economics, politics or sociology, yet it contains all those things as well as the foundations of legality, spirituality and morality" (Vasilyeva 1989).

The policy towards women's work during Perestroika therefore set out to address these concerns over reproduction and social problems. There were two ways in which this problem was addressed. Firstly, attention was turned to women's work in industry and the ways in which this could be improved, most notably through their removal from dangerous and heavy work. Secondly, women were to be given a choice concerning the level of their involvement in paid labour. In relation to both these options, there was considerable emphasis on women as mother and homemaker in ideological pronouncements and through legislative measures.

Modernisation and the protection of women

A primary aim of the economic reforms of Perestroika was to raise the rate of economic growth by improving labour productivity and so to

create a more viable economic system to support the interests of the central elite. The economy would be modernised in line with an intensive rather than extensive pattern of development. It was intended that the widespread mechanisation of production would not only improve production both quantitatively and qualitatively, but would also remove the central condition through which the workers could control the labour process, that is, the labour shortage (Filtzer 1994). The protection of women was integrally linked to the mechanisation of industry. Article 21 of the Constitution declares that "the state is concerned about improving the conditions and the protection of labour, its scientific organisation and about the reduction, and in the future, complete eradication, of heavy physical labour on the basis of mechanisation and automisation of industrial processes in all branches of the national economy."(Strukova 1990: 59)

However the legislation employed to regulate women's labour was simply an extension of earlier protective measures and the real obstacles, in the form of the managers and the workers themselves, were not addressed. Firstly, there was a review of the protective job lists, barring women from such work. Additions were made to the list in 1987, in cooperation with the Health and Labour Ministries and the AUCCTU, to sections on chemical production, cellulose, paper and cardboard production and river transport (Strukova 1990: 61). According to the Handbook of Wage Rates and Qualifications there are 600, that is 20% of the 3000 jobs listed from which women are barred (Khotkina 1994: 94). The list was said to take into account the degree of harmful factors in relation to the female organism, for example chemical substances, air quality, vibrations, temperatures, irradiation and exclude women from such work.

The responsibility of enterprises and of labour collectives for improving the conditions within which women work was also outlined in the Law on State Enterprise 1987 and the Law on Enterprises 1990. Article 29 of the latter stated that enterprises must improve the conditions of labour for women. Enterprises with harmful working conditions can, with the agreement of the labour collective, create sections for women who have been moved to lighter work (Strukova 1990: 69). In addition, there were calls for lists which, rather than excluding women from jobs, reserved particular occupations for them. Occupations within the service sector were often regarded as most suitable for women (Rabotnitsa no.1 1990 p20).

Secondly, reviews of the lifting restrictions for women took place. In 1932 on the advice of doctors, the limit was set at 20kg and was reduced in1981 to 15kg and in 1990 to 10kg (Illic 1995 :26). These limits however, were frequently exceeded by women. For example the railway workers mentioned above lifted 300kg sleepers between a group of women. The trade union representative recognised that "everyone lifts from 40-50 kilos which is significantly more than the permitted norm for women" (Barishev 1988). The violation of such protective legislation was recognised by Pukhova, Chair of the Soviet Women's Committee, who noted that "the fact that the laws are being violated, and quite often, is indicated by the tens of thousands of women who appeal to our committee for justice" (Pravda 2/7/88: 3). However, the violation of lifting restrictions was often unavoidable given that the level of mechanisation was so low, the machinery needed to reduce lifting requirements was frequently unavailable.

However, while the centre legislated to prevent women's involvement in heavy manual labour in order on the one hand to raise productivity and on the other to protect their ability to reproduce, enterprise managers continued to create such jobs and to employ women in them because the labour hierarchy was fundamental to their control over the workforce. They had no concern with improving working conditions for women, with a view to their protection and indeed the tendency to employ women in manual labour was "maintained by the tendency to substitute men...with women. Such gender displacement is particularly characteristic of the machine building industry" (Shinyelova 1989). This was reflected in the attitude of male workers, for example fishermen who had a common joke that while women are on board no mechanisation is needed (Dekov 1988).

While mechanisation was viewed by the centre as fundamental to raising the rate of economic growth and to limiting the dangers posed by women's involvement in paid labour for raising the birth rate, for managers and for women themselves these matters were of little concern. Indeed there were disincentives to introducing mechanisation which were inherent within the system. Firstly, managers' main interest was in reaching output targets with little concern for the actual way in which this was achieved (Clarke et al. 1993: 16). Since labour was so cheap in the USSR, and introducing new forms of mechanisation disrupted work and so placed the targets in jeopardy, managers were far more inclined to add to the workforce than to rationalise it through mechanisation and automation.

Secondly, the compensatory payments for difficult and dangerous work were a disincentive for both workers and managers to mechanise production. Compensation formed a part of the 'employment package' that managers were able to offer workers in the attempt to attract and hold workers in the context of the labour shortage (Laputina 1990b). This compensation was also a key part of wages for many workers, particularly women, whose basic wage was lower than men's. 42% of those working in industry had a higher pay through receiving compensatory payments, 47% had extra holidays and 24% had pension privileges (Laputina 1990b). So workers worked for extra money, or privileges and were willing to risk anything in doing so, even their health.

Moreover, the system of penalty fines was wholly inadequate and virtually ineffectual. While a system of inspection by trade union officials did exist, the fines of 10-15 roubles for failing to meet safety standards, were hardly sufficient to deter would be offenders or to force those breaking regulations to improve conditions (Laputina 1990b). Even fatality cases resulting from working conditions rarely ended in prosecution (Filtzer 1994: 160).

It was no surprise therefore that the central programme for the reduction in the use of manual labour in the economy up to the year 2000, which envisaged the removal of women from heavy manual work was either not carried out at all or was carried out at such a slow pace that it was ineffective. For example, the Ministry for Machine Building planned to reduce the number of women working in such jobs by 1000 every year, but considering 24000 women are employed this would take nearly a quarter of a century (Shinelova 1989).

It is clear that the 'protection' of women workers was very closely related to the wider aims of the economic reforms. While it was argued that women women needed to be removed from harmful work environments, far less attention was given to the conditions that men were subjected to and indeed the 'protection' of women was by no means universaly applied to all categories of work. Rather, the 'protection' of women was one aspect of the centre's attempts to regulate female labour to best suit the needs of the economic reforms during Perestroika. On the one hand, this concern for women's health related to the concern over the low birth rate, but it also reflected the move from extensive to intensive economic development and the resulting plan to reduce the size of the industrial labour force. It is in this context that attempt to tie women more closely to the home must be understood.

A 'purely womanly mission'.

During Perestroika, women were given a choice to spend more time, or all of their time with the family as wives and most importantly as mothers. Gorbachev noted that,

"over the years of our difficult and heroic history, we failed to pay attention to women's specific rights and needs arising from their role as mother and home maker and their indispensable educational function as regards children. Engaged in scientific research, working on construction sites, in production and in the services and involved in creative activities, women no longer have enough time to perform their everyday duties at home - housework, the upbringing of children and the creation of a good family atmosphere....That is why we are holding heated debates in then press, in public organisations, at work and at home, about the question of what we should do to

make it possible for women to return to their purely womanly mission" (Gorbachev 1987: 117).

Similarly, at the resolutions of the 19th Party Conference in 1988 he stated that "it is necessary to evaluate their [women's] role, to protect and safeguard the authority and rights of mothers, to create conditions for them to fulfil their duties"(Pravda 5/7/88). There was a definite attempt therefore to bring motherhood to the fore in discussions of women's place within society and to stress the importance of this for women.

The concern over the birth rate and the encouragement of motherhood among women during Perestroika, was integrally tied to the perceived role of the family, as the unit of reproduction. "The strengthening of the family is an important factor in raising the birth rate, that is in carrying out its reproductive function" (Trinko 1986: 12). In this respect, the family, as the articulation of demographic policy, became the central focus of concern both amongst demographers and medical academia (Klyueva 1986).

This focus on women as mother and homemaker was also part of the reappraisal of femininity. It was argued that traditional feminine traits, such as kindness, tenderness, caring, understanding and beauty, that had been neglected in the years since the revolution, should be allowed to develop (Bridger 1996: 22). In line with educational theorists of the Brezhnev era, it was argued that there are natural differences between men and women that were masked, as a result of women's participation in paid labour. The involvement of women in work could, it was argued, result in confusion over gender roles and

indeed over sexuality. In turn this had a detrimental effect on family stability and on reproduction.

For example it was implied that homosexuality was a result of the predominance of women in education, which then brought about an equalisation of sex roles. "Who, according to the teacher is the best boy in class? - a quiet, obedient one. And the best girl?- one who is energetic and active...The common goals and targets that we put in front of our children lead in their minds to a sexually neutral self-evaluation" (Einhorn 1993: 82). The re-evaluation of sexuality was therefore an important aspect of the attempts to foster maternal concerns amongst women. Femininity was linked to motherhood and as such, sexuality remained defined completely in heterosexual, that is, reproductive terms.

Secondly, legislation in the Perestroika period concentrated on giving material and ideological support to the family unit and on tying women more closely to it with a view to raising the birth rate. Such legislation was not a break from previous legislation on women and the family, but rather "they encompass aspects that are traditional in our legislation relating to the position of women" (Rimashevskaya 1992).

Protective legislation throughout the Soviet period acted as a mechanism by which the centre could address the difficulties of utilising women in the labour force, while at the same time ensuring that biological reproduction was maintained. This is not to say that there was a philanthropic attitude towards protecting the female labour force. On the contrary, protective legislation was often

abandoned when the needs of the economy required it. As the central focus of policy towards female labour it can be seen to reflect the contradictions inherent in the system and the ways in which these were perpetuated. Nevertheless it is perhaps indicative of the nature of Perestroika that the resolution of the contradiction between production and reproduction under Perestroika offered little in the way of new ideas and it was to protective legislation that attention was initially turned.

Firstly, legislative guarantees to pregnant women and women with children were extended. In 1987, women were granted fourteen days paid leave to care for sick children and at the same time, the age limit of children, at which benefits were given to families on low incomes, was raised from eight to twelve years (Ilic 1995 : 30). On the whole the value of benefits paid in 1988, to pregnant women and women looking after young children was double the amount in 1980 and quadruple that of 1970 (Pilkington 1992: 205). While it was argued that this was expensive, it was also believed to be worthwhile because, "if it leads to the raising of the quality of female labour, strengthening of the health of children, improvements in the demographic situation and lowering of the expenditure on medical services, then it has clear social and economic benefits" (Maslova and Novikova 1991: 18-19).

Secondly, maternity leave was extended in 1987 from fifty six to seventy days, fully paid; from one year to eighteen months on partial pay; and from eighteen months to two years unpaid (Ilic 1995: 30). In April 1990 the Supreme Soviet resolution 'On Urgent Measures to Improve the Position of Women and Safeguard Maternity and Childhood' raised the period for unpaid maternity leave to three

years. This resolution also introduced the concept of parental leave for the first time (Rimashevskaya 1992: 73). However, as Anastasia Posadskaya, director of the Moscow Gender Studies Centre, pointed out, "it would appear that once again the achievement is more symbolic than real. We obviously cannot expect men to make use of parental leave on an equal footing with women when the average female wage is two thirds of the male wage" (Posadskaya 1994a: 181).

Women were also to be offered opportunities for part time and for home work. The intention of such an approach was clearly related to the wider state aim of encouraging the reproduction of the next generation, rhetorically by allowing them to combine their interests and responsibilities in work and in the home, but in practice by establishing one form of limiting women's involvement in paid labour. The take-up by women of such rights was limited in this period however. Only 1% of women worked on a part time basis (Laputina 1988) and only 250000 worked from home (Bridger 1995: 69). Many women simply did not know that these options existed and for those that did there were several drawbacks.

While both ideological and legislative measures aimed at limiting women's options in paid labour in general there was also an attempt to redistribute women in the economy. The industrial labour force was the target of reduction but the service sector was set to expand. So while on the one hand, women were encouraged to make the choice to withdraw from the workforce either partially or wholly, on the other hand, it was argued that any involvement in paid labour was best placed within sectors of the economy most suited to women, that

is, in the service sector. In this way, women were encouraged to stay at home or to work in jobs that most closely resembled domestic work.

Women's Work: the Service Sector

Social policy during Perestroika centred on the concept of social justice. It was argued that the Brezhnev regime led to corruption and the alienation of the population (Buckley 1990: 186). As Gerchikov pointed out, "the gravest, most significant social consequence of the preceding period of our country's history has been the alienation of the bulk of workers from the management of production and from the whole of social life" (Gerchikov 1990). The solution to this lay in raising the interest of all members of society in their work by creating the conditions for social justice. Zaslavskaya argued that "socialist justice consists first and foremost in the encouragement and all round support of those groups that make the most important contribution to social development and that use all their energy and capacities to this end" (Zaslavskaya 1989: 124).

It was argued that in conditions of social justice, people would appreciate that their work met with direct rewards and so would be encouraged to work harder and better (Rogovin 1989). The aim of social policy during Perestroika was therefore clearly to raise productivity. Also inherent within this policy was the shift in responsibility from the state to the individual. It was argued that with social justice you will receive what you work for so the responsibility was on the individual to work harder. Similarly in relation to employment, labour economist Kostakov argued that "we will have to accustom ourselves to the thought that finding employment is to a considerable extent the individual's concern" (Kostakov 1986).

The service sector was also important in relation to problems of family stability attention was turned to the adequacy of the service sector in reducing the amount of work women had to cope with in the home. Similarly Rimashevskaya argues that "women's second shift is due first and foremost to underdevelopment of the social infrastructure, the lack of necessary conveniences, running about from shop to shop in search of scarce goods, children's illness due to the low quality service and functioning of children's institutions and overburdened transport" (Rimashevskaya 1991: 67).

Not only was the "residual approach" to the service sector regarded as detrimental to the position of women, but it was also seen as waste of resources (Boldyreva 1989). Shinelova argues that working within the house was not regarded as 'real' work and as such the need for technological improvements was ignored. This resulted in a huge waste of time and effort for society and women with domestic labour 'eating up' 275 billion 'man' hours. As such, this could no longer remain a 'kitchen' problem, but had to be addressed by the state (Shinelova 1989).

The inadequacy of the service sector was therefore an important concern in relieving women of some of their burdens and freeing her for more important work in producing and raising children. However, there was far less concern with reassessing gender relations within the family, in particular in terms of the division of labour. The primary focus was on reducing women's burden through an improvement of the service sector rather than by a redistribution of familial responsibilities between men and women. Nevertheless this was recognised as a problem and was contained within the

resolutions of the Soviet Women's Conference in 1987. "We strive to achieve the situation in which husband and wife carry out household chores equally and take responsibility for childrearing" (Izvestia 1/2/87).

In line with these aims, grand claims were made at the start of Perestroika concerning the expansion of the consumer goods industry and the service sector. Without the provision of goods and services as an enticement to work harder the whole basis of the policy of social justice would fall flat. In 1985 the 'Consumer Goods and Services Programme' was launched and goals were set for the following five years and for the year 2000. However it was clear from the outset that the aims to expand services were not matched by increased investment. While total investment was to grow by 18% in the five year period, productive investment was to grow by 25%. This was obviously going to leave consumer goods and services in their traditional 'residual' position in relation to funding (Connor 1986). On the contrary investment into the traditional priority sectors of the economy remained high (Davis 1990).

On the one hand therefore, the service sector was to play an increasingly important role within the economy, but at the same time, its priority status in relation to investment remained low. It is within this context that women's paid labour within the service sector is all the more significant. Women's labour provided a cheap workforce to allow the provision of a functioning service sector with minimal investment required. However, as will be shown, it was clear from discussions about the quality of work in the health service that to maintain low levels of investment in this area was by no

means without its contradictions. This also serves to highlight again how women were viewed essentially as a cheap and flexible labour force.

The redistribution of women into the service sector was regarded as an inevitable outcome of the transition of the economy to a primarily intensive path of development and the transition of enterprises to the new economic method of self financing and cost accounting. During Perestroika it was estimated that 20% of industrial workers were to be removed. Yet this did not have to be a disruptive process for it could be carried out by "combining the redistribution of workers with the natural movement of cadres. The only category of workers for whom the real movement between spheres of work connected with a change of workplace is expedient and economically and socially justifiable is women employed in heavy manual labour" (Boginya and Bon' 1988: 19).

Women were therefore regarded as the group most suitable for redistribution, in part because the work they were currently employed in was the object of mechanisation and was argued to be unsuitable for women, but also because the destination of the redistribution was to be the service sector, and women were said to be particularly suited to this type of work. Not only would this type of work be more suited to "the psycho-physiological particularities of the female organism", but it also allowed women to have a more flexible work schedule and so to spend more time with their families (Krasinets 1988: 11). In addition since this sector was already female dominated, the movement of more women into it would not create any disruptions

within the gender division of labour but would on the contrary create a "pleasant moral climate"(Boginya and Bon' 1988: 20).

As was noted above, the reliance on women as cheap labour within the service sector was contradictory. Firstly, not only were the essentialist arguments that men are more suited to industrial work and women to service work not founded, but this ignored the nature of work within the service sector itself. The conditions of work within the service sector were often as heavy as those within industry, for example, saleswomen often lifted heavy boxes and roll thirty kilogram bolts of fabric (Boldyreva 1989).

Moreover, within professional jobs in the service sector, women were subjected to difficult conditions, for example, teachers often worked long hours and the working day was not fixed to a shift as in industry, they suffered heavy emotional and psychological strains and often worked in stressful situations (Plotnikov 1994: 61). There were also direct threats to women's health from the supposedly safe work in the service sector. The millions of women who formed the majority of the health labour force, were continually subjected to contamination from disease, irradiation among other things, as a result of the poor state of medical facilities in Soviet Russia. Work within the service sector was not therefore the 'ideal' form of employment that it was presented as. These problems were overlooked and at the same time the conditions in industry highlighted in a concerted effort to justify and encourage women to comply with the redistribution policy.

Secondly, as was noted in an earlier chapter, the lack of investment in services meant that women were often unable to perform their work

to the standards they would wish and had little incentive to improve. This is most clearly demonstrated in relation to the Soviet health service. Despite the fact that this was acknowledged, during Perestroika, attention was focused on ways to improve the work of doctors rather than on the desperate need for increased resources. While women were encouraged into the service sector therefore, they were not rewarded financially for such work and indeed in the case of doctors their work was heavily criticised.

Female Doctors and Perestroika

In industry, the unmechanised nature of much of women's work was recognised as being of low quality, as inefficient and creating bottlenecks in the system. But it was in health care that women's labour came under the fiercest attack. While the focus on women's labour in industry had been on the poor working conditions, in order to justify the redistribution of women from this sector, in the health sector, the quality of their work rather than the nature of the work itself was the focus of attention.

There were several ways in which the work of doctors was important to the Perestroika reforms. Firstly, in line with social justice, the health care system had to be improved. There was concern about the health of the population which would not only lower their morale, but more importantly limit attempts to raise productivity. Like a mirror of the Soviet system itself, the general health of the population had been deteriorating since the mid 1960s, yet little was done to provide a cure. On the contrary in true Soviet style, the problems were never discussed and to ensure this, health statistics such as the death rate and infant mortality were subject to strict

censorship. In line with the spirit of Glas'nost, information on health became more widely available and as it did so, the gravity of the situation quickly became apparent. In the period from 1964 to 1980 the average life expectancy in the Soviet Union consistently fell and stood at 67.3 years by the mid 1980s (Mezentseva and Rimashevskaya 1990). The health crisis can best be highlighted with reference to levels of infant mortality. In 1986, infant mortality rates were cited at 25.1 per 1000 births as compared to 9.3 in Scotland or 10.4 in the USA (Buckley 1990: 197). This was more than likely still an underestimate as statistics were not only withheld from public debate, but were also frequently falsified by the doctors or administration involved (Buckley 1990: 196).

Secondly, concern over the falling birthrate was closely tied to improving the health of the population and to the system of health care. With an unhealthy population, productivity will inevitably be lower and the death rate will be higher, so making the need for a new generation even greater, while at the same time, this very reproduction is jeopardised by the ill health of the population and the poor state of health care. Doctors not only carried out research into demographics, which informed state policy, but they were also on the front line working in women's clinics and were expected to help implement such policy.

Yet doctors were by no means state pawns, and often acted contrary to state policy. This is clearest in relation to concern over the high number of abortions in Russia, and the role of doctors in carrying them out. There was considerable attention paid to the high level of abortions in Russia (Bardina 1987; Saninkov 1987; Zangieva et al.

1989). In 1985 there were 123.2 abortions for every 100 live births. This was 25 times as high as in West Germany and most other West European countries (Remennik 1987). The Soviet Union as a whole accounted for 25% of the world's abortions, yet it only constituted 5% of the world's population (Popov 1988). These figures are alarming whether a pro-life or pro-choice stance is taken, but in Russia the overwhelming concern was for neither the rights of the unborn child nor the rights of women.

Rather, the primary concern was the impact abortion had on women's health and so on their ability to reproduce in the future. As Remennik notes in relation to the negative impact of abortion, "first and foremost, a woman's health suffers a great deal from an abortion, as does her ability to have children in the future". Demographer, Shneideman estimated that eliminating post abortion sterility alone would raise the birth rate by 30% (Remennik 1987). Particular attention was given in this respect to first pregnancy abortions. Given the risks of sterility or the inability to carry for a full term, the abortion of a first child was regarded as a particularly serious threat to the birth rate and there were calls by doctors for increased state intervention in this matter (Gvin 1981).

As part of the battle against abortion, during Perestroika, renewed emphasis was given to the provision of contraception, without which it was argued, it was impossible to reduce the number of abortions. Yet the provision of contraception was abysmally low and considerable ground had to be made up. In 1980 only 25% of the demand for contraceptives were met in the RSFSR (Popov 1988). However, as was noted in an earlier chapter, one of the main

disincentives to the introduction of contraception rather than abortion was the attitudes of doctors and the Ministry of Health.

Addressing and finding solutions to the health problems of the Soviet people was regarded as central to the improvement of both production and reproduction, that is, to the success of the reform of the system as a whole. In an article in Literaturnia Gazeta in 1987 health minister Chazov outlined what he saw as the central problems facing the Soviet health care system. He noted that "the number of problems that have piled up is larger than in any other sphere of activity in Soviet society". Indicative of this was the large number of complaints that the Ministry of Health received. In 1986 the ministry received 66 000 letters, mostly referring to overcrowding, shortages of staff and medicine, lack of expertise and corruption within the system (Galayeva 1987).

Mention was made in the last chapter of the poor state of resources within Russian health care and for Chazov this was a key problem. He noted the example of the surgeon who had to sharpen his own scalpel because of the lack of replacements. He also pointed to the deficit in drug supplies. In 1986 there was only 60% of the required amount of antibiotics available and the need for cardiovascular preparations was only being met by 40%. Chazov noted that health care funding was very low throughout the Soviet system, at around 4% of the net material product. In line with the wider claims for increased investment into the service sector, he proposed that spending on health care should rise to at least 8% by the year 2000 (Galayeva 1987). However, in the absence of such inputs, attention was focused on changes to the organisation of healthcare, particularly

in relation to the work of the medical labour force, with the view to bringing about improvements without fundamentally increasing state financing to the health sector.

Firstly the work of doctors was to be rationalised to remove any inefficiencies. It was argued that "in carrying out rationalisation, particular attention must be paid to activating the human factor. It is necessary to create the conditions for the encouragement of medical workers to evaluate measures for the scientific organisation of work and raising the quality of work and in every way to encourage their initiative and creativity, which in the new system of payment for work will be a real possibility" (Zotov 1988: 143).

Within health care the human factor had a dual meaning. It referred to the functions of individuals as subjects of the system of health care, that is both to medical personnel and to patients. Doctors were involved in both aspects. On the one hand they were expected to contribute to the 'awakening' of the population's responsibility for its own health through propaganda on healthy lifestyles. However the apathy of doctors themselves had also to be addressed in this respect. Not only was it noted that they did not set a good example of healthy living, since for example, many smoked, but it was also noted that nearly one third of doctors did not regard health education amongst the population as of particular importance. The second aspect of the human factor related to doctors as medical employees. It was argued that their creativity, initiative and more realistically their increased productivity had to be 'activated' (Kalchenko 1990). In addition to redirecting responsibility for improving health care, to the hospital or

clinic as a whole, the doctors themselves were also to be made more responsible for their work.

In order to activate the human factor, there had to be changes to the organisation and payment of labour. As in industry, in health care this meant the introduction of the brigade form of labour organisation. In March 1988 the collegium of the Ministry of Health noted that "the effective form for the organisational stimulation of medical personnel in health care institutions is the brigade form". As in industry, the main purpose of brigades was to increase labour productivity in terms of quantity and quality. This was defined as the main purpose of the brigade council, the body elected by the brigade members. The council "carries out work directed at increasing labour productivity, its quality and the creation of a good psychological climate in the brigade and improve the selection and placement of cadres and strengthening labour discipline"(Zdravookhranenie RSFSR no.7 1988: 47). This was in fact the essence of the whole brigade system. It was argued that by making people responsible for their own work they would be inspired to work harder.

It is clear therefore that the organisational changes directed at the health service were intended to improve efficiency in health care institutions, particularly in respect to the quality of care. While it was recognised that to a certain extent, the quality of work of doctors was determined by the resources available to them, the level of knowledge and capabilities of doctors was also under question. In the article in *Literaturnia Gazeta,* Chazov was highly critical of the existing system of medical education which concentrated on passing students

regardless of their actual knowledge and medical skills. Speaking about the way students were treated, he said,

"we have coddled them: God forbid that a student should ever get a 'two' and not be graduated from an institute! We have carried them in our arms from one year of courses to the next...approximately 40% of them are completely lacking in practical skills...After graduating from the institute, a student doesn't know how to read a cardiogram or an x-ray. And how many of our graduates can perform an operation by themselves?" (Galayeva 1987).

Professor Shteingardt noted the impact that this concern with increasing the number of doctors had on the quality of graduates. While it was stipulated that students could only re-sit exams twice it was common practice that they were allowed to do so three or four times. Similarly, students who were dismissed for failure or lack of discipline were often reinstated the following year, contrary to the regulations. He noted that the standards had gradually fallen. Whereas in 1917 students were expected to pass ten exams, in 1947 this had dropped to five and by 1986 they had only to pass two. For him, "state examinations in medical schools [have turned into] a pro forma act of self deception". It is no wonder, he said, that out of 242 graduates with 2-3 years experience not one could answer correctly all the basic questions regarded as essential knowledge for a practising physician (Shteingardt 1987).

The solution to these problems was firstly to increase the length of the course from six to seven years. Exams were also made stricter with the introduction of practical as well as theoretical exams. Those who did not reach the required standards were to be awarded a feldsher's

certificate, to allow them to practise medicine, but in a reduced capacity. Finally, post graduate and continuing education was to be encouraged by widening the pay differentials according to the qualifications held by doctors.

Nevertheless, one reform which was advocated by some, was not considered. Professor Smirnov, member of the Academy of Medicine noted that "until we make up our minds to return medical institutes to universities, we can hardly expect an improvement in the level of basic research and in the resulting level of treatment" (Smirnov 1987). Medical training was still segregated therefore from the other sciences and as such retained its secondary standing in the academic world. This certainly did not assist in the attempt to raise the quality of education and so of care.

Health care and the quality of doctors' work came under such scrutiny during Perestroika because of the role that doctors were expected to play during the reform process. It was noted above that doctors were expected to encourage reproduction and indeed themselves to set a good example, but the work of doctors was also important in relation to the reform of the economy. The relationship between the social and the industrial spheres of the economy was addressed in the Basic Guidelines of the Communist Party presented by Gorbachev at the 27th Congress. In this it states that there had been,

"an underestimate of the urgent problems of the material base of the country's social and cultural sphere. As a result, what is in effect, a 'left overs' principle of the allocation of resources for its development has developed. A certain warping in the direction of technocratic approaches has lessened attention to the social aspect of

productions... which could not help but lead to a lowering of the working people's state in the results of their labour and to the weakening of discipline and other negative phenomena" (Pravda 26/2/86 :1).

From this it is clear that problems relating to health care were closely related to the wider aims of the reforms to reorganise production in order to raise productivity. At the 18th Trade Union Congress it was estimated that the total losses to production due to the ineffectiveness of public health was ninety billion rubles ever year. This problem was addressed at a meeting of the CPSU Central Committee in January 1986. It was noted that,

"many officials of ministries, departments, enterprises and organisations are underestimating the importance of efforts to prevent and to reduce worker morbidity...As a result, losses due to temporary disability remain high. Worker morbidity is being reduced at a slow pace.,All this is having a negative impact on the state of affairs in industry and is preventing the effective use of labour resources" (Pravda 15/1/86).

Improving the health of the population was therefore central to the productivity campaign. Without a healthy workforce, it would have been impossible to raise productivity and so to improve the economy. However as was noted above, the attention of the medical profession was particularly focussed on female labour. In addition, improving the health sector by raising standards of work amongst doctors was also an important element in the attempt to raise the morale of the population. There would be no point in expecting the population to work harder if they received nothing in return. The provision of a decent health service was a bargaining chip in this respect.

The policy towards female doctors was very different to that directed at women in industry. Their work was not regarded as dispensable, as was that of many industrial workers, on the contrary it gained in importance in relation to the aims of the Perestroika campaign. Nevertheless, it was severely criticised and so undermined. On the one hand, the regime wanted to explain the disastrous state of the health service by using the medical labour force as a scapegoat. At the same time, it cannot be forgotten that the labour force was predominantly female. While it was never explicitly stated, implicit in the critique of the work of doctors was a critique of women's work. It was argued that the concern with quantity meant that the quality of candidates for medical schools and so of doctors was neglected, implying that it was easy and required little or no knowledge or ability to become a doctor. The already low status of the female medical profession was therefore further undermined during Perestroika.

As was noted above, in doing so, attention was turned away from the lack of resources and underfunding of the health sector. However, it may also be that the long term intention was to 'redistribute' women out of the medical profession and to create a more westernised male dominated occupational group. Since it was believed that women's work was second rate in general, the best way to improve the work of doctors was to reverse the gender ratio that characterised the profession. Yet given the continuing low status of health care work and more importantly the continuing low pay, such an intention was not realised. Indeed while the method of calculating wages was targeted fro reform during Perestroika, this had little impact on the low pay within the medical profession, or indeed on low pay for women in general.

Gender and the 1986 Wage Reforms

Within his conceptualisation of social justice, Gorbachev stated his desire to move away from the equalisation of earnings. "Only work determines a citizen's real place in society, his social status. And this precludes any manifestation of equalising... Today when social justice is the point of issue in our country, much is said about benefits and privileges for individuals and groups of individuals. We have benefits and privileges that have been established by the state and are granted on the basis of the quantity and quality of socially useful work" (Gorbachev 1987: 100-1). This had obvious implications for women in relation to the 'return to the home' initiative and also in relation to the widening of their segregation into sectors of the economy regarded as the least productive.

Outwith the rhetoric of social justice, the 1986 Wage Reform was intended to give the centre more control over production through its control over wages as an incentive to workers. Not only was there little correspondence between workers' performance and earnings, but there were also arbitrary differences in earnings between workers in different plants. While the reforms aimed at increasing wage differentials, it was to be in an ordered fashion, with a strict hierarchy of pay that would be uniform throughout the economy. However, enterprise managers had little interest in reforming the wage system. Their interests lay in securing a workforce of the necessary skill range in order to reach output targets and one card they had in their hands was the benefits, consumer goods, services and housing that they could offer as incentives to workers to remain within the factory and to continue to work. Improving money wages that could then be used to buy goods outwith the enterprise, would threaten the traditional

worker/manager relationship, so gave managers little incentive to implement the reform. In addition, workers found little within the reform that was to their benefit as in the context of self financing enterprises began to cut back on production and raise prices thereby making any monetary incentive worthless. By 1990 the wage reform was recognised to have failed and wage control was fully decentralised (Filtzer 1994: 56-77).

The wage reforms also intended to improve pay within light industry and the service sector, again reflecting the importance of these branches of the economy for the reforms. In relation to the health sector, Genkin pointed out that "an important element in the transition to contract brigades is the fact that the size of the means for paying and stimulating labour is not determined by the staff schedules of medical institutions, but in the amount of work carried out and the guarantee of high quality" (Filtzer 1994: 63). While as a whole, more resources were to be channelled into health care in order to raise the wages of all medical personnel, the focus was more on a fundamental shift in the way that payment was organised. Under conditions of economic autonomy, not only would managers of hospitals and clinics have more leeway to raise wages to reflect any particular achievements of their workers, but the brigade system would also encourage this. The coefficient of labour participation (KTU) was the mechanism by which each member's contribution was calculated, so ensuring that wages were closely tied to work effort.

By introducing these changes, it was hoped that real improvements would be shown in the work of doctors as they came to realise that better work would mean higher pay. It was also intended that the

perceptions of the public towards the health care system would alter. Many of the complaints to the ministry criticised the practice of 'gifts' to doctors, not so much in terms of an objection to any form of payment, but as an objection to payment for poor services. One reader in Izvestia pointed out that "often we don't feel that we're getting even a small portion of the attention that one has a right to expect from medical personnel. Moreover, it has become so fashionable here to 'thank' physicians with tidy sums of money that expanding economic accountability in medical assistance would only be a blessing" (Ivchenko 1986).

However, the wage reforms did not take into account the fact that the lower levels of pay among women was the result of a series of factors including protective legislation, the education system and the attitudes of managers and as such, it was impossible to give low paid sectors a boost and then hope that pay levels would even out. While wage differentials were to a considerable extent arbitrary prior to Perestroika, in terms of gender differentiation they were not. In all sectors, women's earnings were less tied to performance than to their gender and as such the wage reforms meant less to women than to men.

The general feeling among doctors was that any real change in the levels of pay could only be brought about by improving the level of funding to health care to allow them to upgrade and increase resources and their pay (Tatarnikov 1991). While the brigade system was intended to tie work more closely to reward, and so increase incentives to improve work, if the rewards remained low, so did the incentive. Without meaningful increases in pay, brigades became

more of an organisational nuisance than an improvement. One paediatrician noted this problem, saying "the brigade form of work organisation doesn't work. We found it very hard to get used to and to adapt to it. It doesn't justify itself because our pay did not really improve for the work that we did".[1]

Moreover, the very idea that by offering higher wages, the quality of care will automatically improve, was somewhat dubious. Russian doctors would unquestionably have welcomed higher pay, but there were many other factors which influenced the quality of their work, not least the lack of resources with which they had to contend. In addition, the idea of 'activating the human factor' to help release the potential of doctors conveniently forgets that, as a primarily female profession, doctor's potential, creativity and innovation was limited by or perhaps redirected into their family responsibilities.

It was noted in the last chapter that women had little time to devote to raising their qualifications because of the amount of time they used up in caring for their family. Nevertheless, it was not only in relation to family responsibilities that women were less inclined than men to devote more to their careers. There were also legislative restrictions on the work women could engage in, and administrative restrictions from health managers who denied women the opportunities to upgrade their qualifications. The rhetoric of making people the 'masters' of their workplace, held little relevance to women, not only in relation to the language used, but also in terms of the realities of women's lives. The organisational and pay reforms in the health care institutions therefore, had little impact on the work of female doctors.

[1] Interview 6.

The centre's wage policy towards women was therefore problematic. In part as an outcome of protective legislation designed to ensure women's role in biological reproduction, women were limited to low paid sectors and their training options, and so hope of improving their wages, were also fewer than men's. This was contradictory however, because the aim to raise qualifications was an important aspect of the activation of the human factor and so to raising productivity. By improving the skills of the workforce, and releasing their creativity, the centre hoped to entice the workers to produce more. This meant not only that women were not included in this release of creativity, for their creativity rested first and foremost in giving birth, but also that the qualifications and consequently the quality and quantity of production by female workers would suffer. Given that the female dominated branches of light industry and the service sector were crucial to the reforms in relation to raising the standard of living and so supporting the wage reforms, and also in relation to their support of heavy industry, the contradictions between women's role in biological reproduction and production, had consequences far beyond the immediate effect of policy on women.

As a result, the differentiation between men and women's wages remained unchanged throughout the Perestroika period. While it is doubtful that this was even intended as an aspect of the wage reform, the failure to bring about any change in this area highlights the problems this reform faced. If the intention was to tie pay more closely to work and yet both central policy and the relations within the enterprise ensured that half the workforce, that is, the female workers, were paid, not according to work but according to their gender, then from the start such a reform was destined to fail.

Conclusion

There were three broad policy priorities during the period of Perestroika. Firstly, there were concerns with raising economic productivity by, rationalising production through the redistribution of workers throughout the economy; raising the technological level of production and reducing the waste of resources in an overwhelmingly unmechanised economy; introducing new forms of labour organisation in line with cost accounting and self financing; and offering economic incentives in terms of wage reforms. Secondly the reforms intended to gain popular support and so to raise the morale of the population by introducing a degree of political freedom through glasnost and the democratisation campaigns, but also by improving the standard of living of the population through the provision of more consumer goods and better services. This was summed up by the policy of social justice. Thirdly, there were concerns over the falling birth rate, particularly in the European regions of the Soviet Union which were addressed directly by demographic policies, but also by a review of the role that women played within the economy and the impact that this had on their maternal duties. Gender relations are obviously central to questions of raising the birth rate, but it has been shown that gender was also a central component in the productivity campaign and the political strategy that characterised Perestroika. It is in this context that the impact of Perestroika on female doctors should be understood.

The reforms in health care failed to bring about any real improvements either to the health of the population or to the work of the medical profession. Yet this is not surprising given the nature of the Perestroika reforms as a whole. The intention was to bring

about improvements without substantial change - reform not revolution. In relation to health care this meant that improvements were sought without upsetting the financial balance between industry and the service sector. The service sector as a whole, and health care within it remained the poor relation in the economy.

Instead, attention turned to improving the work of the medical labour force. In no other area of the economy were the qualifications, abilities and integrity of the labour force exposed to such scrutiny and criticism. In essence, it was argued that the medical profession was a sham because of the ease with which students were awarded their diplomas, and as a result, many of the practising doctors had barely sufficient knowledge to allow them to continue to practise. For an already low prestige profession, such an attack was extremely damaging and seemed to give the public a scapegoat to blame for the poor standards, rather than seeking to address the fundamental financial problems facing health care institutions and the labour force within it. The critique of the medical profession at this time served to exacerbate the already low status and so morale of the profession, without introducing any real changes, particularly in relation to pay. In this respect, by concentrating on the labour force as the target for reform, the situation within health care at best was unlikely to improve and at a worse could have worsened.

The nature of the attack on the medical profession was all the more worrying when it is considered that it was a predominantly female profession. Though not explicitly stated as a criticism of the female workforce, when placed in the context of the policy towards women during this time, the critique of doctors' work can be viewed as an

insidious element in the attempt by the centre to resolve the problems that women's labour posed for the system. Within the argument, that the focus on quantitative rather than qualitative concerns was detrimental to the population's health, lay the implication that the large-scale recruitment of women was a mistake. Women's entrance into medicine was simply a result of the push for greater numbers and had quality been a concern, the situation would have been very different.

Yet this concern also reflected the contradictions that women's labour posed in relation to the reform of the system. There were two ways in which the extent and nature of women's paid labour was addressed. On the one hand women were encouraged to 'return to the home'. It was perceived that in this way both the demographic and social problems and the rationalisation of the economy could be achieved. However, the removal of women from paid labour was contradictory given that the sex typing of their jobs and the low pay associated with them meant that men were unlikely to want to replace them.

On the other hand women were encouraged to enter more suitable occupations outwith industry. It was felt that by encouraging women to enter service sector occupations, the rationalisation of the industrial labour force could take place smoothly and at the same time, women could be contained within work which was less damaging to their reproductive capabilities. Presented as a caring and nurturing profession, medicine was deemed to be suitable work for women, regardless of the inherent dangers, the long hours and the poor working conditions. However, as we have seen, in health care, the focus of the reforms was on improving the quality of care by

raising the standards of doctor's work. This entailed a greater commitment to work in particularly in relation to raising qualifications.

So on the one hand women were being asked to limit their workforce participation. As women, female doctors were also expected to contribute to raising the birthrate. Indeed their work placed increased pressures on them in this respect. As doctors, they were expected, not only to give advice to women and to encourage them to have more children, but also to set a good example by having children themselves (Grigor'ev 1985). Female doctors therefore were seen to play a crucial role in regulating women's reproduction in order to assist the centre's aim of raising the birthrate, and as women themselves, they were also expected to participate in this process. In a sense they were therefore both controllers and controlled.

But on the other hand, in female dominated areas such as medicine, it was impossible to remove women from the workforce, or to limit their participation, if improvements were to be brought about. There was certainly an intention to gradually increase the proportion of men within medicine, reflected in the priorities given to male candidates to the medical institutes, but in the meantime it remained female dominated. Moreover, any large scale change to the gender ratio within medicine was unlikely given the reluctance to raise the status of the medical profession, highlighted by Chazov's critique of standards, and by the reluctance to raise funding and so pay rates in health care.

The reform of the organisation of labour within the medical profession was therefore indicative of the problems faced by women workers in other areas of the economy. During Perestroika, women were expected to be the flexible workforce, to fill in labour shortages, carry out professional work, be 'redistributed' throughout the economy, or indeed be removed if required. At the same time, they were expected to improve the birth rate by having more children and raising them to acceptable socialist standards. Much of the reform rhetoric was therefore lost on women. By 1990 the tide had turned and Perestroika was in ruins and the reforms had failed in terms of restructuring the economy, improving the birth rate and improving the health of the population.

During Perestroika, as throughout the rest of the Soviet period, the concerns with ensuring biological reproduction and maintaining control over the population remained central. The main difference during this period was that the reforms set in motion, served to exacerbate all the underlying contradictions of the Soviet system . It is impossible to speak of cause and effect in terms of these contradictions and the relations they manifest, for they represent an interrelated network of problems faced by central elite. It proved impossible to raise the birth rate for several reasons. The fall in living standards, the threats and reality of unemployment and the persistently bad working conditions all acted as deterrents to women to having children. The rhetoric of the natural role of women in motherhood and the material incentives offered in the way of maternity benefits and leave did little to mitigate the harsh social realities.

Similarly, the aim to raise productivity was turned on its head as production fell in line with the collapse of central control. The rationalisation or mechanisation of industrial production did not take place and women's labour played a crucial role in this since it was primarily women working in manual jobs. Both the women themselves and the managers were unwilling to change from a system that benefited them both. Women received compensation for working in bad conditions and managers were able to retain a labour surplus which was important in their ability to provide the core workers with concessions in order to both attract and hold them. Finally, the failure to improve production in light industry and to invest in the service sector was contradictory to the attempts both to raise the birth rate and to establishing a more solid base of support for the regime.

Therefore, Perestroika as a reform process was permeated with contradictions not least because everyone involved in this process had their own agendas. This was also apparent amongst the medical profession. The work of doctors often deviated from their expected state role as the agents of state policy. As low paid workers they sought opportunities to increase their earnings through payment for abortions or issuing sick leave certificates, both of which ran against the grain of the reforms. But the work of doctors was further limited by inadequacies in the reform process and by the dual position that female doctors held as both part of the system of regulation of women's reproduction and paid labour but also as women themselves.

While much of the reforms were rhetoric or unrealised goals, they nevertheless served as the basis for policy in post-communist Russia. Following the collapse of the Soviet Union, more radical reforms were initiated and it is to this that I will turn next.

7

THE MEDICAL PROFESSION IN POST-COMMUNIST RUSSIA

Since the collapse of the Soviet Union in 1991 Russia has undergone many significant reforms. The political arena has become one of fierce competition with the emergence and alignment of political forces following the end to one party rule. But the most sweeping institutional changes have occurred in the economy where the state monopoly has been eroded. By 1994 60% of the workforce were employed in the private sector (Aslund 1995:273). The economic reforms have created many new opportunities for those in the position to be able to exploit them, but for the majority of the population the reforms have lowered their living standards and pushed many below the poverty line (Varoli 1996; Morvant and Rutland 1997). The social costs of the reforms is also clearly illustrated by the alarming deterioration in the health of the population (Field 1994). The rising death rate that this has resulted in, coupled with a falling birthrate in response to the hardships experienced by many, has meant that the demographic crisis is considered to be one of the most serious problems facing Russia (Tkachenko 1995).

Nevertheless, despite the rising social problems and the impact these have on the population's health, the health sector in Russia remains one of the most neglected areas of the economy and the conditions for

those working within it have deteriorated significantly. The work of women in medicine was challenged during perestroika and is now being further challenged by increasingly inadequate resources and pay. Rather than taking responsibility for the growing social problems, there has been a shift away from collective to individual responsibility, seen clearly through the transition to insurance medicine. Doctors are now individually responsible for their own health and also for that of their patients, despite conditions of material insecurity.

This occurs simultaneously with an undermining of the position of women in paid labour in general through discriminatory family policy and employment practices. The post-communist period has not seen radical changes in the policy towards women and much of the language and indeed content of the Soviet era has been retained. There are still concerns over the nature and extent of women's labour force participation and concerns over their role in reproduction. But the context of these concerns has changed in that for the first time since the 1920s unemployment is a real option and indeed a growing concern for the leadership in terms of social unrest. The ways in which the post-communist leadership has addressed the 'women question' must therefore be viewed in relation to the wider economic and social context.

In this chapter, the ways in which the reforms of the transition are gendered, and the impact this has on the lives of Russian women will be examined in relation to the experiences of female doctors. Firstly the significance of the social problems, particularly demographic concerns, for the new Russia state, and the expected role of doctors in

addressing these problems will be examined. Secondly, the changing context within which doctors are working will be addressed. On the one hand, doctors are experiencing increased freedom to organise collectively and to earn money through private practice, yet on the other hand they are experiencing increased pressures through the shift away from state financing and difficulties of low pay.

The Social Costs of Transition

In post-communist Russia there is a growing concern about the social costs of the reforms, particularly in relation to poverty and ill health. In 1995 there were 39 million people living below the poverty line in Russia Indeed by the beginning of 1995 the average real income was still 30% below its 1991 level in real terms. In a survey carried out in 1995, 68% of respondents regarded themselves as living below the poverty line, compared with 56% in the previous year (Morvant 1996: 57). The gap between rich and poor is also growing. In 1995, the 10% with the highest income received 30% of the total income while the lowest poorest 10% received only 2.3% (Morvant 1996: 56). This is probably an underestimate given the failure to disclose earnings by the richest strata in society.

Having shed the rhetoric of socialism, it is clear that the reason for concern is less a desire for social justice than a realisation of the consequences such problems may engender. Social problems such as poverty and ill health pose a potential threat of social unrest. Given Russia's history, the threat of the mass uprising is constantly felt, and while as yet has not materialised in the post communist period, it remains a possibility. Moreover demographic trends which characterise the transition - rising death rate and the falling birthrate -

have created a situation in which the Russian population is actually declining. Indeed it is estimated that the population will fall by 9 million in the period up to the year 2005 (Baiduzhy 1994b).

There are two main aspects to the demographic crisis in post-soviet Russia - rising mortality rates and falling birth rates. In the period from 1990 to 1993 the birth rate dropped from 13 to 9.6% and the death rate rose from 11.2 to 12% (Raletskii 1993 :58). Many diseases, previously eradicated are again prevalent in Russia, for example scurvy, indicating the poor levels of nutrition. Both infant and maternal mortality are also rising. In 1991 there were 16.8 infant deaths for every 1000 births and by 1993 the figure had risen to 18.9. Maternal mortality is five times higher than that in the UK. There are also concerns about the poor health of children today as an indicator of future problems. It has been estimated that 60% of babies are born with health problems (Baiduzhy 1994a). The significance of the demographic crisis is not being underestimated and at an assembly called Protecting the Health of Mothers and Children in 1994, one speaker noted that "the situation can be described in one word - catastrophe" (Baiduzhy 1994a).

The implications of the population decline for the state are significant in both real and rhetorical terms. With a declining and indeed an aging population, it will be harder to reproduce the labour force to carry out the economic restructuring of the transition and beyond. The demographic crisis is perceived as being problematic for the economy not only in quantitative but also qualitative terms. Raletskii argues that there will be a "lowering in the quality of functioning labour potential by age, health, level of education and professional

training" as there occurs "a simultaneous over-employment of old people and women...and a reduction in the effective employment of more able workers - youth and men" (Raletskii 1993 :59). Similarly it will be very difficult to sustain the armed forces numerically which may be problematic given the high level of conflict in the region. There are concerns that both these issues will further reduce the standing of Russia in the post-communist world. As one journalist noted, "depopulation is leading to the degeneration of the people. The country's leaders go on and on about some sort of rebirth. Degeneration instead of the promised rebirth - that is what the reforms have given us" (Pravda 16/7/94 p2).

The demographic crisis is seen to arise from a number of factors (Presidential Commission 1995). Firstly that there is a general tendency throughout Europe towards a lowering of the birthrate. Secondly, the current crisis is in part a consequence of earlier demographic difficulties creating a situation in which in the 1990s there is a reduction in the number of people of reproductive age. Finally, the problems relate to the social, economic and political problems of the transition. As G Sillaste pointed out, "surveys have shown that it is not that husbands and wives do not want to have children: its just that they are unable to support them. This is the reality of post-perestroika Russia" (Artamonova 1996: 31).

The resolution of these problems has focussed on two main areas - the protection of women, as mothers, by strengthening the family as an institution, offering less damaging means of birth control than abortion and limiting their involvement in paid labour; and improving the health of the population in general and of women in

particular. It is clear from that the strategy of the state in relation to social reproduction continues to rely on attempts to control women's participation in the labour force and their role in biological reproduction and that the medical profession is still expected to play a key role.

Health care reform and the demographic crisis

In a government report in 1991 'Russia's White Book: the State Report on the Health of the Russian Population', it was noted that "health is a indispensable condition for the well being not only of every human being but also of a nation, of the country as a whole. It is virtually the most important criteria for evaluating the activity of the individual and of an entire social system and may be used as a basis for evaluating the quality of life". The conclusion of the report was that "the state of health of the inhabitants of Russia is quite alarming. We are far behind the majority of countries in all principal indices" (Russia's White Book 1994). In order to address this problem, it concluded that standards of care would have to rise, but also that the population must take more responsibility for their own health.

During perestroika, it was recognised that there were fundamental problems within the health service in terms of resources and standards of care. As was noted in the last chapter the medical profession was heavily criticised during that period. In post-soviet Russia attention has focussed more on organisational matters, in particular on the introduction of compulsory medical insurance schemes as a means of funding health care and as a way to raise standards of care in order to improve the health of the population. The medical insurance system, set up in 1993, is based on the

collection of resources from enterprises (3.6% of their wage fund). These funds are then organised and controlled by insurance companies and cover people for basic health care.[1] Medicine in Russia is not fully insured, but is budget insured. This means that medical institutions still rely on state funds to cover expenditure on operating costs - gas, electricity, repairs and so on (Golovisnin 1996). It is possible to take on voluntary medical insurance policies to cover additional services. For example insurance for care at the government medical centre costs 6-8 million rubles per year (Kulesh 1995).

It is hoped that the transition to insurance medicine will improve the health of the population in general. There are also measures targeted specifically at women. Firstly, more emphasis is to be placed on encouraging the use of contraception rather than abortion as a means of birth control. Family planning centres are now being opened in order to advise women on such matters. As on doctor noted "the problem of family planning in the Russian Federation takes on a new significance in conditions of a sharp reduction in the birthrate" (Volgina and Frolova 1994 :29).

Like most official statistics, accurate information on abortion is hard to obtain. It may be assumed that official statistics actually underestimate the number of abortions, but a recent nationwide study questions this assumption. The Russian Longitudinal Monitoring Survey (RLMS) carried out yearly since 1992 has given estimates lower than the official level (Entwisle and Kozyreva 1997). They argue

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[1] Services provided under basic compulsory insurance are primary health care; services for acute non chronic illness care during pregnancy and births; diagnostics; dental care for children; and specific specialised dental care for everyone.

that this can be explained in part by the different criteria for inclusion since the RLMS does not include mini-abortions, that is, those performed on an outpatient basis in the first seven weeks of pregnancy. But it may also be a reflection of the role that abortion plays in the fight for resources among health care institutions with hospitals over-representing the number of abortions carried out in order to obtain more resources. Nevertheless, even using the lower RLMS figures, the rate of abortion is still twice that of the U.S. and three times that of Britain or France.

Throughout the Soviet era, abortion was always regarded as a necessary evil with the focus on the dangers it posed to women's health. In the post-soviet era, anti-abortion sentiments have again been raised. It is pointed out that abortion is a surgical procedure and can be dangerous. Indeed 30% of all maternal deaths occur as a result of abortions (Tutorskaya 1994). In the press, articles are written that emotionalise the issue in quite extreme ways. In Rabotnitsa an article gave photos of the weekly development of a foetus. This was accompanied by a diary of the unborn child beginning with its conception - "today my life began" - and ending with the termination - "today my mama killed me". At three weeks old the unborn child was even given the thoughts, "I know that my first word will be mama" (Rabotnitsa no 8. 1994: 6). Similar emotional blackmail was used by pro-life campaigners fighting against the government's 1994 law 'on state support for citizens having children', with the use of the head of an aborted foetus on their campaign literature.

Unlike other former communist states however the Russian government has not banned abortion. As in the Soviet period, it is

recognised that a ban on abortion will not stop it taking place but will only serve to endanger women's health. Nevertheless the desire to see the removal of abortion as an easy solution to the demographic crisis was illustrated by the exclusion of abortion from basic medical care covered by medical insurance in 1994. As one journalist commented, "once again in a very clumsy and insulting manner, an attempt is being made to manage procreation...It is being done according to fashion with the use of market mechanisms and the principles of medical insurance" (Frolov 1994). The decision was reversed in 1995 as part of the 'Safe Maternity' programme and abortions were included in medical insurance cover (Timashova 1994).

The only way to reduce the number of abortions however, is to offer women better means of birth control. However, as Popov pointed out, there exists in Russia "a general cultural and mental resistance of the entire society to make a shift away from 'post hoc' family planning strategies to preventive ones" (Popov 1993 :25). In 1993 as part of the Children of Russian program plans were made to introduce 35 million packages of birth control pills, but the plan was never realised and in 1993 no money was actually given from the federal budget to purchase oral contraceptives (Tutorskaya 1994). Though the pill is now widely available it is very expensive for women to buy and many women still prefer to use the coil or traditional methods. The reluctance on women's part to try new methods of birth control is in part a reflection of the lack of attention this matter was given in health care. V Serov, head gynaecologist at the Ministry of Health noted that "unfortunately our doctors are too used to abortions and not too interested in acquiring foreign science". He was aware of the

fact that "abortion 'cares for' a large army of doctors" and for gynaecologists it remains a primary source of income (Lobanova 1993).

The question of making money from abortion was at the root of a scandal facing an obstetric clinic in 1996. The centre was accused of encouraging women to have abortions late into their pregnancy so that tissue and organs from the fetus could be used for medical experimentation. What concerns people is that the large number of abortions taking place in Russia makes Russia one of the largest producers of foetal material in the world and at risk from exploitation by western entrepreneurs. In the true spirit of the free market, even an aborted fetus can be regarded as a money making opportunity (Virkunin 1996; Current Digest of the Post Soviet Press vol 48 no1 :17).

Secondly, in the attempt to improve women's health and raise the birthrate, a new specialisation in medicine was introduced - the family doctor - playing a role very similar to that of the general practitioner in Britain, but whose specific responsibility was to provide care for the whole family unit. The family doctor will be expected to know individual patients' living conditions, relationships and general way of life in order to build a complete picture of their mental and physical well being. The long term aim is that primary care be organised according to "family principles", in line with other aspects of family policy (Kosarev and Vladimirtsev 1992; Novak et al. 1992; Ovanyesov 1994).

The post-communist period has so far been characterised by its pro-natalist family policy. In drafting the bill 'On the Protection of the

Family, Mother, Father and Child', deputy V. Juskevicius said, "I am convinced that a revival of society is possible only if there is a revival of the institution of the family" (Izvestia 18/3/92: 2). Similarly the presidential commission on questions of women, the family and demography noted that " a full examination of the current demographic, economic and psychological position of the family in the Russian Federation singles out extremely acute problems and demands the adoption of concrete measures by the authorities and all levels of government". (Presidential Commission 1995). Both these points highlight the fact that in post-soviet Russia, there is a renewed emphasis on the family as the key institution for raising children. Implicit in the state's family policy is the renewed emphasis on the role that women should play within the family.

The State Family Policy Document from May 1993 noted that "state family policy is a constituent part of social policy in Russia and represents the value system of measures of economic, legal, social, information-propaganda and organisation character, directed at improving the conditions of life for the family" (Presidential Commission 1995). The perceived role of women in the family is very much the same as in the Soviet era. While pressure from women's organisations has led to a change in the content of family policy to include the rights and responsibilities of fathers, in reality such a direction is either contradicted within the legislation itself or by the realities of everyday life. The 1993 family policy documents maintains in its basic principles that it is "directed at the formation in the family of equality in relations between men and women and a more equal distribution of family responsibilities". Yet it repeatedly mentions the need to protect motherhood and specifically states that women of

reproductive age will be banned from work that will damage their reproductive function.

Similarly, the 1992 draft family law stated that increases in paid leave for child care for up to 3 years should be available for mothers or fathers, but at the same time has a special section 'On the protection of the working (or student) mother' which limits women's working week to 35 hours if she has a child under 14 years of age. It was also stated that employers had to pay women twice the minimum wage for maternity leave and if unable to transfer women to lighter work while pregnant they were obliged to release them but continue to pay an average wage (Lyuka 1992: 6). By refering solely to working mothers and not parents, it is clear that it was expected that women would be the primary child carers and that they were actually being encouraged to take more time out of the workplace to fulfil that role. While the draft was never enacted as legislation, it is clear from the discussions surrounding it that despite the statements concerning equality in the family, it is clear that the main intention of family legislation is to encourage reproduction and in order to do this, 'protection' is provided for women.

Thirdly, doctors are to contribute directly to the protection of women. As one doctor noted, "wide democratic reforms in health care are inconceivable without...the creation of new laws which would assist in the protection of the health of specific groups in society...Children and mothers are one such group". Indeed, "the question of maintaining optimum working conditions and granting women additional privileges and guarantees has important social significance" (Volkov et al. 1992). The 1993 Employment Law

established the protection to be given to women in post-soviet Russia, and in effect differed very little from legislation in the Soviet era. While on the one hand equal rights in employment were guarantied regardless of sex, race, nationality, or religion, at the same time point 2 of Article 11 noted that "differences in the spheres of work, brought about by the particular demands of a given type of work or by the state's special concern for individuals in need of extra social protection (women, minors, people with disabilities), do not count as discrimination" (Bridger 1996: 46).

Similarly, as during the Soviet period, women are 'protected' from certain types of work which involves heavy labour or work in harmful conditions. Pregnant women and women with children under three years of age are banned from overtime and nightwork. Despite the attention women's working conditions received during perestroika, 34% of working women worked in harmful conditions (Podshibyakina 1993). The consequences of this type of 'protection' of women will be discussed further shortly.

It was widely recognised that while such legislation was in place, it was often not implemented. In May 1994 a decree was issued 'On state inspection and control of observance of legislation of the Russian Federation on labour and the protection of labour"(Levina 1994). For doctors, "control over the implementation of legislation guarantees is extremely necessary in the aims of maintaining the health of women...and the well being of her family" (Volkov et al. 1992). Yet the doctors themselves are also part of the problem of lack of implementation. Doctors are responsible for defining the character of work that women who are pregnant or with young children should

be involved in, but it is often left up to the woman to ask for transferral to lighter work rather than being an automatic course of action taken by doctors. In part this may be because the responsibility of doctors in Soviet industry was not only to ensure the health of workers but also to ensure that production took place at an optimum level. As Volkov notes, "usually the character of lighter work is defined in connection with the recommendations of doctors and the needs of industry". He argues that doctors need further training in legal matters so that they are more aware of such protective legislation(Volkovetal.1992).

Doctors and the State in Post- Communist Russia

In post-communist Russia, the role of the doctor in addressing the state's concerns about the population's health, particularly in relation to reproduction remains central. Nevertheless, the relationship between doctors and the state is changing within the context of the transition to the market. The shift to insurance medicine, changing the means of payment to doctors and new opportunities for private practice, have placed female doctors in an extremely vulnerable position, highlighting the trend towards the feminisation of poverty in Russia. Indeed, the attempt to shift responsibility for social welfare from the state to the individual, or the family is an attempt to cope with the mounting social costs with dwindling resources, but it also reflects an ideological shift away from the socialist ideal of the caring state towards the application of individualised market principles in the social sphere as well as in the economy. This has implications for women, who figure prominently amongst the sections of society worst affected by the reforms.

The aim of the introduction of insurance medicine is to relieve the state of the responsibility of funding the ever increasing demands for health care while at the same time improving the nation's health and the quality of care. It is hoped that by giving health care users and providers defined market roles as buyer and seller, both sides will become more conscientious in their attitudes towards health. The population, realising now that they have to pay for health care, will, it is hoped, take better care of themselves. They are also being given the incentive of having a choice of the doctor that they attend.

The logic follows that doctors realising that their wages now depend on the satisfaction of their clients will provide better care. As V Kalinin from the Ministry of Health pointed out, the medical insurance system "not only widens the financial base for health care, but also makes provision for the decentralisation of management and strengthening the responsibility of medical institutions for the quality of medical care and creates a greater interest amongst enterprises and citizens in caring for their health...and carrying out natural measures for stimulating a health way of life and lowering illness" (Chernyakhovski 1991: 7). But this logic is flawed, not least because people's health is not simply determined by their own actions but often by environmental causes such as poor quality housing and pollution. Moreover, the insurance system has been the subject of a considerable amount of corruption and mismanagement, the losers in which tend to be the doctors, whose financial position is certainly no better and in many cases worse than before.

One of the key reasons why women are included in the category of those experiencing poverty is a result of their low pay. In industry the

highest paid workers are in gas, oil and steel. In July 1995 the average earnings in the oil industry was 1.33 million rubles. Even their bonus of 308 000 was higher than the average wage in education (Morvant 1996 : 57). In general women continue to earn around 1/3 less than men, but it is in the feminised, state sectors of employment that pay levels remain lowest, often at or below subsistence levels. The situation for public sector workers, or *biudzhetniky* is made worse by the fact that their wages are only increased on a quarterly or half yearly basis and so often lag behind inflation. During the high inflation of 1994-5 public sector employees real incomes fell by 20-30% (Morvant 1996: 57).

Amongst the medical profession, the question of low pay is of the greatest concern and indeed lies at the root of the series of protests since 1992. There is a definite feeling of injustice that the work of doctors is not recognised and that as state employees they are disadvantaged. One cardiologist pointed out that "doctors don't receive pay directly. Rather, people pay their taxes or insurance to the state and it enters the state system and the state then pays the doctors. But the money seems to disappear and is used for something else or the administrators keep it for themselves".[2]

Many feel not only that their pay is not enough to live on, but that it is an insult to their status as doctors. As one paediatrician noted, "everyone gives everything to their work and yet the pay is very low and always has been. It doesn't depend on how hard we work. It means that because the pay is low, the prestige will also be low. Also because the pay is low people don't want to bother raising their

[2] Interview with respondent 4.

qualifications since it makes very little difference to their pay. And now life has changed so that education in general is not as prestigious. Now everyone want to be a businessman and even though often their level of education is not high they have a high standard of living. What kind of message does this give to people - that our work is less worthwhile than business dealings".[3] Similarly, the the head of a women's clinic noted, "low pay corrupts people. There is no stimulus to work better and to raise qualifications. There is no big difference between levels of doctors. Different categories of qualification don't give people much more money, only more prestige. The pay for a doctor without a category is 320-350 000, for II category it is 397 000 and for I category it is 449 000".[4]

Moreover, it was noted by many that the government were totally disinterested in doctor's pay. "Because the government and high officials don't have to stay in our hospitals or be treated by ordinary doctors, what do they care how much we are paid or if the care is poor. Yeltsin gave an interview recently and said that he was told by a woman on the street in Vladivostock, that doctors were only paid 350 000 and he was surprised to hear this. But he only learned of this form a woman in the street so there is obviously very little discussion or concern over this matter in the Kremlin".[5]

As was noted above, the shift to the system of insurance medicine has also had an impact on doctor's pay. One of the aims of the introduction of insurance medicine was to tie work more closely to pay since the doctors would receive payment from the insurance

[3] Interview with respondent 5.
[4] Interview with respondent 14.
[5] Interview with respondent 15.

companies for the work carried out. Kalinin from the Ministry of health noted that when doctors are paid a minimum for sitting in their offices and not for the end result of their work, they become like bureaucrats and their creativity is suppressed (Chernyakhovskii 1991: 8). From a different perspective, the change over to insurance medicine could be viewed as a more coercive measure. As the director of the Moscow territorial insurance fund said, the aim of insurance medicine was to "help to separate those who can and want to work from those who are used to receiving unearned money" (Golovisnin 1996:5).

However, the intentions of the reforms have not been achieved. Indeed, one of of the most apparent problems with insurance medicine in Russia is the failure of funds to reach the required destination, that is, the health care institutions and medical personnel. One journalist noted that "in Moscow and some other larger cities, the system of medical insurance has already been operating for two years. What has changed? To a large extent nothing. Doctors didn't receive that money which they have earned. In the hospitals as before, there is not enough medicine and equipment" (Golovisnin 1996: 5).

In part the explanation for this lies at the feet of the insurance companies. They are commercial organisations, not charities and will try to make as much money as possible from this venture. Based on research in St Petersburg, Curtis et al. concluded that "significant amounts of the health insurance fund are likely to be used for the development of insurance companies rather than being spent directly on patient care". Indeed they argue that the intermediary role of the

insurance companies is unnecessary and based solely on the premise that free market competition is always a good thing (Curtis et al. 1995). The head doctor of a women's clinic complained about the role of the insurance companies.

"In Voronezh, the system serves to profit the insurance company. Our work is evaluated by the representatives from the insurance company. He checks all the documentation and looks for ways to pay the clinic less, for example if the diagnosis was not written out in full, that is an administrative error, it is classed as a mistake and the doctor is paid less. Insurance companies are mediators between the sick and the doctors and don't want to pay out money. This may be profitable for them but it is not profitable for the patients or the doctors".[6]

There is also the problem of corruption. Doctors are at the bottom of the line when it comes to receiving payment from the insurance fund and there are others including ministry officials, local councils and the insurance companies who try to make the most of the opportunity to handle large sums of money for their own good. In 1993, the first year of medical insurance only 40% of the money collected made its way into the health care system. Dr Akopyan is highly critical of the corruption involved in the medical insurance system and noted that the remaining money was either "eaten up by inflation, used by heads of local administrations to patch up budgetary holes or amounted to a credit resource for the commercial turnover of criminal structures" (Strokan 1994).

Whatever the reason, the consequences for doctors are the same - their pay is not increasing and is often delayed and the conditions

[6] Interview with respondent 14.

they are working in are worsening. The impoverished state of health care institutions is so bad that patients are now commonly asked to bring with them to the hospital any medication required, equipment such as needles, sheets for the bed, soap and so on (Argumenty i Fakty no.19 1996). This was made clear in an interview with an endocrinologist.

"After perestroika things became much worse. We became familiar with a lot more foreign medicines, but only in theory, in practice there are none in the hospitals. Therefore, the patients have to buy their own medicine and they don't have enough money. I know hospitals and doctors who work there who extort money before operations. Sometimes patients are forced to leave before the operation because they can't buy the correct medicine or pay the surgeon the money he has asked for".[7]

Even though in state sectors like health, pay is on the whole low, there are still quite large differentials between men and women. In health care, men earn on average 50% more than women (Morvant 1995 :7). This is likely to be reinforced by the new system of payment. In 1992 a new tariff scale was introduced for the payment of public sector workers. it was argued that the new scale would make it easier to keep wages in line with inflation and would also provide an incentive to health workers to work harder and to raise their standards. However, it is likely that the assessment of levels will be influenced as much by work or standards as by the specialist's gender. Each doctor's rating is assessed by a committee at their place of work, based on their education, length of service and subjective factors such as skill, independence and responsibility. The lower position of women in the medical profession will simply be reinforced by this

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[7] Interview with respondent 9.

measure. This was made clear by Testov from the Ministry of Labour when he noted that "there are surgeons who carry out complex operations and there are doctors doing simple work in sanatoria. The obligations are different and the difference in pay will be more noticeable" (Levina 1993: 10).

Moreover, women seem to be trapped in a vicious circle in relation to low pay and training opportunities. As Fedulova, Chair of the Russian Women's League noted, women's lower pay is in part "due to a gap in the level of skills and training" (Pankova 1993). Indirectly by receiving low pay, women do not have money to spend on goods and services that that would free their time to spend on career development. More directly however, training courses are now often quite costly either as a result of registration costs or due to the fact that they are held in locations that require some nights or weeks payment for accommodation and travel. One doctor expressed her anger at this situation. "previously it was easy to go on courses, in fact it was mandatory and if you had the desire you could raise your qualifications. Now you need thousands or millions of rubles to sit exams and of course I don't have any money for such a luxury. Today Shariky are ruling the country. They are uneducated, uncultured and insolent".[8] It was recognised by the doctors interviewed that while there were far more opportunities for them to attend lectures and courses, in particular with foreign colleagues, they now do not have the money to do so. For women therefore, lower pay means less opportunities to improve their knowledge and qualifications which

[8] Interview with respondent 9. 'Shariky' refers to the hero of the novel by Mikhail Bulgakov, Heart of a Dog, and is taken to refer to someone who is thought to be uncultured or stupid.

in turn means that they have fewer opportunities to gain promotion and so remain on low pay.

In addition to receiving lower pay on average than men, there is also the problem of wages being withheld. This is not simply a problem for women and it is in fact widespread in state and private sectors as a result of inter-enterprise debt. In July 1995 wage arrears affected 13 million people (Morvant 1996 :58). One doctor complained about this saying, "at the moment I haven't been paid for three months, so we are working for nothing"and as if to highlight the hopelessness of the situation, refering to the 1996 Presidential election, she remarked that "only if Fyodorov was elected would our wages be raised".[9]

The low pay of women within medicine is resentative of the problems women face by virtue of their segregation in public sector occupations. Not only were women traditionally concentrated in areas such as health and education, but as will be discussed shortly, women find it harder than men to take advantage of new opportunities in the market to move out of low paying public sector jobs. The patterns of occupational segregation established in the Soviet era have remained in place despite the economic reforms. It is not only within public sector jobs that the traditional patterns of occupational segregation are having a negative impact for women. Women are also more likely to find themselves out of work either temporarily or permanently in part as a result of their concentration in manual or unskilled work or in skilled positions which have faced the largest cutbacks.[10]

[9] Interview with respondent 2. Fyodorov is a physician who opened a private eye clinic in Moscow and was a candidate in the 1996 Presidential elections.

[10] While unemployment is very significant for certain groups of women in Russia today, it is

Despite the difficulties over low pay and conditions, the extent of strike action among the medical profession remains relatively limited. In part this can be explained by the willingness of the government to give concessions to striking workers. For example following strikes among health care workers in 1992, Yeltsin issued a decree reforming the pay levels in this sector. It was recognised that the decree would do little towards solving the crisis in health care, and was simply a means to ease social tension (Izvestia 14/5/92: 2). Amongst the doctors interviewed there was a general feeling that strikes were a waste of time. As one *terapevt* said, "what would strikes change anyway? It is not possible to make money appear from nowhere. If there is not enough money to pay us then strikes won't make any difference".[11]

The lack of interest in strike action also relates to people's attitudes towards the trade unions. In a study carried out in 1994, 73% of workers said that unions played no role or a negative role in Russia (Morvant and Rutland 1996). Most of the doctors interviewed saw the trade unions as part of the management, in the Soviet vein rather than as their representatives. As one doctor said, "the trade unions and the administration are closely connected" and in this respect "very little has changed".[12] For many the main function of trade unions is to provide services, for example holiday passes and in failing to carry out this role today they have become a pointless organisation. One doctor complained that she has to "pay 40 000 each month to the union but I don't see any use in it - there's no result for

not as yet a problem among the medical profession, so will not be discussed in any detail here. For a discussion of the extent of and implications of unemployment for women see Baskina 1994; Bridger 1996; Dakin 1995; Lyuka 1992; Morvant and Rutland 1996;Posadskaya 1994.

[11] Interview with respondent 1.

[12] Interview with respondent 1.

me. It used to be possible to receive free holiday passes but not now".[13] While a new Interregional Medical Association, modelled on the American and British medical associations, has been set up, most of the doctors interviewed were not aware of it and were not interested in its activities.

New Opportunities for Women ?

Nevertheless surely the market brings new opportunities for women in medicine? Privatisation in medicine is still in the very early stages, but indications so far within medicine and from other areas of business do not indicate that such an assumption can be made. During Perestroika, health care services figured prominently in the introduction of non-state forms of property. In a Moscow directory advertising individual's services in the Persestroika era, of the 236 entries, 88 were for medical services (Cox 1996: 75). The most frequently visited type of medical cooperatives were gynaecologists, urologists and dentists (Grishin 1991). There were two types of medical cooperatives. Firstly, independent medical institutions unconnected to government agencies with their own equipment and premises. Secondly, those renting premises and equipment from medical institutions, employing people who work there already and operating outwith the normal working hours of that institution. The majority fell into the latter category, with only 6.4% of cooperatives with their own building (Ryan 1989: 104). It is interesting to note that the second largest entry was for teaching, another female dominated low paid profession. While both these occupations were easily transformed into private sector activities, with their greatest resource being the knowledge of the individuals involved, it was also the case

[13] Interview with respondent 2.

that given their low pay, they had an added incentive to supplement their earnings.

For doctors, the main enticement to work outwith the state sector is undoubtedly the higher pay, but there is also the issue of independence and control over their own work. As one doctor noted, "in Voronezh there is a very good dental cooperative clinic which has bought new equipment and materials. They work for themselves...If our services are paid for then we can earn a lot. I have a friend who is a dentist and she works both for free and for payment. In relation to me she earns a lot. She can earn in one day almost as much as I earn in one month".[14] The issue of pay, therefore, while important is supplemented by the desire of doctors to work in situations in which they could fully achieve their potential. Indeed the majority of doctors who were involved in the initial cooperatives were highly qualified, for example in the first medical cooperative in Moscow, LiK, 90% of the doctors had advanced degrees (Izvestia 28/2/88:3).

Nevertheless the scope for private earnings in health care has so far been limited. During Perestroika, overall restrictions specified the areas in which individual labour activity was prohibited.[15] In relation to medicine, the activities of doctors were restricted in several ways. They were not allowed to perform surgery, to treat infectious diseases, to care for pregnant women, to treat drug addicts or to authorise the hospitalisation of patients (Izvestia 30/4/87:6). Their range of activities was therefore limited to routine, minor treatments. Indeed, the number of doctors involved in work in this sector was limited.

[14] Interview with respondent 1.

[15] This included armed forces, education information and ideology, the manufacture of chemicals and drugs, firearms, processing of precious metals, gambling.

Only 10% of doctors working in the cooperative as their main occupation (Powell 1992: 229). While doctors were permitted to work and earn as individuals therefore the scope for such activity remained tightly controlled. In Russia today some private clinics have been set up particularly as joint ventures with foreign firms. Nevertheless the privatisation of health care remains limited today with the main focus of the health care reforms remaining the shift to insurance medicine.

As in other areas of business it is likely that there will be a gender segregation in relation to the privatisation of health care. On the one hand, given that the majority of doctors are women, a large number of those working in cooperatives and private clinics would also be women. This is particularly the case in relation to gynaecological clinics. Nevertheless, if as was the case with the cooperatives, the emphasis is placed on recruiting doctors with the best qualifications, male doctors are at an advantage, for the reasons discussed earlier. Moreover, the heads of cooperative clinics are also more likely to be men given the fact that they held the majority of top positions within the state sector.

It appears therefore that women's involvement in business, including private medicine will be limited. It appears however that women have not taken up the new opportunities to set up a business to the same extent as men. Women compose 39% of co-owners of limited trading companies, 23% of cooperative owners and 17-19% of entrepreneurs hiring wage labour. In 1993 only 9% of sole proprietors of new private businesses were women. Only 27% of women said they would like to be the sole owners of a business rather than just the

manager, compared with 64% of men. 44% of women said that they did not want to take the responsibility for other people in the work collective, as the reason why they did not want to become sole owners of a business. 27% said they did not see themselves as owners of a business since they were not "proprietors by nature". 17% mentioned the difficult economic position as a disincentive (Babaeva and Chirkova 1997).

There are several factors which can explain this. Firstly there are stereotypes that surround the work women can and should do which influence women's choices and the chances of receiving financial backing. Both the type of businesses that women are entering and the character of the work they carry out differs from men. There are mixed views as to whether women are suited to being businesswomen. In relation to the psychological characteristics required to work in business, some argue that it depends on the individual. As one doctor noted, "success or failure doesn't depend on sex but on the internal spirit and character of a person. there are women who can be enterprising and men who couldn't work in the conditions of the market".[16] However, much discussion in the press of the characteristics required tended to focus on traditional 'male' attributes such as aggression, competitiveness. Gender stereotypes are also raised in defence of women's abilities, for example it was pointed out that women may be more intuitive than men (Kostygova 1991). There was also some discussion of the negative impact for children and the family that may ensue if women were involved in business (Brigder et al. 121). The images of women's fundamental reproductive

[16] Interview with respondent 5.

role in society were therefore also transfered and served to limit women's opportunities in business.

This is clear also from the character and the type of work women are involved in. In small business women are encouraged to work in traditional female areas such as crafts, hairdressing and so on. It is argued that such areas of work were most suited to women's character and skills (Karyakina 1991). There is also a segregation in the type of women women do as managers. Even where women are entering male sectors of business, they tend to do so, not as owners or as directors, but as the second in command. There is a clear division between their work and that of the male director. It is argued that women are suited most of all to dealing with personnel matters and communicating with people. Babaeva and Chirkova noted that women have advantages because of "their communicability, their emotional engagement with their clients, their ability to establish trustworthy relationships and their aversion to victory at any price" (Babaeva and Chirkova 1997). Similarly Roshin and Roshina argue that there a different spheres of activity for women and men in business. Men are concerned with the 'external' activities, for example contracts, meetings with buyers, while women are involved with the 'internal' activities such as paperwork and discussions with the workforce (Roshin and Roshina 1994).

Secondly, in addition to the stereotypes surrounding female employment . women are a step behind men in relation to the acquisition of skills necessary for business. The fact that fewer women than men were managers in the Soviet era is significant for women's opportunities in business today, both in terms of real experience and

also as a matter of self confidence. Many of women (and men) that have taken leadership positions were former enterprise directors (Roshin and Roshina 1994). This point was noted by one doctor who was well aware of the disadvantages faced by women. "I think men have more possibilities than women. They have more time to start a new clinic and they also have more experience than women in being managers and organisers. In the market it is not enough just to be a doctor anymore, you also have to be a businessman. For women it is harder. They have to be geniuses whereas men just have to be men".[17] Organisations like Guildia have been set up to help women to learn the skills they need and to acquire knowledge on the legal procedures involved in setting up and running a business (Brigder et al. 1996 :126-31).

Thirdly, there are also problems for women in acquiring the capital needed to start up a business. Not only is there discrimination on the part of banks in lending to women, but there is also the difficulty of loan repayment. Moreover, there are many of payments in the form of taxation and bribes which are virtually essential if a business is to get off the ground (Bridger et al. 1996: 131-141). These difficulties serve to deter women from entering business.

Finally, it is also interesting to note the motivations for women entering business. While for some it is a matter of self fulfilment and ambition, for many, business activities are a means to an end. As Babaeva and Chirkova note, "women's individual economic activity is directed toward providing for their families and has the character of 'additional income'" (Babaeva and Chirkova 1997). While there are

[17] Interview with respondent 4.

new opportunities for women in post-communist Russia, as yet they remain limited.

Conclusion

In the period of transition, the state is placed in a contradictory position. On the one hand, the government wants to resolve the demographic problems and so to 'protect' women. The system of social security and the provision of quality health care are central to this. Yet the period of transition is characterised by a large budget deficit which limits the amount that can be allocated to such programmes of protection. The priority has been given to economic stabilisation, often at the request of international monetary organisations and at the expense of social policy funding (Morvant 1996). This has turned the focus of attention to individuals and the family as the state tries to minimise the social consequences of the reforms and the costs involved.

The contradictory role of doctors in the Soviet system remains to a large extent intact today. While the relationship between the state and doctors is changing with the de-statisation of health care, the work of doctors is nevertheless central to addressing the mounting social problems in Russia. The reforms in health care in fact have exacerbated the contradictions. On the one hand it is recognised that many people need assistance and the social sector is the key to providing this. But on the other hand, financial restrictions limit the means available to invest in this area and focus attention on alternative sources of funding, resulting in increasing impoverishment for the very people targeted for assistance in the first place and for those working in that area. As a result, doctors find

themselves unable to work effectively. The head doctor of a women's clinic noted this problem. "If something goes wrong in a factory it is possible to fix it but in relation to health its more dangerous. So the low pay is not only not justified, but it has a detrimental effect on people's health".[18]

Moreover, the central role that doctors are expected to play in addressing social problems, is contradicted by the pro-natalist direction of family policy and the discriminatory nature of employment policy and practices, which have implications for them, as women. Employment policy in post-communist Russia draws heavily on the stereotypes of women as second rate workers whose real responsibility lies in the home. This must be understood as part of the state's strategy to tackle the demographic and economic problems facing Russia today. The position of women in the labour market must also be understood however as the result of managerial strategies to establish new forms of control within a market system. Not only are women often an expensive option as a result of their protective legislation, but gender ideology is also used to justify the abuse of equal rights of women in the labour market and so creating the conditions within which many women are left in poverty.

The economic transition in Russia is accompanied by a shift in the form of gender inequality, but as with the economic reforms, the nature of this inequality remains rooted in the social relations that lay at the heart of the Soviet system. Gender relations still play a central and contradictory role in attempts to reform post-communist Russia.

[18] Interview with respondent 14.

CONCLUSION

This thesis sought to explain patterns of gender inequality, with particular reference to paid labour, within a theoretical framework of gender inequality. It has been argued that gender inequality should be understood in relation to the state's strategy of social reproduction and the reaction of individuals (particularly of women) to this. The analysis of gender inequality within the framework of social reproduction enables the social system to be understood as a whole. Through this holistic and integrated approach, it is possible to move away from examinations of gender inequality in separate locations such as the family, or work. Instead an analysis of social reproduction addresses the ways in which the forms of gender inequality in such locations are related and act upon each other.

It is also possible in this way to understand the relations between different social actors, that is between male and female workers, between women and the state and between the state and economic managers. It is clear that the structures of the social system which shape the relations between certain groups are in turn shaped by them in a constant process of structuration. The process of social reproduction, understood as a state strategy, can be seen to act upon women, shaping, often limiting their choices, but in turn their actions, for example the reluctance of women in medicine to undertake further training, has implications for state policy and social reproduction.

It has been argued that gender played an important part in the strategy of social reproduction. On the one hand women were important productive resources both quantitatively boosting the numbers of the labour force, and qualitatively by virtue of their place within the labour hierarchy. On the other hand, women were also expected to ensure the biological reproduction of the nation as a whole and in particular of the long term reproduction of the labour force. The contradiction between these two aspects resulted in attempts by the state to control women's biological reproduction and to control their paid labour.

When understood from this perspective, an examination of the feminised medical profession offers insight into gender inequality in Soviet Russia. Women were drawn into the medical profession to fill gaps in the labour force in the early stages of the extensive economic development of the Soviet economic system. Their use as a productive resource, in this respect was clear. The focus of investment, into heavy industry and defence and the deprofessionalisation of medicine determined the low priority status of the health sector. While this meant that for men, it was no longer a desirable or prestigious profession to enter, particularly when compared with the newly emerging industrial occupations, for women a career in medicine was an opportunity to be welcomed. Women therefore provided the Soviet Union with a numerically strong health labour force.

Women's work in the health sector allowed the provision of health care despite the low investment in this area. In the economy as a whole therefore, their work was a key component of the labour

hierarchy. In addition, within medicine there was a definite gender hierarchy with women underrepresented or excluded from the most prestigious and well paying specialisations or career paths. This was most notable in their virtual exclusion from the academic medical elite. Women were limited in the amount of time they could devote to further training to advance their careers, because of their family responsibilities. This was reinforced both materially and ideologically by the state's family policy which gave women primary and often sole responsibility for child care.

In addition, health care managers were more likely to take on male doctors to the best positions because women were seen as less reliable due to childcare responsibilities. Indeed, as a result of this, for many women, medicine was regarded not as a career, but simply as a job. So while women did tend to have lower human capital than men in advanced medical education, this was a result of pressures on them to manage not only a job and family and as a result of discrimination in relation to career opportunities.

The labour hierarchy within medicine illustrates the way in which gender was used to fragment the workforce and to allow concessions to what were regarded as the most skilled elements within it. There was the intention within medicine to encourage more men into the profession by reserving the best positions and the most prestigious and highly paid specialisations for them. In part this was a result of the belief that men were, in general, better workers than women, particularly as it became clear that the quality of care provided by the Soviet health care system was well below western standards. The concern to reverse the gender balance in medicine also arose from the

general concerns over women in paid labour. The involvement of women in paid labour was implicitly questioned from the 1960s and more directly since the onset of the reforms in 1986, in part as a result of economic needs, for example the rationalisation of industry, but also as a result of the demographic problems faced in Russia.

The analysis of gender inequality in the medical profession in Soviet Russia from the standpoint of social reproduction is important in this respect because it highlights the contradictions which were inherent in the Soviet system and of which, gender was a central element. Female doctors were both state agents exercising control over certain aspects of production and reproduction, but at the same time as women, were marginalised into a low paid, low prestige, feminised profession.

Doctors were expected to serve the state by fostering higher productivity among the workforce by attending to their health and by acting as regulators of time off work, but they were also expected to encourage biological reproduction among women by devoting special attention to women's working conditions and their health in general. In this respect doctors acted, on the state's behalf to regulate, or control, production and reproduction. The work of women within medicine was particularly important given the lack in interest shown by men to enter this profession. Yet at the same time, female doctors were themselves controlled. As doctors, their work was subject to tight regulations, arising foremostly from the deprofessionalisation of the medical profession after 1917. As women, their opportunities and choices in life and work were shaped by state policy. In particular they

were subject to pressure to have more children, to set an example to other women.

However, women's position as female doctors was contradictory. Firstly, the state's attempt to control the medical profession by devaluing their work through the widening of the profession, low pay and poor working conditions served to lower the standards of their work, and so their ability to carry out their designated role as regulators in production and reproduction. Secondly, it meant that female doctors themselves were in a worse position when it came to raising their own family, and so contributing to reproduction. The very women that were meant to advise on increasing the birthrate were themselves unable to do so. Therefore, while the state was provided with a health labour force, the gendered character of this labour force was contradictory for social reproduction.

Gender was therefore a key, and often contradictory element within the Soviet system, in relation to social reproduction. To what extent has this changed during the period of transition? In post-communist Russia, it appears at first glance that the contradictions that women posed for the state in terms of their role in production and reproduction could be eliminated. If there was to be unemployment, then women could be targeted, 'returned to the home' and so the demographic problems eased. However this is based on a series of false assumptions. It wrongly assumes first of all that it would be possible to remove women from the workforce since it has been acknowledged that men would not do many of the jobs that women are employed in.

Secondly it assumes that if women are not working the birthrate would rise. However, it has been shown that unemployment causes poverty, not a desire to have more children. What is consistent in post-soviet policy towards women with the Soviet era is the fact that women are presented primarily as mothers. Of greatest concern at the moment is that their ability to take on this role is being hampered by problems characteristic of the Soviet era, most notably their involvement in work that posed a danger to their reproductive function, but also by new social problems arising from the economic reforms.

The 'protection' of women as mothers that was characteristic of Soviet policy has been further complicated by their impoverished position in Russia today. The protection of women has focussed on the traditional methods such as limiting women's involvement in paid labour rather than the provision of large cash benefits. But this is in fact a vicious circle because by 'protecting' women, the state is in fact making women's position in the labour market worse and so establishing a greater and more real need for protection. While it is recognised that women are often experiencing greater hardships than men in the period of transition and so require state assistance, the pro-natalist character of the 'protection' of women in effect serves to worsen their position in the labour market and so reinforce their need for state assistance.

At the same time, this can also be understood as part of the shift in responsibility from the state to the individual and the family. The responsibility for health care, for child care and for finding work is increasingly seen to lie within the family. This acts as an increased

pressure on women since it is they who have been attributed the key role in this respect. The transition to the market has not only brought with it the privatisation of the economy but is also seeing a privatisation of the family. While state support is offered, in real terms it is often meaningless, creating a situation in which family members have to rely on each other to a much greater extent. By giving the family responsibility for bearing the burden of the social costs of the reforms, a clearer distinction is being drawn between private and public spheres. In the profit orientated context of a market economy the private sphere of the family is being devalued. In this context, the implications of women's 'protection', becomes more significant.

The shift in responsibility from the state to the family is also reflected in the gradual dissolution of the paternalistic form of control. Both the state and individual enterprises are incapable of financing the much needed social programmes. The clearest indication of the break in the paternalistic pact comes with the growth of unemployment. Women's position within the labour hierarchy has placed them in a precarious position in the labour market in part as a result of the types of jobs they are in, for example the textile workers, but also as a result of the increasing costs associated with employing women, which enterprises cannot, or are unwilling to pay. As as result, it is women who are experiencing the worst aspects of the economic reforms. Therefore, the shift in the form of control from paternalism to unemployment has a gendered nature.

While for women in medicine, unemployment is not an immediate danger, their position is nevertheless precarious. Their contradictory

role has in fact been exacerbated by the reforms. Like women in Russia as a whole, they are expected to contribute to society by being a flexible workforce, carrying out work, often central to the system. Yet they are expected to endure poor working conditions, low pay and the constant undermining of their position through state legislation.

Therefore, the contradictions that women pose for social reproduction have shifted in the post-communist era. The economic reforms have reduced the demand for female labour and so there is less concern over the impact their participation in the workforce will have on biological reproduction. Rather, concerns now lie implicitly with the impact that their removal from the workforce will have. While removing women from paid labour may avoid the dangers of working in heavy and harmful conditions, it has left many women in poverty. Moreover, as options for men are wider than for women, the jobs that remain open to women will tend to be the lowest paid, again leaving many women in hardship.

Nevertheless the picture may not be all that bleak. There are some women who have benefited from the reforms and have been able to grasp new opportunities in business and in developing links with the international community. Moreover there are many new women's organisations which aim develop women's potential through financial, and educational support both at the local grass roots level and in the political arena. The extent to which these groups will have an overall impact on the position of women remains to be seen. For many women, their faith in organisations acting on their behalf may simply be exhausted. Regardless of the outcome of the reforms for women and the choices they will make, one thing seems certain -

given their strength of spirit and endurance, Russian women will survive.

APPENDIX I: DETAILS OF DOCTORS INTERVIEWED

Interviewees	Medical Specialisation	Age
1	Terapevt	33
2	Gastroenterologist	33
3	Head of Medical Institute	61
4	Child Cardiologist	35
5	Physical Culture doctor	28
6	Paediatrician	57
7	Paediatrician	52
8	Medical-statistician	39
9	Endocrinologist	35
10	Opthalmologist	45
11	Gynaecologist	53
12	Gynaecologist	30
13	Dentist	41
14	Gynaecologist	50
15	Gynaecologist	29
16	Terapevt	44
17	Paediatrician	39
18	Terapevt	52
19	Gynaecologist	29
20	Gynaecologist	40
21	Terapevt	41
22	Paediatrician	43
23	Child cardiologist	29
24	Terapevt (retired)	71
25	Endocrinologist	74
26	Stomotologist	35
27	Bacteriologist	33
28	Paediatrician	42
29	Terapevt	34
30	Sector doctor	25
31	Neuropathologist	48
32	Gynaecologist	35
33	Physical culture doctor	55
34	Stomotologist	47
35	Physical culture doctor	24
36	Opthalmologist	38
37	Gynaecologist	49
38	Dermatologist	45
39	Endocrinologist	35
40	Otolaryngologist	46

APPENDIX II - INTERVIEW SCHEDULE

Choice of Profession

1. When did you decide to become a doctor?
2. Why did you choose this profession?
3. Who, or what influenced your decision?
4. Did the low pay of doctors influence your decision?
5. Did you consider any other professions?
6. Why do you think the majority of doctors are women?
7. Do you think that medicine is a traditional female profession?
8. What factors influenced your choice of specialisation?
9. Do you think there are some specialisations in medicine which are more suitable for women? If so, which and why?

10a. What specialisation in medicine is the most prestigious?

10b.Are there more men or women in this specialisation?

Work Placements after Graduation

1. How was your work placement decided after graduation?
2. Do you think the first placement is an important stage in the career of a doctor?
3. Is is easier for men or for women to receive a good placement?

Post Graduate Training and Education

1. Did you have the possibility to raise your qualifications after graduating?
2. Was this useful for you?
3. Do you have the possibility to raise your qualifications now?
4. Do you use this chance?

5. What is the usual path for raising qualifications for Russian doctors?
6. For whom do you think it is easier their qualifications - men or women?
7. Do you take any courses for doctors? How often?
8. Do you have free time to attend such courses?
9. Why do you think there are fewer women than men in top positions within medicine?

Working Conditions

1. What do you like and dislike about your work?
2. Are you satisfied in your work?
3. How many hours a day do you work? How do you feel about this?
4. Do you work in any other jobs?
5. How would you characterise your relations with your colleagues?
6. How would you characterise your relations with other medical workers?
7. Do you think there is discrimination against women in medicine? Why and in what form?

Pay

1. Are you satisfied with your pay?
2. Why do you think doctors in Russia are low paid?
3. Do doctors receive presents from patients?
4. Are presents a form of payment for services?
5. Do you think the quality of care depends on presents or money from patients?
6. Have you received presents?

Changes in Health Care

1. Were there changes in your job during the years of Perestroika (1986-1991).

- in the organisation of work?
- in the provision of equipment and medicine?
- in pay?
- in the possibility to receive scientific information?
- in the possibility to raise qualifications?
-

2. Have there been any changes in your job after 1991?

- in the organisation of work?
- in the provision of equipment and medicine?
- in pay?
- in the possibility to receive scientific information?
- in the possibility to raise qualifications?

3. Has your attitude to your work changed in the last ten years?
4. Do you worry about unemployment?
5. Are there different opportunities for male and female doctors in the transition to the market?
6. What improvements would you like to see in your job?

Privatisation

1. Have you worked in a non-state medical institution?
2. Do you think the privatisation of medical institutions is necessary?
3. What is you attitude towards insurance medicine?
4. Do you think insurance medicine has changed relations between patients and doctors?

5. Do you agree with the possibility of allowing patients to choose their doctor?

Trade Union Organisation and Strikes

1. Have you participated in any strikes?
2. Do you think the trade union is an effective representative of your interests?
3. Do you know the name of your trade union representative in Voronezh
4. Do you think doctors should form a new professional organisation?

The Position of Women in Russia

1. What kind of problems do Russian women have?
2. What should the government do to solve these?
3. Do you think the law to protect women workers in effective?
4. What kind of role do you think doctors play in resolving women's problems?
5. Do you think doctors play a role in raising the birthrate?
6. Do you think doctors play a role in the protection of women from harmful or heavy types of work?
7. Why are many unemployed, women?
8. Do you think there is equality between men and women?

BIBLIOGRAPHY

Abramova, A. (1989) 'Zakonodatel'stvo o trude zhenshchin' *Sotsialisticheskii trud,* no.4.

Adamushkina, M. (1995) 'Domestic violence? There is no such problem', *Current Digest of the Post Soviet Press,* Vol 47. no.44, 18.

Adkins,L. and Lury, C. (1992) 'Gender and the labour market: old theory for new?' in H. Hinds, A. Phoenix and J Stacey (eds) *Working Out : New Directions for Women's Studies,* Flamer Press

Artamonova, L. (1996) 'All of society's ailments are reflected in the family : an interview with Galina Sillaste', *Russian Education and Society* , April, 30-4.

Artyukhov, I. (1985) 'Mediko-demograficheskie faktory dinamiki rozhdaemosti v Krasnoyarskom krae' , *Zdravookhranenie RSFSR,* no.8.

Aslund, A (1995) *How Russia Became a Market Economy,* Washington:Brookings Institute.

Attwood, L. (1996) 'The post-Soviet woman in the move to the market: a return to domesticity and dependence?', in R. Marsh(ed), *Women in Russia and the Ukraine,* Cambridge University Press.

Babaeva, L.V. and Chirkova, A .E. (1997), 'Women in Business', *Sociological Research,* January- February, 81-91.

Baiduzhy, A. (1994a) 'Demographic catastrophe has become a reality', *Current Digest of the Post Soviet Press,* Vol. 46, no5, 18-19.

_____(1994b) 'The people of Russia are getting sick and dying early' *Current Digest of the Post Soviet Press* , Vol. 46, no.28, 8.

Bailles, K. (1978) *Technology and Society under Lenin and Stalin: Origins of the Soviet Technical Intelligentsia 1917-41,* Princeton.

Bardina, G. (1987) 'Planirovanie sem'i i profilaktika abortov v Tatarskoi ASSR' *Zdravookhranenie RSFSR,* no.3

Barishev, V. (1988) 'Chem signalyat oranzhevie zhiletki?' *Rabotnitsa* no 8.

Barrett, M. (1980) *Women's Oppression Today,* Verso

______(1992) 'Words and things: materialism and method in contemporary feminist analysis' in M. Barrett and A. Philips (eds), *Destabilising Theory,* Polity.

Barron, R.D. and Norris, G.M. (1976) 'Sexual divisions and the dual labour market', in S. Allen and D. Leonard Barker (eds), *Dependence and Exploitation in Work and Marriage,* Longmans.

Baskina, A. (1994) 'Amerikanskiye zhenshchiny usilivayut bor'by protiv muzhchin, a nashi sdayut svoi positsii bez boya', *Izvestia* 7 September.

Bedny, M (1983) 'The illegitmate child', *Current Digest of the Soviet Press,* Vol.35, no.37,11.

Beechy, V. (1979) 'On patriarchy', *Feminist Review*, no. 3.

Bezgrebel'naya, I. and Kondrat'eva, O. (1995) ' Zhenskaya bezrabotitsa - novye aspekty', *Chelokek i Trud* no4, 11-12.

Bodorova, V. (1995), 'The Russian family in flux', *Transition*, Vol. 1, no.16, 10-11.

Boginya, D.P and Bon' A.V. (1988) 'Sovershenstvovanie struktury zhenskoi zanyatosti - vazhnii faktor rosta effektivnosti truda', in Morosov, G.V et al (eds) *Problemy Okhrany Truda i Zdorov'ya Zhenshchin Na Sovremenom Etape i Puti ikh Resheniya*, Ivanova.

Boldyreva, T (1989) 'You won't stop the revolutionary horse in its tracks', *Soviet Sociology*, Vol. 28, no.2, 102-118 .

Bowers, E. (1996) 'Gender stereotyping and the gender division of labour in Russia' in S. Clarke (ed), *Conflict and Change in the Russian Industrial Enterprise*, Edward Elgar.

Brenner, J. and Rammas, M. (1984), 'Rethinking Women's Oppression', *New Left Review* 144.

Bridger, S. (1987) *Women in the Soviet Countryside*, Cambridge University Press.

_______(1995) 'Women and homeworking: from protection to survival', in S. Bridger (ed) *Women in Post-Communist Russia*, INTERFACE, no.1 University of Bradford.

Bridger, S, Kay, R. and Pinnick, K (1996) *No More Heroines? Russia, Women and the Market*, London: Routledge .

Brzhevsky, V. (1973) 'Why the examiner isn't strict', *Current Digest of the Soviet Press,* Vol. 25, no.11.

Buckley, M. (1988) *Women and Soviet Ideology,* Harvester Wheatsheaf.

______(1990) 'Social policies and new social issues', in S. White, A. Pravda and Z. Gitelman, (eds) *Developments in Soviet Politics,* Macmillan.

Chapman, J. (1978) 'Equal pay for equal work?' in D. Attkinson, A Dallin and G. Lapidus (eds), *Women in Russia,* Harvester Press.

Chernyakhovskii, A. (1991) 'Chto sul'it strakhovaya meditsina' *Vrach* no3 7-9.

Chetvernikova, N.A. (1987) *Zhenskaya Sotsialno-Demograficheskaya Gruppa Kak Spetsificheskoe Proyavlenie Chelovecheskogo Faktora,* Kaliningrad.

Chikin, S. Ya. (1990) 'O merakh po uluchcniyu sotsial'noi zashchishchennosti meditsinskikh rabotnikov', *Zdravookhranenie RSFSR,* no 8.

Clarke, S, Fairbrother, P. Michael Burawoy and Krotov, P. (1993) *What About the Workers ?,* Verso.

Clarke,S. Fairbrother,P. Borisov,V. Bizyukov,P (1994) 'The Privatisation of Industrial Enterprises in Russia :Four Case Studies', *Europe Asia Studies,* Vol. 46 no.2

Cockburn, C. (1983), *Brothers: Male Dominance and Technological Change,* London: Pluto Press.

Connell, R.W (1987) *Gender and Power,* Polity Press.

Connor, W. (1986) 'Social policy under Gorbachev', *Problems of Communism,* July- August.

Corrigan, P. and Sayer, D. (1978) 'Hindess and Hirst : a critical review', *Socialist Register.*

Corrin, C. (1990) 'Women's liberation within socialist patriarchy' *Slovo,* vol. 3 no.2.

_______(1992) *Superwoman and the Double Burden,* Scarlet Press.

Cox, T (1996) *From Perestroika to Privatisation* , Aldershot: Avebury.

Criag, C. et al (1982) *Labour Market Structure, Industrial Organisation and Low Pay, University of Cambridge,* Dept of Applied Economics, Occasional Paper no.54, Cambridge University Press.

Crompton, R. and Sanderson, K. (1990) *Gender and Social Change,* London: Unwin Hyman.

Curtis, S, Petukhova, N. and Taket, A. (1995) 'Health care reforms in Russia: the example of St Petersburg', *Social Science and Medicine,* Vol.40, no.6, 755-765.

Curtiss, J. (1966) 'Russian Sisters of Mercy in the Crimea 1854-5' *Slavic Review,* no.25 , 84-100

Dakin, M. I. (1995) 'Women and employment policy in contemporary Russia' *Demokratizatsiya,* Summer.

Davin, D. (1992) 'Population Policy and Reform: the Soviet Union, Eastern Europe and China' in S. Rai, H. Pilkington and A. Phizacklea (eds) *Women in the Face of Change,* Routledge.

Davis, C. (1983) 'The economics of the Soviet health system' in *Soviet Economy in the 1980s: Probems and Prospects Part 2,* Washington: U.S. Government Printing Office.

______(1990) 'The high priority military sector in a shortatge economy', in H. Rowen and C. Wolf Jr. (eds) *The Impoverished Superpower: Perestroika and the Soviet Military Burden,* ICS Press.

Dekov, V (1988) 'Nevesty s pridanym', *Rabotnitsa* no. 11.

Delphy, C. (1993) 'Rethinking sex and gender', *Women's Studies International Forum,* Vol. 116, no.1.

Dewar, M. (1956) *Labour Policy in the USSR,* Oxford University Press

Doeringer, P and Piore M (1971) *Internal Labour Markets and Manpower Analysis,* Mass: Lexington Books.

Du Plessix Gray, F. (1991) *Soviet Women Walking the Tightrope,* London: Virago Press

Edholm, F, et al (1977) 'Conceptualising women', *Critique of Anthropology,* no. 3 .

Einhorn, B (1992) *Cinderella Goes to Market*, Verso.

Elston, M.A. (1993) 'Women doctors in a changing profession: the case of Britain', in E. Riska and K. Wegar (eds) *Gender, Work and Medicine: Women and the Medical Division of Labour,* Sage.

Engel, B (1994) *Between the Field and the City,* Cambridge University Press

Engels, F. (1985) *The Origin of the Family Private Property and the State,* Penguin.

Entwisle, B. and Kozyreva, P. (1997) 'New estimates of induced abortion in Russia', *Studies in Family Planning,* Vol. 28, no.1, 14-23.

Field, M.G. (1957) *Doctor and the Patient in Soviet Russia,* Harvard University Press.

_______(1975) 'American and Soviet medical manpower: growth and evolution 1910-1970', *International Journal of Health Services.* Vol. 5, No. 3, 455-474.

_______(1994) 'Postcommunist medicine: morbidity, mortality and the deteriorating health situation', in James R. Miller and Sharon L. Wolchik, *The Social Legacy of Communism,* Cambridge University Press 1994.

Filtzer, D. (1992) *Soviet Workers and De-Stalinisation,* Cambridge University Press.

_______(1994) *Soviet Workers and the Collapse of Perestroika,* Cambridge University Press.

Fitzpatrick, S (1979) *Education and Social Mobility in the Soviet Union 1921-34,* Cambridge University Press.

Fraser, N. and Nicholson, L. (1992) 'Social criticism without philosophy: an encounter between feminism and post modernism', in L. Nicholson *Feminism/Post Modernism,* Routledge.

Frieden, N. (1981) *Russian Physicians in an Era of Reform and Revolution,* Princeton.

Friedson, E (1984) 'The changing nature of professional control', *Annual Review of Sociology,* 10: 1-20.

Frolov, D. (1994) 'Bureaucrats show concern for multiplying the nation', *Current Digest of the Post Soviet Press,* Vol.46, no.10, 16.

Funk, N. (1993) 'Feminism east and west', in N.Funk and M. Mueller (eds), *Gender Politics and Post Communism,* New York: Routledge.

Fyodorova, M. (1987) 'Factory-Sealed Defective Goods', *Current Digest of the Soviet Press* Vol. 39, no.10, 22.

Galayeva, A. (1987) 'The physician on the threshold of the third millenium', *Current Digest of the Soviet Press,* Vol.39, no.19, 1-4, from Literaturnaia Gazeta 29/4/87.

Game, A. and Pringle, R (1983) *Gender at Work,* George Allen and Unwin.

Gerchikov, V.I. (1990) 'The human factor and industrial democracy', *Soviet Sociology*, Vol.29, no.2, 41-62.

Giddens, A. (1984) *The Constitution of Society,* Polity Press.

Glickman, R. (1984) *Russian Factory Women: Workplace and Society 1880-1914,* Berkeley: California University Press.

Gogol,N and Mosin,I (1989) 'Burn trauma: epilogue to a tragedy', *Current Digest of the Soviet Press* Vol.41, no.26, 16.

Goldman, W. (1993) *Women the state and revolution : Soviet family policy and social life 1917-36,* Cambridge University Press.

Golovisnin, M. (1996) 'Dlya chevo nuzhen strakhovoi polis?' *Argumenty i Fakty,* no.13.

Gorbachev, M. (1987) *Perestroika,* Fontana

Goskomstat USSR (1990) *Demographicheskii Yezhegodnik SSSR,* Moscow.

Gracheva, A.G. (1989) 'Okhrana zdorov'ya zhenshchiny-materi - prioritetnaya zadacha Zdravookhraneniia Rossiiskoi Federatsii' *Zdravookhranenie RSFSR,* no. 3, 3-6.

Granovetter, M. (1985) 'Economic action and social structure; the problem of embededness', *The American Journal of Sociology,* vol.91, no.3, 481-510.

Griffin, F. (1968) 'The prohibition of night work for women and young persons : the Russian Factory Law of June 3 1885', *Canadian Slavic Studies,* no. 2.

Grigorev, S. (1985) 'Demograficheskoe povedenie v sem'yakh vrachei', in *Zdorov'e i Organizatsiya Meditsinskoi Pomoshchi Naseleniyu Zapadno-Sibirskogo Territorial'no Proizvodstvennogo Kompleksa v Svete Reshenii XXII S'ezda KPSS,* Tomsk.

Grigoryan, G. (1986) *Sfera Uslug i ego Rol' v Vosproizvodstve Rabochei Sily,* Dissertation Abstract, Yerevan.

Grishin, V.(1991) 'Meditsinskie kooperativy: mnenie patsientov i ekspertov' *Vrach,* no4 .

Gruzdeva,E.V and Chertikhina, E.S (1987) 'The Occupational Status and Wages of Women in the USSR' *Soviet Sociology* Winter 1987/8

Guseinov, G. and Korchagin, V. (1971) 'Voprosy trudovykh resursov', *Voprosy Ekonomiki* no.2, 45-51 .

Gvin, L (1981) 'Is induced abortion murder by experts?' *Current Digest of the Soviet Press',* Vol. 33, no.5, 11.

Hakim, C. (1991) 'Grateful slaves and self-made women: fact and fantasy in women's work orientations', *European Sociological Review,* vol.7, no.2, 101-121.

Hartmann, H. (1981) 'The unhappy marriage of Marxism and feminism : towards a more progressive union' in L. Sargent (ed) *Women and Revolution : The Unhappy Marriage of Marxism and Feminism,* London: Pluto Press.

Haug, F. (1991) 'The end of socialism in Europe: a new challenge for socialist feminism', *Feminist Review* 39.

Hearst, D. (1994) 'Trouble looms in Red Manchester',*Guardian* 25 July, 7.

Helgeson, A. (1982) 'Demographic policy' in A. Brown and M. Kaser *Soviet Policy for the 1980s* , London: Macmillan.

Heitlinger, A. (1979) *Women and State Socialism,* Macmillan.

__________(1991) 'Hierarchy of status and prestige within the medical profession in Czechoslovakia' in A. Jones (ed), *Professions and the State,* Philadelphia: Temple University Press.

Humphries, J. and Rubery, J. (1984) 'The reconstitution of the supply side of the labour market: the relative autonomy of social reproduction', *Cambridge Journal of Economics* 331-46.

Hyer, J. (1996) 'Managing the female organism: doctors and the medicalisation of women's paid work in Soviet Russia during the 1920s', in R. Marsh *Women in Russia and the Ukraine* , Cambridge University Press.

Ilic, M. (1995) 'Equal rights with restrictions: women, work and protective legislation in Russia', in S. Bridger (ed) ,*Women in Post Communist Russia,* INTERFACE, no. 1 University of Bradford.

Ivanov, S.A. (1989) *Problemy Ravnopraviya Zhenshchiny i Muzhchiny v Sotsial'nom Obespechenie v SSSR,* Moscow.

Ivchenko, L. (1986) 'Fee charging clinics -pro and con', *Current Digest of the Soviet Press,* Vol. 38, no.28, 7-8.

Johanson, C. (1979) 'Autocratic politics, public opinion and women's medical education during the reign of Alexander II, 1855-1881' *Slavic Review,* Vol. 38, no. 3, 426-443.

Joy, L. (1995) 'Who owns the means of reproduction?' in S. Bridger (ed) *Women in Post Communist Russia,* Bradford INTERFACE no. 1.

Jung, N. (1994) 'Eastern European Women with Western Eyes', in G. Griffin, M. Hester, S. Rai, S. Roseneil (eds), *Stirring It : Challenges for Feminism,* Taylor and Francis.

Kadzhaya, V (1977) 'When there is no child in the family', *Current Digest of the Soviet Press,* Vol. 29, no.37, 1.

Kalchenko, E. (1990) 'Chelovecheskii faktor zdorov'ya', *Vrachebnoe Delo,* no. 9.

Kamalov, M. (1986) 'Rol' zdravookhraneniya v osushchestvlenii demograficheskoi politiki', *Zdravookhranenie RSFSR,* no.2 ,7-10.

Karyakina, I. (1991) 'Okh, idu na rynok', *Rabotnitsa,* no.9, 22-3.

Kharchev, A.G (1986) 'Issledovania sem'i na poroge novogo etapa' *Sotsiologicheskie Issledovaniya,* no.3.

Khotkina, Z (1994) 'Women in the labour market, yesterday, today and tomorrow', in A. Posadskaya (ed) *Women in Russia,* Verso.

Kiseleva, G. (1982) 'The position of women and demographic policy', in G. Lapidus *Women, Work and the Family in the Soviet Union.,* London: M.E. Sharpe.

Kligman, G. (1994) 'The social legacy of communism: women, children and the feminization of poverty', in James R. Miller and Sharon L. Wolchik (eds), *The Social Legacy of Communism,* Cambridge University Press .

Klyueva, S.K. (1986) 'Sem'ya kak ob'ekt meditsinskogo nablyudeniya', *Zdravookhranenie RSFSR,* no. 1, 18-20.

Knaus, W. (1981) *Inside Russian Medicine,* Everest House Publishers.

Kobyashchkaya, E. (1997) 'Sotsial'nye problemy tekstil'noi promishlennosti Rossii na etape ekonomicheskikh reform 1991-6', *Sotsiologicheskie Issledovaniya,* no.3., 68-73.

Komissiya Po Meditsinskoi Demografii Minzdrav RSFSR (1986) 'V problemnoi komissii', *Zdravookhranenie RSFSR,* no.9

Koregin, A. (1985) *Sotsial'no-politicheskie Aspekty Problemy Narodononaseleniya v Razvitom Sotsialisticheskom Obshchestve,* Kiev.

Korolev, Yu. (1978) *Brak i Razvod: Sovremennye Tendentsii,* Moscow.

Kosarev, I and Vladimirtsev, V. (1992) 'Chto stoit za ponyatiem 'sem'einyi vrach', *Vrach* no.7, 32-5.

Kostakov, V (1986) 'One person must work like seven', *Current Digest of the Soviet Press,* Vol. 38, no.1, 1.

Kostygova, T. (1991) 'Reshaites -ne raskaetes', *Krest'yanka,* no.8, 10-11.

Kotliar, A. and Shlemin, A. (1974) "Problemy ratsional'noi zaniatosti zhenshchin', *Sotsialisticheskii trud,* no.7.

Kransinets, E. (1988) 'Sovershenstvovanie zanyatosti zhenshchin na sovremenom etape', in Morosov, G.V et al (eds) *Problemy Okhrany Truda i Zdorov'ya Zhenshchin Na Sovremennom Etape i Puti ikh Resheniya,* Ivanovo.

Kulakov, V (1987) 'Unattended child?' *Current Digest of the Soviet Press,* Vol.39, no.32, 23.

Kulesh, L. (1995) 'What does it cost to get sick?', *Current Digest of the Post Soviet Press,* Vol.47, no.37, 23.

Kurasov,V. (1981) 'Medical certificate for a bribe', *Current Digest of the Soviet Press,* Vol. 33, no.48, 21.

Lane, C (1993) 'Gender and the labour market in Europe: Britain, Germany and France compared', *The Sociological Review,* vol. 41, no.2, 274-301.

Lapidus, G. (1978) *Women in Soviet Society,* Berkeley: California University Press.

Laputina, O. (1988) 'Nepolnii rabochii den', *Rabotnitsa* , no.11.

________(1990a) 'Underground women come into the open' *Soviet Weekly,* 18 October.

______(1990b) 'Skol'ko stoit nasha zhizn?', *Rabotnitsa* no. 7.

Lazreg, M. (1988) 'Feminism and difference : the perils of writing as a woman on women in Algeria', *Feminist Studies* Vol. 14 no.1.

Lenin, V.I (1965) *On the Emancipation of Women,* Moscow: Progress.

Levina, A. (1988) 'Tysiacha i odna noch' *Rabotnitsa* no 4

____(1992), 'Yarmarka Vakansii', *Rabotnitsa,* no.2, 10-11.

____(1993) 'Kakogo razryada vasha zarplata? ', *Rabotnitsa* , no.1, 10.

____(1994) 'Vash novyi zashchitnik postrudinspektsiya', *Rabotnitsa,* no.10, 5.

Lipovskaya, O. (1994) 'Sisters or Stepsisters' , *Women's Studies International Forum,* Vol. 17 nos. 2-3.

Lissyutkina, L (1993) 'Soviet Women at the Crossroads of Perestroika', in N. Funk and M. Mueller (eds) (1993) , *Gender and Politics in Post Communism,* Routledge.

Lobanova, O. (1993) 'Oborotnaya storona lyubvi' *My,* August.

Losoto, E (1980) 'Once again about a second child', *Current Digest of the Soviet Press,* Vol.32, no.6, 9.

Lupandin, V. (1980) 'Alcoholism and Offspring', *Current Digest of the Soviet Press,* Vol.32, no.6, 5.

Lyuka, G. (1992) 'Russian Authorities Decide to Concern Themselves with Children and Parents', *Nezavisimaya Gazeta,* 5 June, 6.

McAndrew, M. (1985) 'Soviet Women's Magazines' in B. Holland (ed) *Soviet Sisterhood*, Fourth Estate.

McAuley, A. (1981) *Women's Work and Wages in the Soviet Union,* London: George Allen and Unwin.

McIntosh, M. (1981) 'The sexual division of labour and the subordination of women', in K. Young, C. Wolkowitz and R McCullagh (eds), *Of Marriage and the Market : Women's Subordination in International Perspective,* London: CSE Books.

McKinlay, J. and Stoeckle, J (1988) 'Corporatization and the social transformation of doctoring', *International Journal of Health Services,* 18: 191-205.

Manerova, O. (1993) 'Kharakteristika vrachebnikh kadrov Tulskoi Oblasti' *Zdravookhranenie RSFSR,* no. 1.

Martin, S. (1993) 'The women have their work cut out for them', *Irish Times*, 15 February, 7.

Maslova, N.I. and Novikova, Ye. (1991) 'Zhenskii vopros v svete perestroiki', in *Zhenskii Vopros: Tochki Zreniya i Podkhody k Novomu Myshleniyu,* Moscow: AON.

Medkov, M. (1991) 'Intensifikatsiya obshchestvennogo proizvodstva i vosproizvodstvo naseleniya', in Steshenko (ed) (1991) *Demograficheskie Problemy Sotsialisticheskogo Obshchestva,* Moscow.

Medvedskii, Ye. (1990) 'Studencheskie orientiri v vyborye vrachebnoi spetsial'nosti' *Sovetskoe Zdravookhranenie,* no.11.

Melikyan, G. (1997) 'Sil'naya sotsial'naya politika nachinaetsya s proizvoditel'nogo truda', *Chelovek i Trud* no. 3, 4-9.

Mezentseva, Ye. (1994) 'What Does the Future Hold? (Some thoughts on the prospects of women's employment) in A. Posadskaya (ed) *Women in Russia,* London:Verso.

Mezentseva, Ye. and Rimashevskaya, N. (1990) 'The Soviet country profile: health of the USSR population in the 1970s and 1980s - an approach to a comprehensive analysis', *Social Science and Medicine* , Vol. 31, no.8, 867-77.

Miles, R. (1989) *Racism,* Routledge.

Mincer, J. and Polachek, S. (1974) Family investments in human capital: earnings of women', *Journal of Political Economy,* Vol. 82, no.2, 76-108.

Mitchell, J. (1983) 'Case and Situation Analysis', *Sociological Review,* Vol 31, 187-211.

Molyneux, M. (1981) 'Women in Socialist Societies', in K. Young, C. Wolkowitz and R McCullagh (eds), *Of Marriage and the Market : Women's Subordination in International Perspective*, London: CSE Books.

Monousova, G. (1996) 'Gender differentiations and industrial relations', in Simon Clarke (ed), *Conflict and Change in the Russian Industrial Enterprise*, Edward Elgar.

Morvant, P. (1995) 'Bearing the double burden', *Transition* Vol. 1, no.16, 4-9.

________(1996) ' The changing face of poverty' *Transition* Vol.2, no. 1, 56-61.

Morvant, P. and Rutland, P. (1996) 'Russian workers face the market',*Transition*, Vol.2, no.13, 6-11.

______ (1997) 'A society under strain', *Transition* Vol. 3 no 2, 76-77.

Moses, J.C. (1978) *The Politics of Female Labour in the Soviet Union*, Western Societies Occasional Paper No. 10, Cornell University.

Moskoff, W. (1994) 'Unemployment in the Former Soviet Union' in James, R. Millar and Sharon, L. Wolchik (eds), *The Social Legacy of Communism*, Cambridge University Press.

Moss, P. (1994) 'Spatially different conceptions of gender in the workplace', *Studies in Political Economy*, 43, 79-116.

Myrdal, A. and Klein, V. (1956) *Women's Two Roles*, Routledge & Kegan Paul.

Nauchno-Prakticheskaya Konferentsiya Po Problemam Ukrepleniya Sem'i i Okhrany Zdorov'ya Naselenia, Rostov-on-Don, *Zdravookhranenie RSFSR* 1985 no 2 ,42-4..

Navarro, V. (1977) *Social Security and Medicine in the USSR,* Lexington Books.

Nicholson, L. (ed) (1992), *Feminism/Post Modernism,* Routledge.

Nikonchik, O. (1959) 'Problema kontratseptsii i organisatsiya bor'bi s abortami v SSSR', *Akusherstvo i Ginekologiya* , no.6 .

Novak, L, Vladimirtsyev, V, Yermolaev, K. and Vorob'eva,N. (1992), 'Sem'einyi vrach', *Vrach* no.2, 41-2.

Novikova, E, Yazykova, V and Iankova, Z. (1978) 'Women's work and family' in G. Lapidus, *Women Work and Family in the Soviet Union,* London:M.E. Sharpe.

Novikova, E and Kutyrev, B. (1978) 'Kolichestvo i kachestvo truda' *Ekonomika i organisatsiya promyshlennogo proizvodstva,* no. 3.

Os'minina, N. (1990) 'Ona s nozhom i bez kol'chugi', *Rabotnitsa* no.5, 4-7.

O'Reilly, J (1996) 'Theoretical Considerations in Cross-National Employment Research', *Sociological Research Online,* vol.1, no.1.

Ovanesov, A. (1994) 'Sem'einyi vrach: opyt dvukh let raboty',*Vrach,* no.10, 39-40.

Paikin, A. and Salina, G. (1978) 'Uchastkovyi vrach', *Literaturnaya Gazeta* 29 November, 11.

Pankova, M. (1993) 'Women are people too', *Current Digest of the Post Soviet Press,* Vol.45, no.10, 23.

Peers, J. (1985) 'Soviet women and the demographic crisis', in B. Holland (ed) *Soviet Sisterhood,* Fourth Estate.

Pereskok, A. (1986) 'O reservakh smeshenia zabolevaemosti s vremennoi utratoi trudosposobnosti' *Zdravookhranenie RSFSR,* no. 2, 39-40.

Petrakov, A. (1986) 'O probleme vnebrachebnoi rozhdaemosti' *Zdravookhranenie RSFSR,* no.12, 14-17.

Phillips, A. and Taylor, B. (1980) 'Sex and skill', *Feminist Review* 6.

Pilkington, H (1992) 'Russia and the Former Soviet Republics', in C. Corrin (ed), *Superwomen and the Double Burden,* Scarlet Press.

Plotnikov, E. (1994) 'Zhenshchina-Pedagog na rabote i doma' in I. Novikova (ed) *Zanyatost Zhenshchin Sevodnya i Zavtra.* Perm.

Podshibyakina, N. (1993) 'Ustanovka na povyshenie konkurentosposobnosti, *Chelovek i Trud,* no.6, 11-14.

Polchanova, S. (1984) 'Present day anti-abortion propaganda', *Current Digest of the Soviet Press,* Vol. 36, no.45, 18.

Popov, A. (1988) 'Kogda vybora nyet', *Ogonyok* no.33.

______(1993) 'A short history of abortion and population policy in Russia', *Planned Parenthood in Europe,* Vol. 22, no.2, 23-25.

Posadskaya, A. (1994a) 'A feminist critique of policy, legislation and social consciousness in Post-Socialist Russia', in A. Posadskaya (ed), *Women in Russia,* Verso 1994.

________(1994b) 'Self portrait of a Russian feminist' in A Posadskaya (ed), *Women In Russia,* London: Verso.

Powell, D. (1992) 'The entrepreneurial spirit and soviet medicine', in B. Dallags, G. Ajan and B. Grancelli (eds),*Privatisation and Entrepreneurship in Post Socialist Countries,* Macmillan.

Presidential Commission for Questions on Women, the Family and Demography (1995) 'Sem'ya kak osnova obshchestvennoi stabil'nosti, mira i progressa' *Chelovek i Trud,* no.3, 48- 53.

Raletskii, V. (1993) 'Demograficheskaya situatsiya i zanyatost'', *Chelovek i Trud* no.7, 58-60.

Relman, A (1980) 'The new medical-industrial complex', *New England Journal of Medicine,* 303: 963-70.

Remennik, L. (1987) 'Mediko-demograficheskaya otsenka gormonal'noi kontratseptii', *Zdravookhranenie RSFSR,* no.12, 23-8.

Reskin, B. and Ros, P. (1990) *Job Queues, Gender Queues,* Philadelphia: Temple University Press

Rimashevskaya, N. (1991) *Zhenshchiny v Obshchestve: Realii, Problemy, Prognozy,* Moscow.

_________(1992) 'Changes in Social Policy and Labour Legislation', *Sociological Review,* Vol. 31, no.5.

Riska, E. and Wegar, K. (1993) *Gender Work and Medicine,* SAGE.

Rogovin, V. (1989) 'Social justice and the socialist distribution of vital goods', in M. Yanowitch (ed) *New Directions in Soviet Social Thought,* New York: M.E. Sharpe Inc.

Romashchenko, A. (1986) 'Zadacha organov zdravookhraneniya i meditsinskoi nauki po sokhraneniyu i vosproisvodstvu trudovykh resursov', *Sovetskoe Zdravookhranenie,* no4 , 7-14.

Romashova, T.I. (1990) 'Otsenka meditsinskimi rabotnikami rezhima ikh trudovoi deyatel'nosti' in *Sotsiologia v Meditsine,* Moskva 1990.

Roseneil, S. (1995) 'The coming of age of feminist sociology: some issues of practice and theory for the next twenty years', *British Journal of Sociology,* Vol. 46 no.2.

Roshin, S. (1995), 'Diskriminatsiya i ravenstvo vozmozhnostei na rynke truda', *Chelovek i Trud* no.4.

Roshin, S and Roshina, Ya. (1994) 'Muzhchiny i zhenshchiny i predprenimatel'stvo', *Chelovek i Trud,* no.12, 109-15.

Rubery, J (1978) 'Structured labour markets, workers organisation and low pay', *Cambridge Journal of Economics,* 2.

Rubery, J (ed) (1988) *Women and Recession: a comparative perspective,* Routledge, Kegan Paul.

Rubery, J. and Fagan, C. (1995) 'Gender segregation in societal context', *Work, Employment and Society,* vol.9, no.2 213-40.

Russia's White Book : the State Report on the Health of the Population of the Russian Federation in 1991,(1994), *Sociological Research,* July-August 84-96.

Ryan, M (1978) *The Organisation of Soviet Health Care,* Basil Blackwell.

______(1989) *Doctors and the State in the Soviet Union,* Macmillan.

Rzhanitsina, L. (1993) 'Rabota ne vsegda khorosho no neobkhodima', *Chelovek i Trud,* no.6, 15-18.

Sacks, M.P. (1976) *Women's Work in Soviet Russia: Continuity in the Midst of Change,* Praeger.

Saninkov, A, Lipkunskaia, V and Solovtsov, A (1987) 'Nekotorye voprosy izucheniya mneniya zhenshchin ob abortakh' *Zdravookhranenie RSFSR,* no.3 23-4.

Seecombe, W. (1988) 'Marxism and demography' *New Left Review,* 137.

Schecter, K. (1992) *Professionals in Post-Revolutionary Regimes: a Case Study of Soviet Doctors,* PhD Dissertation, Arts and Sciences, Columbia University.

Schlesinger, R. (1949) *Changing attitudes in Soviet Russia : the family in the USSR,* Routledge.

Shapvalov, K. (1987) 'Travmatism sredi sanitykh na vodnom transporte', *Zdravookhranenie RSFSR,* no.2.

Sheptulina, N. (1982) 'Protection of female labour' in G. Lapidus, *Women, Work and Family in the Soviet Union,* Berkeley: California University Press.

Sherman, S and Webb, (1988) *Qualitative Research in Education: Focus and Methods,* London: Falmer Press.

Shinelova, D (1989) 'Nuzhna gosudarstvennaya programma resheniya zhenskogo voprosa', *Sotsialisticheskii Trud,* no. 8.

Shishkan, N.M (1976) *Trud Zhenshchin v Usloviyakh Razvitogo Sotsializma,* Kishinev.

Shreeves, R. (1990) 'Sexual Revolution or Sexploitation', *Radio Liberty Report on the USSR,* Vol . 2, no. 31

________(1992) 'Sexual revolution or sexploitation', in S. Rai, H. Pilkington and A. Phizacklea (eds) *Women in the Face of Change,* Routledge.

Shteingardt, Yu. (1987) 'A time for changes for the higher school:where bad doctors come from', *Current Digest of the Soviet Press,* Vol. 39. no.3, 18.

Sigerist, H. (1937) *Socialised Medicine in the Soviet Union* London : Victor Gollancz .

Sillaste, G. (1994), 'Conversion- the sociogender aspect',*Sociological Research,* September/October, 50-64.

________ (1995) ' Evolyutsiya sotsial'nikh pozitsii zhenshchin v menyayushehemsya Rossiiskom obshchestve', *Sotsiologicheskie Issledovaniya* no.4, 58-65.

Smirnov, V. (1987) 'Don't settle for half measures', *Current Digest of the Soviet Press,* Vol.39, no.35, 26.

Smith, D. (1983) 'Women class and family', *The Socialist Register.*

Sonin, I.A. (1982) 'Socio-economic problems of female employment', in G. Lapidus (ed) *Women, Work and Family in the Soviet Union,* London: M.E. Sharpe.

Sorokin, A.I (1983) 'Developed socialism's armed forces', *Current Digest of the Soviet Press,* Vol. 35, no.46, 13.

Starr, P (1982) *The Social Transformation of American Medicine,* New York: Basic Books.

Steshenko, V.S. (1991) (ed) *Demograficheskie Problemy Sotsialisticheskogo Obshchestva,* Moscow.

Stites, R. (1990) *The Women's Liberation Movement in Russia :Feminism, Nihilism and Bolshevism 1860-1930.* Princeton.

Storey, P. (1971) 'Continuing medical education in the Soviet Union', *New England Journal of Medicine,* vol. 285, no.8, 437-442.

Strokin, S. (1994) 'The Myth of Medical Insurance', *Moscow News*, no.37, September 16th.

Strukova, L.G. (1990) *Trud, Sem'ia Byt Sovetskoi Zhenshchiny* Moscow

Sukhov, S. B. (1989) 'Tleivshchii koster ili na chto zhaleites doktor?' *Meditsinskaya Gazeta,* 15 September.

Tatarnikov, M. (1991) 'Sotsial'no psikhologicheskie aspekty vnedreniya novykh uslovii khozyaistvovaniya v uchrezhdeniyakh zdravookhraneniya', *Zdravookhranenie RSFSR,* no.3.

Tilly, L. and Scott, J. (1978) *Women Work and Family,* New York: Holt, Reinhart and Winston.

Timashova, N. (1995) 'Authorities decide to make maternity safe', *Current Digest of the Post Soviet Press,* Vol. 47, no.38, 18-19.

Tkachenko, A. (1995) 'Otsenka situatsii kontseptiya i prognoz demograficheskogo razvitiya', *Chelovek i Trud* no.5, 52-7.

Trinko R.I. (1986) *Reproduktivnaya i vospitatel'naya rol' sem'i.* Lvov.

Tsaregorodtsev, G. (1976) 'Health is social property', *Current Digest of the Soviet Press,* Vol. 28, no.34, 10.

Tsaregorodtsev, G. and Izutkin, A. (1982) 'Socio-cultural functions of contemporary medicine', *Soviet Sociology,* Summer, 41-65.

Tutorskaya, S. (1994) 'Neither mothers nor children are getting close attention from Russia's Ministry of Public Health', *Current Digest of the Post Soviet Press,* Vol 46, no.49, 20-1.

Uglov, F (1981) 'The all-powerful cigarette- the battle with it isn't simple but is imperative for the sake of everyone's health', *Current Digest of the Soviet Press,* Vol. 33, no. 7, 13.

Urlanis, B (1980) 'A wanted child', *Current Digest of the Soviet Press,* Vol.32. no.49, 10.

Vaganov, H. (1990) 'Ob osnovnikh strategicheskikh napravleniyakh okhrany materinstva i detstva v RSFSR', *Zdravookhranenie RSFSR,* no. 6, 3-7.

Varoli, J.D (1996) 'There are more 'new poor' than 'new Russians', *Transition* Vol 2 no 20, 6-11.

Vasilkova, Ye. (1995) 'What is our life coming to?' *Current Digest of the Post Soviet Press,* Vol 47, no. 24, 20.

Vasilyeva, L. (1989) 'First signs of officialdom- post congress reflections on women's role in society', *Current Digest of the Soviet Press,* Vol 41, no.25, 33-4.

Virkunin, T. (1996) 'Strasti po abortu' *Argumenty i Fakty* no 9.

Vogel, L. (1995) *Women Questions:Essays for a Materialist Feminist,* Pluto Press.

Volgina, V and Frolova, O. (1994) 'Problemy Planirovaniya Sem'i', *Vrach,* no.8, 29-30.

Volkov, I.M. et al (1992) 'Sostoyanie i perspektivy razvitiya sotsial'no-pravovoi pomoshchi v okhrane materinstva i detstva', *Zdravookhranenie RSFSR,* no.9.

Walby, S. (1986) *Patriarchy at Work,* Polity

_______(1990) *Theorising Patriarchy,* Blackwell.

_______(1992) 'Post-post modernism? Theorising social complexity', in M Barrett and A. Phillips (eds) *Destabilising Theory.*

Waters, E. (1993) 'Finding a voice: the emergence of a women's movement', in N. Funk and M. Mueller (eds) *Gender in Post-Communism,* Routledge.

Wilkinson, F (ed) (1981) *The Dynamics of Labour Market Segmentation,* Academic Press.

Witz, A (1992) *Professions and Patriarchy,* Routledge.

Yurval Davis, N (1996) 'Women and the biological reproduction of the nation', *Women's Studies International Forum,* Vol. 19 no.1/2, 17-24.

Zangieva, T.D. et al (1989) 'K voprosu profilaktiki aborta sredi molodozhenov', *Zdravookhranenie RSFSR,* no.1, 33-5.

Zaslavskaya, T. (1989) 'Social justice and the human factor in economic development' in M. Yanowitch (ed) *New Directions in Soviet Social Thought,* New York: M.E. Sharpe Inc.

Zguta, R. (1978) *'Witchcraft and Medicine in Pre-Petrine Russia' Russian Review,'* Vol. 37, 438-448.

Zotov, Yu (1988) 'Attestatsiya i ratsionalizatsiya rabochikh mest v zdravookhranenii', in *Novye Formy Raboty Lechebno-Profilakticheskikh Uchrezhdenii, Volume I,* Klaipeda.